

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 Telehealth Par	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat injury or illness.	\$30 copay	Not covered	None
	Specialist visit	\$70 copay	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test†	Diagnostic test (x-ray, blood work)	X-ray: \$175 copay after deductible	Not covered	None
		Lab: \$40 copay		None
	Imaging (CT/PET scans, MRIs)	\$225 copay after deductible	Not covered	None
If you need drugs to treat your illness or condition† More information about prescription drug coverage is available at www.caresource.com/marketplace	Preventive drugs	No charge	Not covered	Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for drugs in Tiers 0-3 All others limited to a 30-day supply Any copays shown are for a 30-day supply 90-day supplies for Retail are 3 times the copay and for Mail Order are 2.5 times the copay. Insulin cost share not to exceed \$30 per 30-day supply in aggregate.
	Generic drugs	Up to \$3 copay	Not covered	
	Preferred brand drugs	Up to \$70 copay	Not covered	
	Non-preferred brand drug	40% coinsurance after deductible	Not covered	
	Specialty drugs	50% coinsurance after deductible	Not covered	
If you have outpatient surgery†	Facility fee (e.g., ambulatory surgery center)	40% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	40% coinsurance after deductible	Not covered	None
If you need immediate medical attention	Emergency room care	\$450 copay after deductible	\$450 copay after deductible	Emergency room copay or coinsurance waived if you are admitted to the hospital directly from the Emergency Department
	Emergency medical transportation	40% coinsurance after deductible	40% coinsurance after deductible	Refer to your Evidence of Coverage

*For more information about limitations and exceptions, please refer to the 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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	Children's dental check-ups	No charge	Not covered	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy document for more information and a list of any excluded services .)

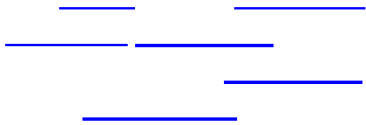
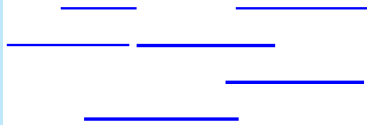
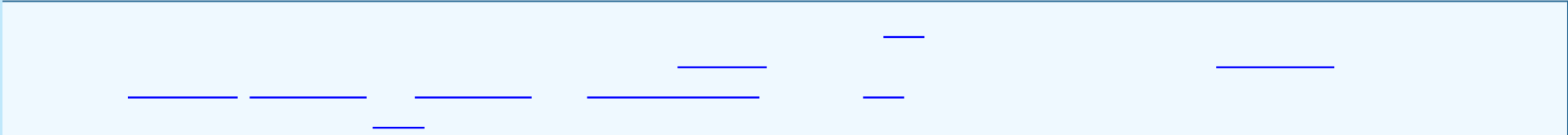
Chinese (): , 844-539-1733

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

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

*For more information about limitations and exceptions, see the plan or policy document at <https://www.ahca.state.fl.us/insurance/health-plans/individual-and-family-marketplace> or call 844-539-1733.

†Prior authorization may be required, for more details see <https://www.ahca.state.fl.us/insurance/health-plans/individual-and-family-marketplace>



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