

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](http://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](http://healthcare.gov/sbc-glossary).

Important Questions	Answers	Why This Matters:
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What is the overall <a href="#">deductible</a> ?	\$1,500 individual/\$3,000 family per Benefit Year	
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\*Balance billing does not apply in West Virginia.  
ADV-SBC-WV001(2024)BFS-Gold

\*For more information about limitations and exceptions, see the plan or policy document at

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)	
	<a href="#">Emergency medical transportation</a>	25% coinsurance after deductible	25% coinsurance after deductible	None

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.caresource.com/marketplace](http://www.caresource.com/marketplace) or call 844-539-1733.

†Prior authorization may be required, for more details see [www.caresource.com/mp-WV-pa](http://www.caresource.com/mp-WV-pa).

\*\*In addition to any visits covered under chronic pain treatment benefit

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)
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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)	
	Children's dental check-up	No charge	Not covered	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage

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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.

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$2,100

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services