

This summary shows in-network benefits only.

Plan Information

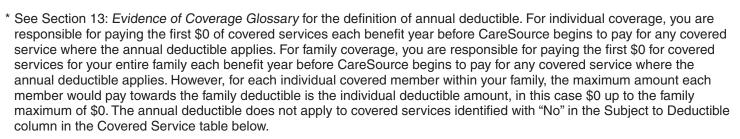
Primary Member	[John Doe]
Member ID	[10400000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2018]
Last Coverage Change Date	[01/01/2017]

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	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Office Visits (includes retail clinics) Primary Care Specialist Care	\$0 \$0	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	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	additionZadion
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 Department
Ambulance Services	0%	No	
Habilitative Services			
Physical Therapy	\$0	No	25 visits per benefit year
Occupational Therapy	\$0	No	25 visits per benefit year
Speech Therapy	\$0	No	25 visits per benefit year
Rehabilitative Services			
Physical Therapy	\$0	No	25 visits per benefit year
Occupational Therapy	\$0	No	25 visits per benefit year
Speech Therapy	\$0	No	25 visits per benefit year
Pulmonary Rehabilitation	0%	No	25 visits per benefit year
Cardiac Rehabilitation Services	0%	No	36 visits per benefit year
Chiropractic Services	0%	No	Manipulation therapy - 20 visits per benefit year
Post-Cochlear Implant Aural Therapy	0%	No	30 visits per benefit year
Cognitive Rehabilitation Therapy	0%	No	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

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Transplant Services	Covered the same as office visits, inpatient services and outpatient services		Prior authorization required
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services and outpatient services		
Skilled Nursing	0%	No	90 day limit per benefit year
Private Duty Nursing	0%	No	250 visits per benefit year. One visit equals 8 hours
Home Health	0%	No	100 visits per benefit year. One visit equals at least 4 hours
Hospice Care	0%	No	Prior authorization required
Diabetic Services Education Equipment Supplies	0% 0% 0%	No No No	
Durable Medical Equipment	0%	No	May require prior authorization
Prescription DrugsRetail — 30-day supplyTier 0: PreventiveTier 1: GenericTier 2: PreferredTier 2: PreferredTier 3: Non-PreferredTier 4: Specialty PreferredTier 5: Specialty Non-PreferredMail Order — 90-day supplyTier 0: PreventiveTier 1: GenericTier 2: PreferredTier 3: Non-PreferredTier 3: Non-PreferredTier 4: Specialty PreferredTier 5: Specialty Non-PreferredTier 5: Specialty Non-PreferredEye Exam for ChildrenEye Wear	\$0 \$0 \$0 \$0 0% 0% \$0 \$0 \$0 \$0 0% 0% \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	No No No No No No No No No No No	Up to a 31 day supply Up to a 90 day supply
Dental (accidental injury)	0%	No	
Dental (pediatric) Preventive/Diagnostic	\$0	No	2 dental check-ups per benefit year
Minor/Major Orthodontic	0% 0%	No No	No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of \$1,700

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.