
Common Medical Eve	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Informatio
		Network Provider (You will pay the leas	Out-of-Network Provide (You will pay the most	

*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.

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	Emergency medical transportation	40% coinsurance aft deductible	40% coinsurance after deductible	Refer to your Evidence of Coverage
	Urgent care	$60 copay	$60 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)	40% coinsurance aft deductible	Not covered	None
	Physician/surgeon fees	40% coinsurance aft deductible	Not covered	1 visit per physician per day
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	$40 copay for office visits and 40% coinsurance after deductible for other outpatient services	Not covered	None
	Inpatient services			

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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)
- Acupuncture
- Adult orthodontia
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Routine foot care
- Weight loss programs

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

- Chiropractic care

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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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