This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at CareSource.com/marketplace or by calling 1-877-806-9284.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$6,650 individual/$13,300 family per benefit year. Deductible does not apply to copayments, physician home and office services for primary care, physician home and office services for specialty care, prescription drugs, preventive health services, urgent care services, and vision services – pediatric.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st.) See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $6,850 individual/$13,700 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see CareSource.com/marketplace or call 1-877-806-9284.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs for covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services.

Questions: Call 1-877-806-9284 or visit us at CareSource.com/marketplace.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at CareSource.com/marketplace or call 1-877-806-9284 to request a copy.

IN-EXCM-0376

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35/visit	Not covered.	No deductible. You only pay the copay.
	Specialist visit	$75/visit	Not covered.	Plan covers 100% of allowed amount in excess of the copayment. Copayment waived when the only charge is for allergy injections/serum. If you receive services in addition to office visits, additional copayments, deductibles, or coinsurance may apply.
	Other practitioner office visit	40% coinsurance after deductible	Not covered.	Manipulation therapy - 12 visits per benefit period.
	Preventive care/screening/immunization	$0/visit	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $100 copay after deductible Lab: 40% coinsurance after deductible	Not covered.	--none--

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	$200/procedure after deductible	Not covered.	Prior authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at CareSource.com/marketplace	Generic drugs	Retail: $25 copay Mail-Order: $62.50 copay	Not covered.	Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply. There is no deductible for prescription drug coverage. You only pay the copayment/coinsurance.
	Preferred brand drugs	Retail: $100 copay Mail-Order: $250 copay	Not covered.	Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply.
	Non-preferred brand drugs	Retail: $250 copay Mail-Order: $625 copay	Not covered.	Retail: Up to a 31-day supply. Mail-Order: Up to a 90-day supply. Certain drugs may require a prior authorization. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Specialty drugs	Retail: 40% coinsurance Mail-Order: 40% coinsurance	Not covered.	Retail: Up to $300 and up to a 31 day supply. Mail-Order: Up to $300 and up to a 90 day supply.
	Specialty drugs non-preferred	Retail: 50% coinsurance Mail-Order: 50% coinsurance	Not covered.	Retail: Up to $300 and up to a 31 day supply. Mail-Order: Up to $300 and up to a 90 day supply.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	40% coinsurance after deductible	Not covered.	Prior authorization required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
surgery	Physician/surgeon fees	40% coinsurance after deductible	Not covered.	--none--
If you need immediate medical attention	Emergency room services	$500 copay after deductible	$500 copay after deductible	Copayment waived if you are admitted to the hospital directly from the Emergency Department.
	Emergency medical transportation	40% coinsurance after deductible	40% coinsurance after deductible	--none--
	Urgent care	$100/visit	Not covered.	If you receive services in addition to urgent care, additional copayments, deductibles, or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 per day for days 1-5, $0 per day for days 6-100	Not covered.	Prior authorization required.
	Physician/surgeon fee	40% coinsurance after deductible	Not covered.	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$35/visit for office visits and 40% coinsurance after deductible for other outpatient services	Not covered.	Prior authorization required for all inpatient stays, partial hospitalization programs, and intensive outpatient services.
	Mental/behavioral health inpatient services	$250 per day for days 1-5, $0 per day for days 6-100	Not covered.	
	Substance use disorder outpatient services	$35/visit for office visits and 40% coinsurance after deductible for other outpatient services	Not covered.	
	Substance use disorder inpatient services	$250 per day for days 1-5, $0 per day for days 6-100	Not covered.	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$75/visit	Not covered.	Copayment covers initial physician visit and all subsequent prenatal visits, postnatal visits, and physician delivery charges covered under the Global Maternity Fee. Additional copayments, deductibles, or coinsurance may apply depending on services rendered in addition to the Global Maternity Fee.
	Delivery and all inpatient services	$250 per day for days 1-5, $0 per day for days 6-100	Not covered.	Your cost for inpatient services only. See above for physician delivery charges.
If you need help recovering or have other special health needs	Home health care	40% coinsurance after deductible	Not covered.	100 combined visits per benefit year.
	Autism Occupational therapy Speech therapy Behavioral therapy	 $35/visit 40% coinsurance after deductible $35/visit	Not covered.	 20 visits per benefit period. 20 visits per benefit period.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Rehabilitation services Physical therapy Occupational therapy Speech therapy Cardiac rehabilitation Chiropractic services	 $35/visit $35/visit 40% coinsurance after deductible 40% coinsurance after deductible 40% coinsurance after deductible	Not covered.	 20 visits per benefit period. 20 visits per benefit period. 20 visits per benefit period. 36 visits per benefit period. Manipulation therapy - 12 visits per benefit period.
	Habilitation services Physical therapy Occupational therapy Speech therapy	 $35/visit $35/visit 40% coinsurance after deductible	Not covered.	 20 visits per benefit period. 20 visits per benefit period. 20 visits per benefit period.
	Skilled nursing care	$100 per day for days 1-5, $0 per day for days 6-100	Not covered.	Any combination of benefits for skilled nursing facility/inpatient rehabilitation services is limited to 90 days per calendar year.
	Private duty nursing	40% coinsurance after deductible	Not covered.	Limited to 100 visits.
	Durable medical equipment	40% coinsurance after deductible	Not covered.	May require prior authorization.
	Hospice service	40% coinsurance after deductible	Not covered.	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	$0/visit	Not covered.	Limit of one routine eye exam per benefit year.
	Low vision exam	40% coinsurance after deductible	Not covered.	1 exam and follow-up visit every 5 years.
	Children's eye wear	40% coinsurance after deductible	Not covered.	Limited to 1 pair per benefit year and 1 replacement pair if medically necessary.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Children's dental	$20/visit for preventive 40% coinsurance for major restorative services 50% coinsurance for orthodontic services	Not covered.	2 dental check-ups per benefit period. Orthodontia lifetime limit $1,700.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Dental care (Adult), if optional Dental + Vision is selected:
  - $20 copay preventive and basic services
  - 40% coinsurance for major restorative services
  - $800 annual maximum
- Private duty nursing
- Routine eye care (Adult), if optional Dental + Vision is selected:
  - $25 copay
  - $150 annual maximum

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to continue health coverage after it would otherwise end. For more information, contact us at 1-877-806-9284 or contact 1-317-232-2385. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, contact the Indiana Department of Insurance: 1-317-232-2385.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-877-806-9284.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-806-9284.]

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-806-9284.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-806-9284.]

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $540
- **Patient pays:** $7,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$6,650
Copays	$200
Coinsurance	$0
Limits or exclusions	$150
Total	$7,000

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $50
- **Patient pays:** $5,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,270
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	$5,350

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-877-806-9284 or visit us at CareSource.com/marketplace
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at CareSource.com/marketplace or call 1-877-806-9284 to request a copy.

If you, or someone you're helping, have questions about CareSource, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-806-9284 TTY:711.

ARABIC
إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، اتصل على 1-877-806-9284 TTY:711.

AMHARIC
እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ CareSource ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-877-806-9284 TTY:711 ይደውሉ።

BURMESE
CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား စကားပြောဆိုရန် 1-877-806-9284 TTY:711 ကျေတွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

CHINESE
如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请致电 1-877-806-9284 TTY:711。

CUSHITE – OROMO
Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-806-9284 TTY:711 tiin bilbilaa.

DUTCH
Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk, bel dan naar 1-877-806-9284 TTY:711.

FRENCH (CANADA)
Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète, veuillez téléphoner au 1-877-806-9284 TTY:711.

GERMAN
Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, rufen Sie die Nummer 1-877-806-9284 TTY:711 an.

GUJARATI જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તેમ ાંથી કોઈને CareSource વિશે પ્રશ્નો હોય તો તમને મદદ અને મ હહતી મેળિ ાનો અવિક ર છે. ત ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર છે. ૬ ભ વષરો ા ત કરિ મ ટે,આ 1-877-806-9284 TTY:711 પર કોલ કરો.

HINDI
यदि आपके, या आप जिसकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल हैं तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, 1-877-806-9284 TTY:711.

ITALIAN
Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete, chiami il 1-877-806-9284 TTY:711.

JAPANESE
ご本人様、または身の回りの方で、CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます（無償）。通訳をご利用の場合は、1-877-806-9284 TTY:711 にご連絡ください。

KOREAN
귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 주십시오: 1-877-806-9284 TTY:711.

PENNSYLVANIA DUTCH
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-877-806-9284 TTY:711 uffrufe.

RUSSIAN
Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком, позвоните по номеру 1-877-806-9284 TTY:711.

SPANISH
Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-877-806-9284 TTY:711.

UKRAINIAN
Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, зателефонуйте за номером 1-877-806-9284 TTY:711.

VIETNAMESE
Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi số 1-877-806-9284 TTY:711.

Notice of Non-Discrimination

CareSource

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-877-806-9284 TTY:711.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.