

This summary shows in-network benefits only.

## **Plan Information**

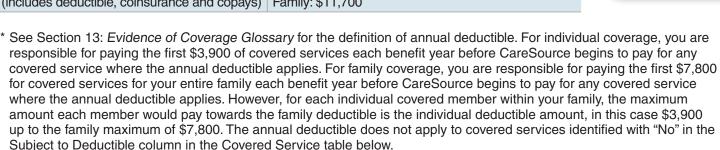
Primary Member	[John Doe]
Member ID	[10400000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2018]
Last Coverage Change Date	[01/01/2017]

## **Dependent Information**

Dependent Name	[Nancy Doe]
Relationship to You	[Spouse]
Date of Birth	[01/01/1966]
Effective Date	[01/01/2018]

## **Highlights**

Annual Deductible*	Individual: \$3,900 Family: \$7,800	
Coinsurance	30%	5
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays)	Individual: \$5,850 Family: \$11,700	



\*\* See Section 13: Evidence of Coverage Glossary for the definition of annual out-of-pocket maximum. For family coverage, each individual covered member within your family is contributing towards the family annual out-of-pocket maximum. However, for each individual covered member within your family, the maximum amount each member would pay towards the family annual out-of-pocket maximum is the individual out-of-pocket maximum, which is \$5,850.

Covered Service	<b>You Pay</b> (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
<b>Office Visits</b> (includes retail clinics) Primary Care Specialist Care	\$10 \$40	No No	
Preventive Care As defined by federal law	\$0	No	

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Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Diagnostic			
Lab	\$75	Yes	May require prior authorization
X-Ray	\$150	Yes	
Major Diagnostic — PET, MRI, MRA, CT, SPECT	\$200	Yes	May require prior authorization
<b>Mammograms</b> (outpatient) Preventive Diagnostic	\$0 \$150	No Yes	
Inpatient Services Facility/Physician	\$300 per day for days 1-5, \$0 per day for days 6-100	No	Prior authorization required
Outpatient Services Facility	30%	Yes	May require prior
Physician	30%	Yes	authorization
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	\$40	No	
Inpatient Services	\$300 per day for days 1-5, \$0 per day for days 6-100	No	
Outpatient Services	30%	Yes	
Urgent Care	\$75	No	
Emergency Services Emergency Room Services	\$500	Yes	Emergency room copay or coinsurance waived if you are admitted to the hospital directly from the Emergency Department
Ambulance Services	30%	Yes	Dopartment
Habilitative Services			
Physical Therapy	\$40	No	20 visits per benefit period
Occupational Therapy	\$40	No	20 visits per benefit period
Speech Therapy	\$40	No	20 visits per benefit period
<b>Rehabilitative Services</b> Physical Therapy Occupational Therapy	\$40 \$40	No No	20 visits per benefit period 20 visits per benefit period
Speech Therapy	\$40	No	20 visits per benefit period
Cardiac Rehabilitation Services	30%	Yes	36 visits per benefit period
Chiropractic Services	30%	Yes	Manipulation therapy - 12 visits per benefit period
Behavioral Health Services	Covered the same as office visits, inpatient services and outpatient services		Prior authorization required for all inpatient stays, partial hospitalization programs and intensive outpatient services
Transplant Services	Covered the same as office services and outpatier	Prior authorization required	

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Covered Service	<b>You Pay</b> (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services and outpatient services		
Skilled Nursing	\$300 per day for days 1-5, \$0 per day for days 6-90	No	90 day limit per benefit period
Private Duty Nursing	30%	Yes	100 visits per benefit year. One visit equals 8 hours.
Home Health	30%	Yes	100 visits per benefit year.
Hospice Care	30%	Yes	Prior authorization required
<b>Diabetic Services</b> Education Equipment Supplies	30% 30% 30%	Yes Yes Yes	
Durable Medical Equipment	30%	Yes	May require prior authorization
Prescription Drugs Retail — 30-day supply Tier 0: Preventive Tier 1: Generic Tier 2: Preferred Tier 3: Non-Preferred Tier 4: Specialty Preferred Tier 5: Specialty Non-Preferred	\$0 \$10 \$50 \$200 40% (up to \$300) 50% (up to \$300)	No No No Yes Yes	Up to a 31 day supply Up to a 31 day supply
Mail Order — 90-day supply Tier 0: Preventive Tier 1: Generic Tier 2: Preferred Tier 3: Non-Preferred Tier 4: Specialty Preferred Tier 5: Specialty Non-Preferred	\$0 \$25 \$125 \$500 40% (up to \$300) 50% (up to \$300)	No No No Yes Yes	Up to a 90 day supply Up to a 90 day supply
<b>Vision</b> (pediatric) Eye Exam for Children Eye Wear	\$0 \$0	No No	One routine eye exam per benefit period Limited to one pair per benefit period
-			and one replacement pair if medically necessary
Dental (accidental injury)	30%	Yes	
<b>Dental</b> (pediatric) Preventive Major Orthodontic	\$0 20% 30%	No No No	2 dental check-ups per benefit period No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of \$2,000

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**Prior Authorization:** Some health care services require prior authorization from the Plan. Prior authorization is the process used by the Plan to determine those health care services listed on the Plan's prior authorization list that meet evidence-based criteria for medical necessity and are covered services under the Plan prior to the health care service being provided. The provider (in-network or out-of-network) is responsible for obtaining prior authorization for the health care services described on the prior authorization list. Please refer to Chapter 2 of the Evidence of Coverage at www.caresource.com/marketplace for complete details after you are enrolled.

This Schedule of Benefits is a summary of your financial responsibility when you receive health care services from a physician, pharmacy, facility or other provider. All covered services are subject to the conditions, exclusions, limitations, terms and rules of the Evidence of Coverage including any rider/enhancements or amendments. Except as otherwise provided in the Evidence of Coverage, covered services must be provided to you by a network provider and medically necessary. The Plan does not cover all health care service expenses. In the event of any discrepancy between this Schedule of Benefits and your Evidence of Coverage, the Evidence of Coverage shall control. For more detailed information about your covered services, please refer to the Evidence of Coverage at www.caresource.com/marketplace.

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