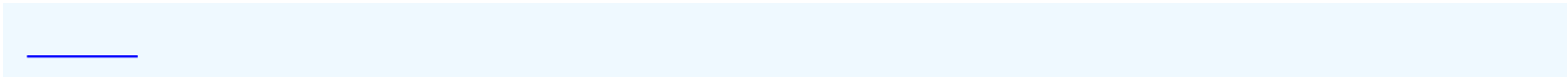
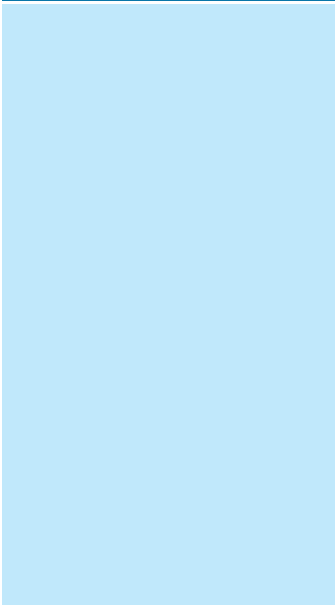


|   |   |   |
|---|---|---|
| What is the overall deductible?                             | \$6,150 individual/\$12,300 family per Benefit Year   | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.  |
| Are there services covered before you meet your deductible? | Yes. Preventive care.   | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.   |
| Are there other deductibles for specific services?          | No  | You don't have to meet deductibles for specific services.   |
| What is the out-of-pocket limit for this plan?              | \$6,150 individual/\$12,300 family  | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.  |
| What is not included in the out-of-pocket limit?            | Premiums, balance-billing 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.  |
| Will you pay less if you use a network provider?            | Yes. See <a href="http://www.caresource.com/marketplace">www.caresource.com/marketplace</a> or call 833-230-2099 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a   |   |   |



—

| Common Medical Event | Services You May Need | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Network Provider Information* |
|----------------------|-----------------------|--|--|--|
|                      |                       | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|                      | _____                 |  |  |  |
|                      | _____                 |  |  | _____  |
|                      | _____                 |  |  | _____  |
|                      |                       |  |  |  |
|                      |                       |  |  |  |
|                      |                       |  |  |  |
|                      |                       |  |  | _____  |
|                      |                       |  |  |  |
|                      | _____                 |  |  |  |
|                      | _____                 |  |  |  |



Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care
- Private duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 800-622-4461. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any of your [plan](#). For [more](#) information about your rights, this notice, or assistance, contact: Indiana Department of Insurance: 800-622-4461.

**Does this plan provide Minimum Essential Coverage?** Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards?** Not Applicable

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) (help you pay for a part of the cost of your plan through the IRS).

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network prenatal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$6,150
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:  
[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:  
*Cost Sharing*

|                             |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$6,100 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$0     |

*What isn't covered*

|                            |         |
|----------------------------|---------|
| Limits or exclusions       | \$60    |
| The total Peg would pay is | \$6,160 |

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$6,150
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:  
[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:  
*Cost Sharing*

|                             |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$5,200 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$0     |

*What isn't covered*

|                            |         |
|----------------------------|---------|
| Limits or exclusions       | \$20    |
| The total Joe would pay is | \$5,220 |

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$6,150
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

|                             |  |
|-----------------------------|--|
| <a href="#">Deductibles</a> |  |
| <a href="#">Copayments</a>  |  |
| <a href="#">Coinsurance</a> |  |

*What isn't covered*

|                            |  |
|----------------------------|--|
| Limits or exclusions       |  |
| The total Mia would pay is |  |