separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact www.caresource.com/marketplace or call 833-230-2099. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.caresource.com/marketplace or call 833-230-2099 to request a copy.

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.
What is the out-of-pocket limit for this plan?	$7,200 individual/$14,400 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 www.caresource.com/marketplace 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 referral to see a specialist?	No	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Zero Cost Telemedicine Partner	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat an injury or illness.	$30 copay	Not covered	None
	Specialist visit	$60 copay	Not covered	None
	Preventive care/screening/immunization	No charge	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, v27hFd 35eQ0 0 1 143.899994 0 5 0.25			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	40% coinsurance after deductible	40% coinsurance after deductible	Refer to your Evidence of Coverage
	Urgent care	$45 copay	$45 copay	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)	40% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	40% coinsurance after deductible	Not covered	1 visit per physician per day
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	$30 copay for office visits and 40% coinsurance after deductible for other outpatient services	Not covered	None
	Inpatient services	40% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	$60 copay	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services†	40% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services†	40% coinsurance after deductible	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 visits per Benefit Year. Refer to your Evidence of Coverage for additional information.
	Rehabilitation services† Physical/Occupational therapy Speech/Post-cochlear implant aural therapy	$30 copay $30 copay	Not covered Not covered	PT, OT, ST, Pulmonary limited to 20 visits each per Benefit Year. Cardiac limited to 36 visits. Manipulation therapy limited to 12 visits. Post-cochlear implant aural therapy

*For more information about limitations and exceptions, see the plan

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 833-230-2099.
†Prior authorization may be required, for more details see www.caresource.com/mp-IN-pa.

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

- Chiropractic care
- Dental care (Adult)
  - No charge for preventive services
  - 25% coinsurance for minor services
  - 45% coinsurance for major services
  - $1,000 annual allowance
- Fitness Benefits – Gym membership, at home kits, online videos, coaching, and more
- Private duty nursing
- Routine eye care (Adult)
  - $45 copay for eye exam with retinal imaging included
  - No cost for glasses or contacts, with $250 annual allowance

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 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 reason to 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 to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 833-230-2099

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-230-2099

Chinese (中文): 如果需要中文的帮助，˙ ˚ ˝ ˛ ˇ ı ⁄ 833-230-2099

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-230-2099.

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

PRA Disclosure Statement:

0938-1146 **0.08**

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 833-230-2099.

†Prior authorization may be required, for more details see www.caresource.com/mp-IN-pa.

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 $5,700
- Specialist *copayment* $60
- Hospital (facility) *coinsurance* 40%
- Other *coinsurance* 40%

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	
Deductibles	$5,700
Copayments	$60
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,220

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