

This summary shows in-network benefits only.

Plan Information

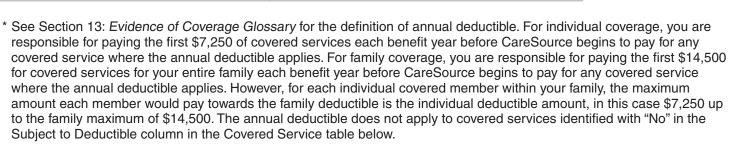
Primary Member	[John Doe]
Member ID	[10400000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2018]
Last Coverage Change Date	[01/01/2017]

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: \$7,250 Family: \$14,500	
Coinsurance	40%	
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	e You Pay Subject to (Network Providers Only)		Limit (If Applicable)	
Office Visits (includes retail clinics) Primary Care Specialist Care	\$30 40%	No Yes		
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	\$100	Yes	
Major Diagnostic — PET, MRI, MRA, CT, SPECT	40%	Yes	May require prior authorization
Mammograms (outpatient)			
Preventive	\$0	No	
Diagnostic	\$100	Yes	
Inpatient Services Facility/Physician	40%	Yes	Prior authorization required
Outpatient Services			
Facility	40%	Yes	May require prior authorization
Physician	40%	Yes	autionzation
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	40%	Yes	
Inpatient Services	40%	Yes	Prior authorization required
Outpatient Services	40%	Yes	
Urgent Care	40%	Yes	
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	Department
Autism			
Occupational Therapy	40%	Yes	20 visits per benefit year
Speech Therapy	40%	Yes	20 visits per benefit year
Behavioral Therapy	\$30	No	
Habilitative Services			
Physical Therapy	40%	Yes	20 visits per benefit year
Occupational Therapy	40%	Yes	20 visits per benefit year
Speech Therapy	40%	Yes	20 visits per benefit year
Rehabilitative Services			
Physical Therapy	40%	Yes	20 visits per benefit year
Occupational Therapy	40%	Yes	20 visits per benefit year
Speech Therapy	40%	Yes	20 visits per benefit year
Cardiac Rehabilitation Services	40%	Yes	36 visits per benefit year
Chiropractic Services	40%	Yes	Manipulation therapy - 12 visits per benefit year
Behavioral Health Services	Covered the same as office services and outpatier	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	

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	100 combined visits per benefit year. A visit equals 15 minutes to 8 hours of service.
Home Health	40%	Yes	100 combined visits per benefit year
Hospice Care	40%	Yes	Prior authorization required
Diabetic Services Education Equipment Supplies	40% 40% 40%	Yes Yes Yes	
Durable Medical Equipment	40%	Yes	May require prior authorization
Prescription DrugsRetail — 30-day supplyTier 0: PreventiveTier 1: GenericTier 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 3: Specialty PreferredTier 4: Specialty PreferredTier 5: Specialty Non-PreferredTier 5: Specialty Non-PreferredTier 5: Specialty Non-Preferred	\$0 \$25 40% 40% 40% (up to \$300) 50% (up to \$300) \$0 \$62.50 40% 40% 40% 40% (up to \$300) 50% (up to \$300)	No No Yes Yes Yes Yes No No Yes Yes Yes Yes	Up to a 31 day supply Up to a 90 day supply
Vision (pediatric) Eye Exam for Children Low Vision Exam Eye Wear	\$0 40% \$0	No Yes No	One routine eye exam per benefit year 1 exam and follow-up visit every 5 years Limited to one pair per benefit year and one replacement pair if medically necessary
Dental (accidental injury)	40%	Yes	
Dental (pediatric) Preventive Major Orthodontic	\$20 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

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.