
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	
If you visit a health car 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/immunizat	No charge	Not covered	You may have to pay for services tha preventive. Ask your provider if the se needed are preventive. Then check w your plan will pay for.
If you have a test†	Diagnostic test (x-ray, blo work)	X-ray: $175 copay at 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 abo 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 s 90-day supplies for Retail are 3 times copay and for Mail Order are 2.5 time copay. Insulin cost share not to exceed $30 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 aft deductible	Not covered	
	Specialty drugs	50% coinsurance aft deductible	Not covered	
If you have outpatient surgery†	Facility fee (e.g., ambulat surgery center)	40% coinsurance aft deductible	Not covered	None
	Physician/surgeon fees	40% coinsurance aft 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 coinsuran waived if you are admitted to the hosp directly from the Emergency Departm
	Emergency medical transportation	40% coinsurance aft deductible	40% coinsurance after deductible	Refer to your Evidence of Coverage

*For more information about limitations and exceptions, see 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-u	No charge	Not covered	2 check-ups per Benefit Year. Additio benefits available. Refer to your Evide Coverage

Excluded Services & Other Covered Services:

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

Chinese ( ): , 844-539-1733

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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