Common Medical Eve	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Informatic
		Network Provider (You will pay the leas	Out-of-Network Provid (You will pay the most	
	Urgent care	$5 copay	$5 copay	If you receive services in addition to u care, additional copayments, deductib coinsurance may apply.
If you have a hospital stay†	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	None
	Physician/surgeon fees	25% coinsurance	Not covered	1 visit per physician per day
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	No charge for office visits and 25% coinsurance for othe outpatient services	Not covered	None
	Inpatient services	25% coinsurance	Not covered	None
If you are pregnant	Office visits	$10 copay	Not covered	Cost sharing does not apply for preve services. Depending on the type of services, coinsurance may apply. Mat care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services†	25% coinsurance	Not covered	
	Childbirth/delivery facility services†	25% coinsurance	Not covered	Your cost for inpatient services only. S above for physician delivery charges.

*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-KY-pa.

Common Medical Eve	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-539-1733.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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 wil depending on the actual care you receive, the prices your provider 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 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 a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$0
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,860

Managing Joe's Type 2 Diabete
(a year of routine in-network care of a controlled condition)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	