

This summary shows in-network benefits only.

## **Plan Information**

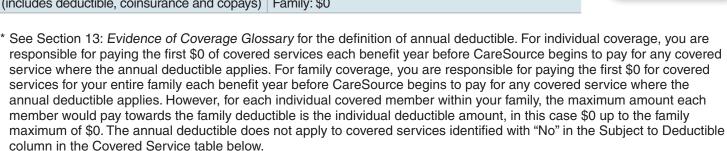
Primary Member	[John Doe]
Member ID	[10400000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2018]
Last Coverage Change Date	[01/01/2017]

## **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: \$0 Family: \$0
Coinsurance	0%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays)	Individual: \$0 Family: \$0



\*\* 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 \$0.

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

Covered Service	<b>You Pay</b> (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Diagnostic			
Lab	0%	No	May require prior
			authorization
X-Ray	0%	No	
Major Diagnostic — PET, MRI, MRA, CT, SPECT	\$0	No	May require prior authorization
Mammograms (outpatient)			
Preventive	\$0	No	
Diagnostic	0%	No	
Inpatient Services			
Facility/Physician	\$0	No	Prior authorization required
Outpatient Services			
Facility	0%	No	May require prior
			authorization
Physician	0%	No	
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	\$0	No	
Inpatient Services	\$0	No	
Outpatient Services	0%	No	
Urgent Care	\$0	No	
Emergency Services			
Emergency Room Services	\$0	No	Emergency room copay or
			coinsurance waived if you
			are admitted to the hospital
			directly from the Emergency
Ambulance Services	0%	No	Department
	070	110	
Habilitative Services Physical Therapy	0%	No	20 visits per benefit period
Occupational Therapy	0%	No	20 visits per benefit period
Speech Therapy	0%	No	20 visits per benefit period
Rehabilitative Services Physical Therapy	0%	No	20 visits per benefit period
Occupational Therapy	0%	No	20 visits per benefit period
Speech Therapy	0%	No	20 visits per benefit period
Cardiac Rehabilitation Services	0%	No	36 visits per benefit period
Chiropractic Services	0%	No	Manipulation therapy - 12
			visits per benefit period
Behavioral Health Services	Covered the same as office	Prior authorization required	
	services and outpatie	for all inpatient stays, partial	
	, · · · · ·	hospitalization programs and	
			intensive outpatient services
Transplant Services	Covered the same as office	e visits, inpatient	Prior authorization required
-	services and outpatie		

Covered Service	You Pay (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		(in Applicable)
Skilled Nursing	\$0	No	90 day limit per benefit period
Private Duty Nursing	0%	No	100 visits per benefit year. One visit equals 8 hours.
Home Health	0%	No	100 visits per benefit year.
Hospice Care	0%	No	Prior authorization required
<b>Diabetic Services</b> Education Equipment Supplies	0% 0% 0%	No No No	
Durable Medical Equipment	0%	No	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 \$0 0% 0% 0% 0%	No No No No No No	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 \$0 \$0 0% 0% 0%	No No No No No	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
Enhanced Vision (adults)	\$0	No	necessary \$250 limit per year One routine eye exam per benefit year at no charge
Dental (accidental injury)	0%	No	
<b>Dental</b> (pediatric) Preventive Major Orthodontic	0% 0% 0%	No No No	2 dental check-ups per benefit period No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of \$2,000
Enhanced Dental (adults) Preventive and Diagnostic (2 check-ups per year) Basic Restorative Major Restorative	\$0 \$0 15%	No No No	\$800 limit for all services combined

**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.