Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Network Provider Information*

*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-KY-pa.

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)	
	Urgent care	$50 copay	$50 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)	$500 copay after deductible per stay	Not covered	None
	Physician/surgeon fees	No charge after deductible	Not covered	1 visit per physician per day
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	$30 copay for office visits and 50% coinsurance after deductible for other outpatient services	Not covered	None
	Inpatient services	$500 copay after deductible per stay	Not covered	None
If you are pregnant	Office visits	$70 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†	No charge after deductible	Not covered	
	Childbirth/delivery facility services†	$500 copay 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†	50% coinsurance after deductible	Not covered	Private Duty Nursing limited to 250 visits per Benefit Year. 100 visits per Benefit Year for other services. Refer to your Evidence of Coverage for additional information.
	Rehabilitation services† Physical/Occupational therapy Speech/Post-cochlear implant aural therapy All other services	 $30 copay 50% coinsurance after deductible 50% coinsurance after deductible	 Not covered Not covered Not covered	PT, OT, ST, Pulmonary limited to 25 visits each per Benefit Year. Cardiac limited to 36 visits. Manipulation therapy and Cognitive limited to 20 visits each per Benefit Year. Post-cochlear implant aural therapy limited to 30 visits.

*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-KY-pa.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Network Provider Information*
	Habilitation services† Physical/Occupational therapy	$30 copay	Not covered	25 visits per Benefit Year
	Speech therapy	50% coinsurance after deductible	Not covered	25 visits per Benefit Year
	Hearing Aids	50% coinsurance after deductible	Not covered	1 hearing aid per hearing-impaired ear every 36 months
	Skilled nursing care†	$500 copay after deductible per stay	Not covered	90 Day limit per Benefit Year
	Durable medical equipment†	50% coinsurance after deductible	Not covered	Refer to your Evidence of Coverage
	Hospice services			

*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-KY-pa.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		

• Chiropractic care
• Dental care (Adult)
  • No charge for preventive services
  • 30% coinsurance for minor services
  • 50% coinsurance for major services
  • $1,000 annual allowance
	• Fitness Benefits – Gym membership, at home kits, online videos, coaching, and more
	• Hearing Aids
		• Private duty nursing
		• Routine eye care (Adult)
		  • $40 copay for eye exam with retinal imaging included
		  • No cost for glasses or contacts, with $250 annual allowance

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: 1-800-595-6053. Other coverage options may be available to you, too, including buying individual insurance coverage through the Kentucky Health Benefit Exchange. For more information about the Kentucky Health Benefit Exchange, visit kynect.ky.gov or call 1-855-306-8959.

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. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Kentucky Department of Insurance: 1-800-595-6053.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan