

nis summary ws in-network enefits only.

Plan Information

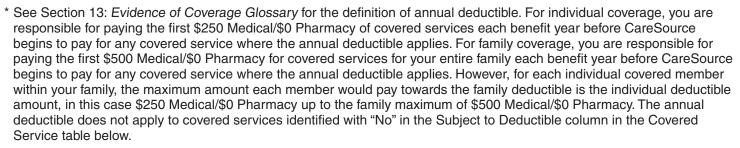
Primary Member	[John Doe]
Member ID	[10400000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2018]
Last Coverage Change Date	[01/01/2017]

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: \$250 Medical/\$0 Pharmacy Family: \$500 Medical/\$0 Pharmacy	Th
Coinsurance	5%	show
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays)	Individual: \$1,250 Family: \$2,500	be



** 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 \$1,250.

Covered Service	You Pay (Network Providers Only)	(Network Providers Deductible	
Office Visits (includes retail clinics) Primary Care Specialist Care	\$5 \$10	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	5%	Yes	May require prior
X-Ray	5%	Yes	authorization
Major Diagnostic — PET, MRI, MRA, CT, SPECT	5%	Yes	May require prior
	576	163	authorization
Mammograms (outpatient)			
Preventive	\$0	No	
Diagnostic	5%	Yes	
Inpatient Services Facility/Physician	5%	Yes	Prior authorization required
Outpatient Services			· · · · · · · · · · · · · · · · · · ·
Facility	5%	Yes	May require prior
			authorization
Physician	5%	Yes	
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	\$10	No	
Inpatient Services	5%	Yes	Prior authorization required
Outpatient Services	5%	Yes	
Urgent Care	\$25	No	
Emergency Services			
Emergency Room Services	5%	Yes	Emergency room copay or
			coinsurance waived if you are admitted to the hospital
			directly from the Emergency
			Department
Ambulance Services	5%	Yes	
Autism			
Occupational Therapy	5%	Yes	20 visits per benefit year
Speech Therapy	5%	Yes	20 visits per benefit year
Behavioral Therapy	\$5	No	
Habilitative Services			
Physical Therapy	5%	Yes	20 visits per benefit year
Occupational Therapy	5%	Yes	20 visits per benefit year
Speech Therapy	5%	Yes	20 visits per benefit year
Rehabilitative Services			
Physical Therapy	5%	Yes	20 visits per benefit year
Occupational Therapy	5%	Yes	20 visits per benefit year
Speech Therapy Cardiac Rehabilitation Services	5% 5%	Yes Yes	20 visits per benefit year
Cardiac Renabilitation Services Chiropractic Services	5% 5%	Yes	36 visits per benefit year Manipulation therapy - 12
	0,0	100	visits per benefit year
Behavioral Health Services	Covered the same as office visits, inpatient		Prior authorization required
	services and outpatier		for all inpatient stays, partial
			hospitalization programs and
			intensive outpatient services
Transplant Services	Covered the same as office		Prior authorization required
	services and outpatier	nt services	

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	5%	Yes	90 day limit per benefit year
Private Duty Nursing	5%	Yes	100 combined visits per benefit year. A visit equals 15 minutes to 8 hours of service.
Home Health	5%	Yes	100 combined visits per benefit year
Hospice Care	5%	Yes	Prior authorization required
Diabetic Services Education Equipment Supplies	5% 5% 5%	Yes Yes Yes	
Durable Medical Equipment	5%	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 \$3 \$5 \$10 25% Not Applicable	No No No Yes N/A	Up to a 31 day supply Up to a 31 day supply Not Applicable
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 \$7.50 \$12.50 \$25 25% Not Applicable	No No No Yes N/A	Up to a 90 day supply Up to a 90 day supply Not Applicable
Vision (pediatric) Eye Exam for Children Low Vision Exam Eye Wear	\$0 5% \$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)	5%	Yes	
Dental (pediatric) Preventive Major Orthodontic	\$5 5% 20%	No No No	2 dental check-ups per benefit year No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of \$3,000

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.