
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)	

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	Urgent care	$25 copay	$25 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)	$325 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	$5 copay for office visits and 20% coinsurance after deductible for other outpatient services	Not covered	None
	Inpatient services	$325 copay after deductible per stay	Not covered	None
If you are pregnant	Office visits	$35 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†	$325 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†	20% 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	 $5 copay 20% coinsurance after deductible 20% 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.

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