
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.

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

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