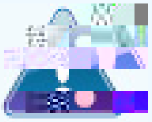
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact www.caresource.com/marketplace or call 844-539-1733. 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 healthcare.gov/sbc-glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$6,500 individual/$13,000 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 this 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?	$6,500 individual/$13,000 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		

Common Medical Eve	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Informatio
		Network Provider (You will pay the leas	Out-of-Network Provid (You will pay the most	
If you visit a health car provider's office or clinic	Zero Cost Telemedicine Partner	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat injury or illness.	$0 for first three visit then no charge after deductible	Not covered	None
	Specialist visit	No charge after deductible	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services tha preventive. Ask your provider if the service needed are preventive. Then check w your plan will pay for.
If you have a test†	Diagnostic test (x-ray, blood work)	X-ray: No charge aft deductible	Not covered	None
		Lab: No charge after deductible		None
	Imaging (CT/PET scans, MRIs)	No charge after deductible	Not covered	None
If you need drugs to treat your illness or condition More information abo prescription drug coverage is available at www.caresource.com/marketplace	Preventive drugs	No charge	Not covered	Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for drugs in Tiers 0-3 All others limited to a 30-day supply Any copays shown are for a 30-day s 90-day supplies for Retail are 3 times copay and for Mail Order are 2.5 time copay.
	Generic drugs	No charge after deductible	Not covered	
	Preferred brand drugs	No charge after deductible	Not covered	
	Non-preferred brand drug	No charge after deductible	Not covered	
	Specialty drugs	No charge after deductible	Not covered	
If you have outpatient surgery†	Facility fee (e.g., ambulat surgery center)	No charge after deductible	Not covered	None
	Physician/surgeon fees	No charge after deductible	Not covered	None
If you need immediate medical attention	Emergency room care	No charge after deductible	No charge after deductible	Emergency room copay or coinsuran waived if you are admitted to the hosp directly from the Emergency Departm

*For more information about limitations and exceptions, see policy document at www.caresource.com/marketplace or call 844-539-1733.
†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 diff 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 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 a

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