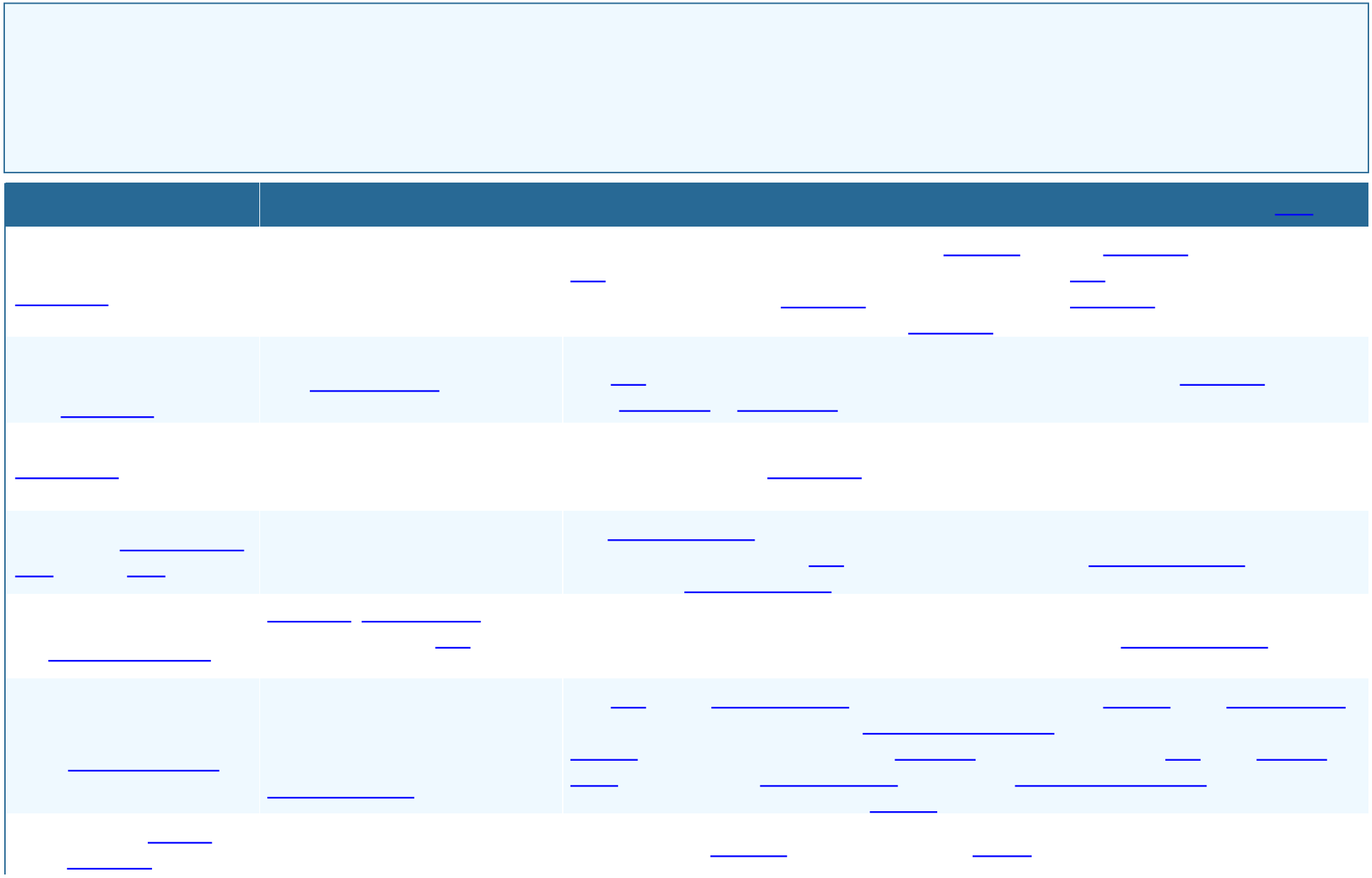

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	Refer to your Evidence of Coverage
	Urgent care	$30 copay	$30 copay	If you receive services in addition to urgent care, additional copayments, deductibles, or coinsurance may apply.
If you have a hospital stay†	Facility fee (e.g., hospital room)	30% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	30% coinsurance after deductible	Not covered	1 visit per physician per day
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	$20 copay for office visits and 30% coinsurance after deductible for other outpatient services	Not covered	None
	Inpatient services	30% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	$40 copay	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services†	30% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services†	30% coinsurance after deductible	Not covered	Your cost for inpatient services only. See above for physician delivery charges.
If you need help recovering or have other special health needs	Home health care†	30% coinsurance after deductible	Not covered	100 visits per Benefit Year. Refer to your Evidence of Coverage for additional information.
	Rehabilitation services† Physical/Occupational therapy Speech/Post-cochlear implant aural therapy	 $20 copay $20 copay	 Not covered Not covered	PT, OT, ST, Pulmonary limited to 20 visits each per Benefit Year. Cardiac limited to 36 visits. Manipulation therapy limited to 12 visits. Post-cochlear implant aural therapy

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 833-230-2099.

†Prior authorization may be required, for more details see www.caresource.com/mp-IN-pa.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 800-622-4461. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim