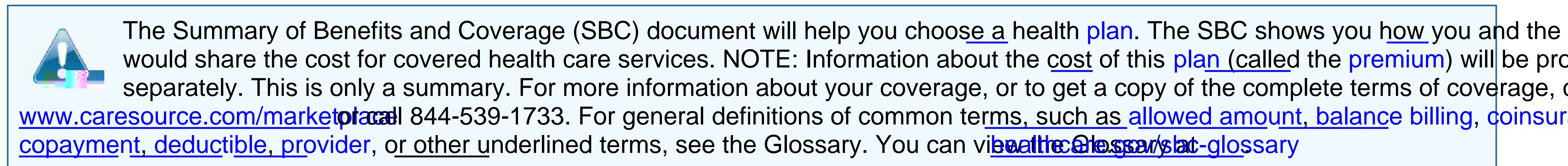
CareSource Marketplace Low Premium Silver Dental, Vision, & Fitness

Coverage for: Individual and Family | Plan Type:



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the p
would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be pro
separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, c
www.caresource.com/marketplace or call 844-539-1733. For general definitions of common terms, such as allowed amount, balance billing, coinsura
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 fan per Benefit Year | Generally, you must pay all of the costs from providers up to the deductible amount befor plan begins to pay. If you have other family members on the plan, each family m meet their own individual deductible until the total amount of deductible expense family members meets the overall family deductible. |
| Are there services covered before you mee your deductible? | Yes. Preventive care. | This plan covers some items and services even if you haven't yet met the dedu 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-pocke limit for this plan? | $9,100 individual/$18,200 fan | The out-of-pocket limit is the most you could pay in a year for covered services. other family members in this plan, they have to meet their own out-of-pocket lim overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billing cha and health care this plan doe cover. | Even though you pay these expenses, they don't count toward the out-of-pocke |
| Will you pay less if you use a network provider? | Yes. See www.caresource.com/marketplace. or call 844-539-1733 for a list network providers. | This plan uses a provider network. You will pay less if you use a provider in the You will pay the most if you use an out-of-network provider, and you might rece provider for the difference between the provider's charge and what your plan pa billing). Be aware your network provider might use an out-of-network provider fo (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 Eve | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Network Provider Informati |
|---|---|---|---|---|
| | | 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 Telehealth Par | No charge | Not covered | Refer to your Evidence of Coverage |
| | Primary care visit to treat injury or illness. | $30 copay | Not covered | None |
| | Specialist visit | $70 copay | Not covered | None |
| | Preventive care/screening/immunizat | No charge | Not covered | You may have to pay for services tha preventive. Ask your provider if the se needed are preventive. Then check w your plan will pay for. |
| If you have a test† | Diagnostic test (x-ray, blo work) | X-ray: $200 copay af deductible | Not covered | None |
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| Common Medical Eve | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Network Provider Informati |
|---|---|---|---|---|
| | | Network Provider (You will pay the leas | Out-of-Network Provid (You will pay the most | |
| | Urgent care | $50 copay | $50 copay | If you receive services in addition to u care, additional copayments, deductib coinsurance may apply. |
| If you have a hospital stay† | Facility fee (e.g., hospital room) | $500 copay after deductible per stay | Not covered | None |
| | Physician/surgeon fees | No charge 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 50% coinsurance after deductible for other outpatient services | Not covered | None |
| | Inpatient services | $500 copay after deductible per stay | Not covered | None |
| If you are pregnant | Office visits | $70 copay | Not covered | Cost sharing does not apply for preve services. Depending on the type of services, coinsurance |
| | | | | |
| | | | | |

| 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 Provide (You will pay the most | |
| If you need help recovering or have other special health needs | Home health care† | 50% coinsurance aft deductible | Not covered | Private-Duty Nursing limited to 250 vis Benefit Year. 100 visits per Benefit Ye Refer to your Evidence of Coverage fo additional information. |
| | Rehabilitation services†<br>Physical/Occupational therapy<br>Speech/Post-cochlear implant aural therapy<br>All other services | $30 copay<br>50% coinsurance after deductible<br>50% coinsurance aft deductible | Not covered<br>Not covered<br>Not covered | PT, OT, ST, Pulmonary limited to 25 v each per Benefit Year. Cardiac limited visits. Manipulation therapy and Cogn limited to 20 visits each per Benefit Ye Post-cochlear implant aural therapy li to 30 visits. |
| | Habilitation services†<br>Physical/Occupational therapy<br>Speech therapy | $30 copay<br>50% coinsurance aft deductible | Not covered<br>Not covered | 25 visits per Benefit Year<br>25 visits per Benefit Year |
| | Hearing Aids | 50% coinsurance aft deductible | Not covered | 1 hearing aid per hearing-impaired ea every 36 months |
| | Skilled nursing care† | $500 copay after deductible per stay | Not covered | 90 Day limit per Benefit Year |
| | Durable medical equipme | 50% coinsurance aft deductible | Not covered | Refer to your Evidence of Coverage |
| | Hospice services | No charge for in-network and out-of-network by Medicare approved providers | No charge for in-netwo and out-of-network by Medicare approved providers | Refer to your Evidence of Coverage |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | 1 routine eye exam per Benefit Year |
| | Children's eyewear | No charge | | |

| Common Medical Eve | Services You May Neec | What You Will Pay | | Limitations, Exceptions, & Other Important Network Provider Informatic |
|---|---|---|---|---|
| | | Network Provider (You will pay the leas | Out-of-Network Provid (You will pay the most | |
| | Children's dental check-u | No charge | Not covered | 2 check-ups per Benefit Year. Additio benefits available. Refer to your Evide Coverage |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) |
|---|
| |

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 Ken
Exchange.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 844-539-1733

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-539-1733

Chinese ( ): , 844-539-1733

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-539-1733.

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

*For more information about limitations and exceptions, see the plan or 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-KY-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 wil 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 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 hospital delivery)

- The plan's overall deductible $6,500
- Specialist copayment $70
- Hospital (facility) copayment $500
- Other coinsurance 50%

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 | $6,500 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $7,560 |

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

- The