



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wellcareexchange.com or by calling 1-855-582-6175.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$ 0 per person/ \$0 per family.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$950 per person/ \$1,900 per family. Co-pay/coinsurance amounts count toward the out-of-pocket limit .	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, Balance-billed charges, Health care received but not covered by this plan and Penalties.	Even though you pay these expenses, they don't count towards the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers ?	Yes. For a list of participating providers, see www.wellcareexchange.com/fap_search or call 1-855-582-6175.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use and out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network, see the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	Yes. A written referral is needed.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Form# KY027103_HIX_SOB_ENG Questions: Call 1-855-582-6175 or visit us at www.wellcareexchange.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.wellcareexchange.com/ky_sb or call 1-855-582-6175 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Visit 1-3; \$0 co-pay Visit 4+; \$15 co-pay /visit	Not covered	-----None-----
	Specialist visit	\$30 co-pay /visit	Not covered	-----None-----
	Other practitioner office visit - Chiropractor	\$30 co-pay /visit	Not covered	Manipulation therapy is limited to 12 visits per year.
	Preventive care/screening/immunization	No charge	Not covered	Limited to the United States Preventive Services Task Force recommendations (A and B only), Advisory Committee on Immunization Practices (ACIP) recommendations, and Health Resources and Service Administration guidelines for women and children.
If you have a test	Diagnostic test (x-ray, blood work)	\$15 co-pay /visit for standard x-rays and diagnostic tests	Not covered	Co-pay may vary based on services provided and the setting where covered services are received.
	Imaging (CT/PET scans, MRIs)	\$30 co-pay /visit	Not covered	Co-pay may vary based on services provided and the setting where covered services are received.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.wellcareexchange.com/ky_form_search	Generic drugs	\$4 co-pay (retail) \$12 co-pay (mail order)	Not covered	Covers up to a 30 day supply (retail) and a 90 day supply (mail order).
	Preferred brand drugs	\$15 co-pay (retail) \$45 co-pay (mail order)	Not covered	Covers up to a 30 day supply (retail) and a 90 day supply (mail order).
	Non-preferred brand drugs	\$35 co-pay (retail) \$105 co-pay (mail order)	Not covered	Covers up to a 30 day supply (retail) and a 90 day supply (mail order).
	Specialty drugs	\$55 co-pay (mail order)	Not covered	Covers up to a 30 day supply (mail order).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 co-pay /visit an ambulatory surgery center	Not covered	Prior auth may be required. Co-pay may vary based on services provided and the setting where covered services are received.
	Physician/surgeon fees	\$35 co-pay /visit in an office setting	Not covered	Prior auth may be required. Co-pay may vary based on services provided and the setting where covered services are received.
If you need immediate medical attention	Emergency room services	\$100 co-pay /visit	\$100 co-pay /visit	Waived if admitted.
	Emergency medical transportation	\$100 co-pay /trip	\$100 co-pay /trip	-----None-----
	Urgent care	\$30 co-pay /visit	\$30 co-pay /visit	Waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 co-pay /stay	Not covered	Prior auth may be required.
	Physician/surgeon fee	\$150 co-pay /stay	Not covered	Prior auth may be required. Included in facility fee.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Visit 1-3; \$0 co-pay Visit 4+; \$15 co-pay /visit	Not covered	Prior auth may be required.
	Mental/Behavioral health inpatient services	\$150 co-pay /stay	Not covered	Prior auth may be required.
	Substance use disorder outpatient services	Visit 1-3; \$0 co-pay Visit 4+; \$15 co-pay /visit	Not covered	Prior auth may be required.
	Substance use disorder inpatient services	\$150 co-pay /stay	Not covered	Prior auth may be required.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Prior auth may be required.
	Delivery and all inpatient services	\$150 co-pay /stay	Not covered	Prior auth may be required.
If you need help recovering or have other special health needs	Home health care	\$30 co-pay /visit	Not covered	Prior auth may be required. Limited to 100 visits /yr lasting no less than four hours /visit.
	Rehabilitation services	Visit 1-3; \$0 co-pay Visit 4+; \$15 co-pay /visit for PT/OT/ST. \$25 co-pay /visit for other rehabilitation and habilitation services	Not covered	Prior auth may be required. Limit of 20 visits / yr for PT/OT/ST and pulmonary rehab. Limit of 36 visits /yr for cardiac rehab. Limit of 12 visits /yr for Manipulation therapy. Limit of 60 visits / year for Outpatient Rehab Therapy.
	Habilitation services	Same co-pay as rehabilitation	Not covered	Prior auth may be required. Same limits as Rehabilitation services.
	Skilled nursing care	\$150 co-pay /stay	Not covered	Prior auth may be required. Limited to 90 days /yr.
	Durable medical equipment	5% coinsurance / item	Not covered	Prior auth may be required. Hearing Aids for those <18 is limited to 1 /ear every 36 months.
	Hospice service	\$0 co-pay /stay	\$0 co-pay /stay	Prior auth may be required.
If your child needs dental or eye care	Eye exam	\$30 co-pay /visit	Not covered	Prior auth may be required. Limited to 1 /yr for members under age 21.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Glasses	5% coinsurance	Not covered	Prior auth may be required. Limited to members under age 21. Limited to 1 pair /yr. Limited to 1 additional replacement pair /yr if medically necessary.
	Dental check-up	\$30 co-pay /visit	Not covered	Limited to members under age 21. Limited to 2 cleanings /yr, extractions and fillings.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery for Morbid Obesity
- Chiropractic care when rendered in a home
- Cosmetic surgery, unless to correct a functional impairment
- Dental care (Adult)
- Hearing aid (except for newborns)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Private Duty Nursing

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-582-6175. You may also contact your state insurance department at Department of Labor Employee Benefits Security Administration at: 1-866-444-EBSA (3272) or the U.S. Department of Health and Human Services at 1-877-267-2323, Ext. 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: WellCare Health Plans of Kentucky, Inc. at www.wellcareexchange.com or 1-855-582-6175.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-374-4056.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-374-4056.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-374-4056.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-374-4056.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,740
- Patient pays \$800

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Co-pays	\$600
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$800

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,720
- Patient pays \$680

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$600
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$680

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.