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 Partner	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat an injury or illness.	$15 copay	Not covered	None
	Specialist visit	$50 copay	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test†	Diagnostic test (x-ray, blood			

*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-OH-pa.

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)	
	Emergency medical transportation	30% coinsurance after deductible for both in-network and out-of-network providers	30% coinsurance after deductible for both in-network and out-of-network providers	None
	Urgent care	$30 copay	$30 copay	If you receive services in addition to urgent care, additional copayments, deductibles, or coinsurance may apply.
If you have a hospital stay†	Facility fee (e.g., hospital room)	$500 copay after deductible per stay	Not covered	None
	Physician/surgeon fees	No charge after deductible	Not covered	1 visit per physician per day
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	$15 copay for office visits and 30% coinsurance after deductible for other outpatient services	Not covered	None
	Inpatient services	$500 copay after deductible per stay	Not covered	None
If you are pregnant	Office visits	$50 copay	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services†	No charge after deductible	Not covered	
	Childbirth/delivery facility services†	$500 copay after deductible	Not covered	Your cost for inpatient services only. See 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-OH-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) • Acupuncture • Bariatric surgery	• Cosmetic surgery • Dental care (Adult) • Hearing Aids • Long-term care	• Non-emergency care when traveling outside the U.S •

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)