

This summary shows in-network benefits only.

Plan Information

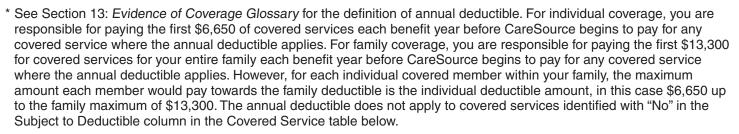
Primary Member	[John Doe]
Member ID	[10400000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2018]
Last Coverage Change Date	[01/01/2017]

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: \$6,650 Family: \$13,300	
Coinsurance	40%	5
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays)	Individual: \$7,350 Family: \$14,700	



** 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 \$7,350.

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Office Visits (includes retail clinics) Primary Care Specialist Care	\$35 \$75	No No	
Preventive Care As defined by federal law	\$0	No	

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Diagnostic Lab	40%	Yes	May require prior authorization
X-Ray	40%	Yes	autionzation
Major Diagnostic — PET, MRI, MRA, CT, SPECT	40%	Yes	May require prior authorization
Mammograms (outpatient) Preventive Diagnostic	\$0 40%	No Yes	
Inpatient Services Facility/Physician	40%	Yes	Prior authorization required
Outpatient Services Facility	40%	Yes	May require prior authorization
Physician	40%	Yes	uutionzation
Maternity Care Prenatal Visit, Office Visits and Postpartum Care Inpatient Services Outpatient Services	\$75 40% 40%	No Yes Yes	
Urgent Care	\$75	No	
Emergency Services Emergency Room Services	40%	Yes	Emergency room copay or coinsurance waived if you are admitted to the hospital directly from the Emergency Department
Ambulance Services	40%	Yes	
Habilitative Services Physical Therapy Occupational Therapy Speech Therapy	\$35 \$35 \$35	No No No	25 visits per benefit year 25 visits per benefit year 25 visits per benefit year
Rehabilitative Services Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Chiropractic Services	\$35 \$35 \$35 40% 40% 40%	No No Yes Yes Yes	25 visits per benefit year 25 visits per benefit year 25 visits per benefit year 25 visits per benefit year 36 visits per benefit year Manipulation therapy - 20
Post-Cochlear Implant Aural Therapy Cognitive Rehabilitation Therapy	40% 40%	Yes Yes	visits per benefit year 30 visits per benefit year 20 visits per benefit year
Behavioral Health Services	Covered the same as office visits, inpatient services and outpatient services		Prior authorization is required for all inpatient stays. Partial hospitalization and intensive outpatient services may require prior authorization
Transplant Services	Covered the same as office services and outpatie		Prior authorization required

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		
Skilled Nursing	40%	Yes	90 day limit per benefit year
Private Duty Nursing	40%	Yes	250 visits per benefit year. One visit equals 8 hours.
Home Health	40%	Yes	100 visits per benefit year. One visit equals at least 4 hours.
Hospice Care	0%	No	Prior authorization required
Diabetic Services Education Equipment Supplies	40% 40% 40%	Yes Yes Yes	
Durable Medical Equipment	40%	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 \$35 \$40 \$45 \$50 Not Applicable	No No Yes Yes Yes N/A	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 \$87.50 \$100 \$112.50 \$125 Not Applicable	No No Yes Yes Yes N/A	Up to a 90 day supply Up to a 90 day supply
Vision (pediatric) Eye Exam for Children	\$0	No	One routine eye exam per benefit
Eye Wear	\$0	No	year Limited to one pair of glasses or a 12-month supply of contact lenses per benefit year. If medically necessary, a replacement pair of glasses is allowed
Enhanced Vision (adults)	\$0	No	\$250 limit per year One routine eye exam per benefit year at no charge
Dental (accidental injury)	40%	Yes	
Dental (pediatric) Preventive/Diagnostic Minor/Major Orthodontic	\$35 40% 50%	No No No	2 dental check-ups per benefit year No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of \$1,700
Enhanced Dental (adults) Preventive/Diagnostic (2 check-ups per year) Basic Restorative Major Restorative	\$35 40% 40%	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.