
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)	
If you visit a health care provider's office or clinic	Zero Cost Telemedicine Partner	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat an injury or illness.	No charge	Not covered	None
	Specialist visit			

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)	
If you need help recovering or have other special health needs	Home health care†	15% 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 All other services	 No charge 15% coinsurance after deductible 15% coinsurance after deductible	 Not covered 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 combined limit with ST.
	Habilitation services† Physical/Occupational therapy Speech therapy	 No charge 15% coinsurance after deductible	 Not covered Not covered	 20 visits per Benefit Year 20 visits per Benefit Year
	Skilled nursing care†	$150 copay after deductible per stay	Not covered	90 Day limit per Benefit Year
	Durable medical equipment†	15% coinsurance after deductible	Not covered	Refer to your Evidence of Coverage
	Hospice services	15% coinsurance after deductible	Not covered	Refer to your Evidence of Coverage
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam per Benefit Year
	Children's eyewear	No charge	Not covered	Limited to one pair of glasses or contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed.
	Children's dental check-up	No charge	Not covered	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 844-539-1733.
†Prior authorization may be required, for more details see www.caresource.com/mp-IN-pa.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)	Cosmetic surgery	Non-emergency care when traveling outside the U.S
Acupuncture	Dental care (Adult)	Routine eye care (Adult)
Bariatric surgery	Hearing Aids	Routine foot care
	Infertility treatment	Weight loss programs
	Long-term care	

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

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: 1-800-622-4461. 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. 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

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. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

- The plan's overall deductible $250
- Specialist *copayment* $15
- Hospital (facility) *copayment* $250
- Other *coinsurance* 15%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$810

Managing Joe's Type 2 Diabetes

(a y isn't covered