

This summary shows in-network benefits only.

Plan Information

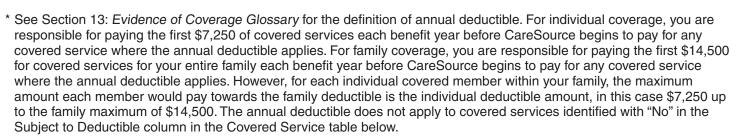
Primary Member	[John Doe]
Member ID	[10400000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2018]
Last Coverage Change Date	[01/01/2017]

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	You Pay (Network Providers Only)	Subject to Deductible	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	

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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
	100/		authorization
Physician	40%	Yes	
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	40%	Yes	
Inpatient Services	40%	Yes	
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	
Habilitative Services			
Physical Therapy	40%	Yes	30 visits per benefit period
Occupational Therapy	40%	Yes	30 visits per benefit period
Speech Therapy	40%	Yes	30 visits per benefit period
Rehabilitative Services			
Physical Therapy	40%	Yes	30 visits per benefit period
Occupational Therapy	40%	Yes	30 visits per benefit period
Speech Therapy	40%	Yes	30 visits per benefit period
Cardiac Rehabilitation Services	40%	Yes	36 visits per benefit period
Chiropractic Services	40%	Yes	Manipulation therapy - 30 visits per benefit period
Behavioral Health Services	Covered the same as office services and outpatie	Prior authorization required for all inpatient stays, partial hospitalization programs and intensive outpatient services	
Transplant Services	Covered the same as office services and outpatie	Prior authorization required	

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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 period
Private Duty Nursing	40%	Yes	100 combined visits per benefit period One visit equals at least 4 hours.
Home Health	40%	Yes	100 combined visits per benefit period
Hospice Care	40%	Yes	Prior authorization required
Diabetic Services Education Equipment Supplies	40% 40% 40%	Yes Yes Yes	May require prior outborization
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 Mail Order — 90-day supply	\$0 \$25 40% 40% 40% (up to \$300) 50% (up to \$300)	No No Yes Yes Yes Yes	Up to a 31 day supply Up to a 31 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 \$62.50 40% 40% 40% (up to \$300) 50% (up to \$300)	No No Yes Yes Yes Yes	Up to a 90 day supply Up to a 90 day supply
Vision (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 necessary
Dental (accidental injury)	40%	Yes	noocosary
Dental (deolecinal injury) Dental (pediatric) Preventive Major Orthodontic	\$20 40% 50%	No No No	2 dental check-ups per benefit period 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.

The copays and coinsurance listed in the 'You Pay' column would only apply if the item or service is not furnished directly by a provider meeting the criteria outlined below, otherwise there would be no cost to you.

1) an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603);

2) a provider who was referred by one of the organizations listed in item 1.

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