Note: Copays and coinsurance may be subject to deductibles with the exception of copays for primary care and specialty care office visits, preventive health services, urgent care visits, prescription drugs, and vision services - pediatric.

Category of Service	Service/Procedure	Prior Auth Required?	Limits & Comments	Specific Exclusions
Out of Network Provider		* = PA required	Coverage is provided (1) when a non-network provider renders emergency health services to a member, (2) when a member receives urgent care services while temporarily outside the service area, (3) when there is a specific situation with continuity of care (see "Section 2-How the Plan Works," under "Continuity of Care"), (4) when a member receives health care services from a non-network provider (such as an anesthesiologist or radiologist) while in the hospital or other facility that is a network provider, or *(5)* when the member is referred by their PCP to a non-network provider because the specialty care required by the member is not available from a network provider. In this case your PCP or network provider must obtain our prior authorization.	-
Behavioral Health				
	Mental/Behavioral Health Outpatient Specialist Visit	**PA required for intensive outpatient services and for visits that exceed 30 visits per benefit year.**	-	Behavioral health coverage excludes custodial or domiciliary care, supervised living or halfway houses, room and board charges unless the treatment provided meets our Medical Necessity criteria for an Inpatient Stay for your condition, services or care provided or billed by a school, halfway house,or Outward Bound programs, even if psychotherapy is included. Also excludes marital and sexual counseling/therapy and wilderness camps.
	Mental/Behavioral Health Outpatient Facility Services			
	Mental/Behavioral Health Inpatient Services	**PA required for inpatient stays and partial hospitalization**		
	Alcohol/Substance Abuse Disorder Outpatient Specialist Visit	**PA required for intensive outpatient services and for visits that exceed 30 visits per benefit year.**		
	Alcohol/Substance Abuse Disorder Outpatient Facility Services			
	Alcohol/Substance Abuse Disorder Inpatient Services	**PA required for inpatient stays and partial hospitalization**		
Dental				
	Routine & Major Dental Services (Adult)	**See Limitations**	N/A	Routine dental services, basic dental care, major dental care and orthodontia are not covered for adults age 19 and older under the basic CareSource plans. Accidental dental (treatment for dental emergencies) is covered for all ages. See Enhanced Plan Benefits below.
	Routine & Major Dental Services (Children)	**NOT COVERED but See Limitations**	CareSource is not offering dental care or orthodontia for children under its basic or enhanced plans. Accidental dental (treatment for dental emergencies) is covered for all ages.	
	Orthodontia – Child	**NOT COVERED**	-	Orthodontia for children age 18 and younger is excluded.
	Orthodontia – Adult	**NOT COVERED**	-	Orthodontia for adults age 19 and older is excluded.
	Accidental Dental	**Prior Authorization is required for reconstructive dental due to an accident**	Coverage is provided for Outpatient Services, Physician Home Visits and Office Services, Emergency Health Services and Urgent Care Services for dental work and oral surgery if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting your condition. ""Initial"" dental work to repair injuries due to an accident means performed within twelve (12) months from the injury, or as clinically appropriate and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to a dental related injury, there may be several years between the accident and the final repair. Covered Services for dental services related to accidental injury include, but are not limited to: Oral examinations; X-rays; Tests and laboratory examinations; Restorations; Prosthetic services; Oral surgery; Mandibular/maxillary reconstruction; and Anesthesia. Injury as a result of chewing or biting is not considered an accidental injury, and services related to such injuries are not Covered Services.	-
Diabetes				
	Diabetes Education, Equipment and Supplies	**If the member is receiving this benefit through a participating provider, then no PA is required.**	Coverage is provided for diabetes self-management training if the member has insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition. Diabetic training and treatment must be medically necessary, ordered in writing by a physician (or a podiatrist) and must be rendered by a network provider who is appropriately licensed, registered, or certified under state law to provide such training. Covered services in this category also include all physician-prescribed, medically necessary equipment and supplies used for the management and treatment of diabetes. Applicable copays and coinsurance are determined by the place of service and type of service, as shown in this schedule under DME, Preventive Care, Physician Office Visits, and Home Health care.	-
Diagnostic Services				
	Laboratory (outpatient) Services	**Prior Authorization is required for Genetic Testing and for Surrogate Markers for Detection of Heart Transplant Rejection - Gene Expression Profiling (i.e., Allomap)**	-	-
	Mammogram (Diagnostic)			
	Colonoscopy (Diagnostic)			
	Outpatient Advanced Diagnostic - Imaging and Nuclear Medicine	**Prior Authorization is required**	All stays: coverage includes Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), CAT scans, single-photon emission computerized tomography (SPECT), cardiographic, encephalographic, and radioisotope tests, nuclear cardiology imaging studies, allergy tests, Electrocardiograms (EKG), Electromyograms (EMG - except that surface EMGs are not covered), capsule endoscopy, echocardiograms, bone density studies, positron emission tomography (PET scans), diagnostic tests as an evaluation to determine the need for a covered transplant procedure, echographies, doppler studies, brainstem evoked potentials (BAER), sleep study, somatosensory evoked potentials (SSEP), visual evoked potentials (VEP), nerve conduction studies, muscle testing, electrocorticograms. Note: If the only charge from a physician office visit is for diagnostic services , then any copayment is waived.	-
	Ultrasounds (Non-maternity)	-	-	
	X-ray	-	-	

Note: Copays and coinsurance may be subject to deductibles with the exception of copays for primary care and specialty care office visits, preventive health services, urgent care visits, prescription drugs, and vision services - pediatric.

Category of Service	Service/Procedure	Prior Auth Required?	Limits & Comments	Specific Exclusions
DME				
	Durable Medical Equipment	PA required as described in Limits & Comments	DME coverage includes breast pumps for mothers with nursing infants. CareSource will follow the physician's recommendations for the proper pump to be provided, whether it is manual or electric, rented or purchased. Coinsurance percentages apply, as shown. PA required for Artificial Intervertebral Disc Replacement, Auditory Brain Stem Implant, Bone Growth Stimulation, Cochlear Implant, Continuous Glucose Monitoring Systems, Cranial Remolding Orthosis, DME Misc. Items (HCPCS Code E1399 >$750), High Frequency Chest Wall Oscillation System, Interspinous Process Decompression System (X-STOP), Knee Braces (Custom Fabricated), Mechanical Insufflation-Exsufflation Therapy, Microprocessor Knee (C-Leg), Mobile Cardiac Outpatient Telemetry, Motorized Wheelchairs and Power Accessories, Negative Pressure Wound Therapy, Vacuum- assisted Closure Device, Nutritional Supplements (Enteral Formulas), Oral Appliances for Obstructive Sleep Apnea- Custom (E0486), Pneumatic Compression Device, Power Operated Vehicles, Pressure Reducing Support Surfaces, Pulse Oximeter- Home use, Seasonal Affective Disorder Phototherapy (SAD Lamps), Speech Generating Device, TENS, Wearable Cardioverter Defibrillator (WED), All Custom Prosthetics/Orthotics, Wigs and anything not listed ove $750.00.	-
	Incontinence Supplies	PA required to establish medical necessity	-	-
	Prosthetic Devices	PA required for purchase or rental of prosthesis that exceed $750 and for all repairs.	Additional Exams, $0	All plans exclude: Dentures, replacing teeth or structures directly supporting teeth; Dental appliances; Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets; Artificial heart implants; wigs (except as otherwise preapproved).; and, penile prosthesis in men suffering impotency resulting from disease or injury
Emergency				
	Emergency Room Facility Fee	-	Covered inside and outside the US, including for out-of-network emergency services. No limitations. Note the emergency room facility copay will be waived if admitted.	
	Emergency Transportation/Ambulance	See Specific Exclusions for more information		**Ambulance services provided by ambulettes or similar vehicles are not covered.**
Family Planning				
	Family Planning	See Specific Exclusions for more information	No copay or coinsurance for family planning services (considered preventive health services). Copays and coinsurance do apply to infertility services based on whether inpatient or outpatient setting - see those sections for amounts. Coverage is provided for family planning services, including birth control and contraceptive devices (including condoms), sexually transmitted infections tests and treatment, screenings for cervical cancer and/or mammograms when indicated by a breast examination during a routine or periodic family planning visit as further described in the member's Explanation of Coverage handbook, and infertility services, including services for the diagnosis and treatment of infertility when provided by or under the direction of a network physician. Infertility-related covered services include medically necessary treatment, and procedures that treat the medical condition that results in infertility (e.g., endometriosis, blockage of fallopian tubes, varicocele, etc.).	**The following services and procedures are not covered**: Health care services and associated expenses for Assisted Reproductive Technology (ART) including but not limited to artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures or any other treatment or procedure designed to create a pregnancy, and any related prescription medication treatment. Other services and procedures that are not covered are: Embryo transport, donor ovum and semen and related costs including collection and preparation, the reversal of surgical sterilization, cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue, and any services related to surrogacy if Member is not the surrogate.
Hearing				
	Hearing Aids	NOT COVERED	Routine hearing screenings are covered as a preventive service.	-
Home Health				
	Private-Duty Nursing	-	Private duty nursing is covered, with no lifetime or annual limits.	-
	Home Health Care Services (including infusion services)	PA required for home infusion services. PA may be required for the medication	Private duty nursing is covered, with no lifetime or annual limits. Home health services are covered up to 100 visits per year. Therapy and infusion services provided as part of home health services are covered, except for manipulation therapy which will not be covered when rendered in the home. Home Care visit limits apply when therapy services are rendered in the home. Any combination of benefits for home health care services is limited to 100 visits per calendar year. One visit consists of no more than 4 hours of skilled care services. Please refer to the "Just4Me Authorization Requirements" (Medical Benefit; located here: https://www.caresource.com/documents/caresource-just4me-list-of-auth-reqs-for-drugs-under-medical-benefit/) or "Drug Formulary" (Pharmacy benefit, located here: https://www.caresource.com/just4me/resources/drug-formulary/)	
	Habilitation Services	PA required for clinical therapeutic intervention for the treatment of Autism Spectrum Disorder exceeding 20 hours per week.	Coverage is provided for habilitative services to children 20 years and younger who have a medical diagnosis of Autism Spectrum Disorder. Covered habilitative services include: Out-patient physical rehabilitation services including speech and language therapy and/or occupational therapy, performed by licensed therapists, 20 visits per benefit year and clinical therapeutic intervention defined as therapies supported by empirical evidence. This includes applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, 20 hours per week.	
Inpatient Services				
	Inpatient Hospital Services (e.g., Hospital Stay)	PA required unless otherwise noted		**Staff consultations required by hospital rules, consultations requested by you, routine radiological or cardiographic consultations, telephone consultation, and EKG transmittal by phone are not covered.**
	Inpatient Physician and Surgical Services	PA required prior to receiving surgery	All plans: Limit of 1 inpatient visit per day per physician or other professional provider. Procedures normally considered cosmetic surgery will be covered as medically necessary.	

Note: Copays and coinsurance may be subject to deductibles with the exception of copays for primary care and specialty care office visits, preventive health services, urgent care visits, prescription drugs, and vision services - pediatric.

Category of Service	Service/Procedure	Prior Auth Required?	Limits & Comments	Specific Exclusions
Maternity				
	Prenatal and Postnatal Care	-	Covered, including prenatal ultrasounds. Minimum stay of 48 hours for delivery and inpatient maternity services. Depending on the package elected, copays and deductible may apply. However, there is no coinsurance for delivery and inpatient services related to maternity care. Breast pumps for mothers with nursing infants are covered under DME; please refer to that section of this grid for details.	-
	Delivery and All Inpatient Services for Maternity Care	-		**CareSource does not cover births when the member is outside the service area and more than 37 weeks pregnant.**
Nursing Facility Services				
	Hospice Services	**See Specific Limits & Comments for more information**	Hospice services are covered for up to 6 months when a terminal illness is diagnosed. When recommended by an attending physician, hospice benefits may be provided for a longer period of time for those diagnosed with a terminal illness. Hospice benefits require a diagnosis of terminal illness, and hospice care may be provided in home or at a hospice facility where medical, social and psychological services are given to help treat individuals with terminal illnesses. Hospice services include routine home care, continuous home care, inpatient hospice and inpatient respite.	**Housekeeping services are excluded from hospice coverage.**
	Long-Term/Custodial Nursing Home Care	**NOT COVERED**	-	
	Skilled Nursing Facility	**PA required**	Covered for up to 90 days per year.	
Other				
	Emergency and Non-Emergency Care When Traveling Outside the U.S.		Coverage for emergency care when traveling outside the U.S. is covered the same as emergency care within the U.S. Non-emergency care when traveling outside the U.S. is not covered.	-
	Abortion	**NOT COVERED**	Induced abortion services are not covered except those in which the physician performing the abortion certifies in writing that the life of the mother would be endangered if the fetus were carried to term or in case of rape or incest. Provider must provide supporting documentation upon claim submission.	
	Treatment for Temporomandibular Joint Disorders	**PA required**	Coverage is subject to office visit copays, facility visit copays, and deductibles prior to coinsurance for services.	
Outpatient Services				
	Outpatient Surgery Physician/Surgical Services	**PA required as described in Limits & Comments**	Procedures normally considered cosmetic surgery will be covered as medically necessary. PA required for Autologous Chondrocyte Implantation, Electromagnetic Navigational Bronchoscopy, Lung Volume Reduction Surgery (LVRS), Osteochondral Allografts and Autografts , Phototherapy- Home Treatment, Psoriasis Laser Treatment, Canaloplasty- Open Angle Glaucoma, RF Ablation for Treatment of Tumors, RF Volumetric Tissue Reduction, Stereotactic Body Radiotherapy, Total Ankle Replacement, Transurethral RF Micro-Remodeling, Uterine Artery Embolization for Treatment of Fibroids, Uvulectomy, Uvulopalatopharyngoplasty, Ventricular Assist Device, Hyperbaric Oxygen Therapy, Balloon Sinusplasty, TMJ Surgery (Orthognathic)	Excludes oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.
	Urgent Care Centers or Facilities	-	-	N/A
	Sterilization (Surgical)	**PA required prior to receiving surgery**	Coverage is provided for female surgical sterilization procedures and related services received in a physician's office or on an outpatient basis at a hospital or alternate facility. Covered services in this category include the facility charge, the charge for required hospital-based professional services, supplies and equipment and for the surgeon's fees. Applicable copays and coinsurance are determined by the place of service and type of service, as shown in this schedule under Outpatient Services or Physician Office Visit.	-
	Dialysis	-	-	-
	Chemotherapy	-		
	Radiation	-		
	Infusion Therapy	**PA required for home infusion services. PA may be required for the medication**	Refer to the "Just4Me Authorization Requirements" (Medical Benefit; located here: https://www.caresource.com/documents/caresource-just4me-list-of-auth-reqs-for-drugs-under-medical-benefit/) or "Drug Formulary" (Pharmacy benefit, located here: https://www.caresource.com/just4me/resources/drug-formulary/)	-
	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	-	-	Excludes oral surgery that is dental in origin; Removal of impacted wisdom teeth; Reversal of voluntary sterilization; radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, weak, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses; surgical treatment of gynecomastia; treatment of hyperhidrosis; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectatic dermal veins.
Pharmacy				
	Generic Drugs	**PA for step-therapy may be required**	-	Pharmacy coverage excludes over the counter drugs and drugs with over the counter equivalents, drugs for weight loss, stop-smoking aids (prescribed medications for smoking cessation are covered), nutritional and/or dietary supplements, drugs for the treatment of sexual or erectile dysfunction or inadequacies, human growth hormone for children born small for gestational age, treatment of onchomycosis (considered cosmetic) and drugs used for cosmetic procedures or purposes. Some nutritional supplements covered under the medical benefit (DME).
	Preferred Brand Drugs	**PA for step-therapy may be required**		-
	Non-Preferred Brand Drugs	**PA for step-therapy may be required**		-
	Specialty Drugs	**PA required**		-

Note: Copays and coinsurance may be subject to deductibles with the exception of copays for primary care and specialty care office visits, preventive health services, urgent care visits, prescription drugs, and vision services - pediatric.

Category of Service	Service/Procedure	Prior Auth Required?	Limits & Comments	Specific Exclusions
Physician Office Visit				
	Primary Care Visit to Treat an Injury or Illness	-	Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations covered under "Preventive Care Services") received in a Physician's office are subject to copayments and coinsurance (see "Allergy testing" and "Diagnostic services"). However, if the only charge from a physician office visit is for allergy injections, allergy serum, diagnostic services or other therapy services, then any copayments are waived.	-
	Specialist Visit	-	-	-
	Office administration of an infused medication	**PA required for home infusion services. PA may be required for the medication**	Supplying and administering an infused or injected medication in the MD office. please refer to the "Just4Me Authorization Requirements" (Medical Benefit; located here: https://www.caresource.com/documents/caresource-just4me-list-of-auth-reqs-for-drugs-under-medical-benefit/) or "Drug Formulary" (Pharmacy benefit, located here: https://www.caresource.com/just4me/resources/drug-formulary/)	-
	Other Practitioner Office Visit (Nurse, Physician Assistant)	-	-	-
	Infertility Treatment	-	-	Excludes Health Care Services and associated expenses for Assisted Reproductive Technology (ART) including but not limited to: artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures or any other treatment or procedure designed to create a Pregnancy, and any related prescription medication treatment. Embryo transport. Donor ovum and semen and related costs including collection and preparation. The reversal of surgical sterilization. Cryo-preservation and other forms of preservation of reproductive materials. Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue. Services related to surrogacy if Member is not the surrogate
	Chiropractic Care	-	Visits to a state-licensed chiropractor are covered, with a limit of 12 spinal manipulations per year. Diagnostic radiology for chiropractic care is also covered - see this grid's section on "Diagnostic Services" for coverage. If a member's visit to a chiropractor does not include spinal manipulation, that visit will require a copay for a Specialist Visit, but will not count toward the member's limit of 12 spinal manipulations per year. If the visit does include both consult and spinal manipulation, both the specialist visit copay and the coinsurance amounts apply and the visit will count toward the 12-per-year maximum. For more details on chiropractic and osteopathic care for our members, refer to the plan's Explanation of Coverage.	-
	Routine Foot Care	**NOT COVERED**	-	**Excludes cutting or removal of corns and calluses; Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including: cleaning and soaking the feet; applying skin creams in order to maintain skin tone; other services that are performed when there is not a localized illness, injury or symptom involving the foot.**
	Acupuncture	**NOT COVERED**	-	**Excludes services or supplies related to alternative or complementary medicine. Examples of services in this category include: acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.**
	Well Baby Visits and Care	-	Well baby/well child visits are considered preventive care and no copays or coinsurance is required. A well-baby visit is when the baby is taken to the doctor for a full checkup, separate from any other visit for sickness or injury. Babies need to see the doctor or nurse 6 times during their first year. The first well-baby visit is 2 to 3 days after coming home from the hospital. After that visit, babies need to see the doctor or nurse for a well-baby visit when they are 1 month old, 2 months old, 4 months old, 6 months old, and 9 months old. A well-child visit is when the child is taken to the doctor for a full checkup, separate from any other visit for sickness or injury. Children ages 1 to 4 need to see the doctor or nurse for a well-child visit when they are 12 months old, 15 months old (1 year and 3 months), 18 months old (1 year and 6 months), 24 months old (2 years), 30 months old (2 years and 6 months), 3 years old, and 4 years old. Children ages 5 to 17 need to go to the doctor or nurse for a well-child visit once a year.	-
	Allergy Testing	-	Allergy testing, pharmaceutical injections and drugs (except immunizations covered under "Preventive Care Services") received in a Physician's office are subject to Copayments and Coinsurance. When the only charge from a Physician office visit is for allergy injections, allergy serum, or other therapy services, then any Copayments are waived.	-
	Preventive Care/Screenings/Immunization	-	The following preventive services are covered when provided by a network provider. No co-pays or coinsurance apply for these preventive services, even if a member's yearly deductible is not yet met for their plan: 1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked. 2. Alcohol Misuse screening and counseling. 3. Aspirin use to prevent cardiovascular disease for men and women of certain ages. 4. Blood Pressure screening for all adults. 5. Cholesterol screening for adults of certain ages or at higher risk. 6. Colorectal Cancer screening (colonoscopies) for adults over 50. 7. Depression screening for adults 8. Diabetes (Type 2) screening for adults with high blood pressure. 8. Diet counseling for adults at higher risk for chronic disease. 9. HIV screening for everyone ages 15 to 65, and other ages at increased risk. 10. Immunization vaccines for adults (doses, recommended ages, and recommended populations vary): Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella. 11. Obesity screening and counseling for all adults 12. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk. 13. Syphilis screening for all adults at higher risk. 14. Tobacco Use screening for all adults and cessation interventions for tobacco users.	-

Note: Copays and coinsurance may be subject to deductibles with the exception of copays for primary care and specialty care office visits, preventive health services, urgent care visits, prescription drugs, and vision services - pediatric.

Category of Service	Service/Procedure	Prior Auth Required?	Limits & Comments	Specific Exclusions
PT/OT/ST				
	Outpatient Rehabilitation Services	-	Includes physical therapy, occupational therapy, speech therapy, pulmonary therapy, cardiac rehabilitation, and spinal manipulation. There are separate 20 visit limits for physical therapy, occupational therapy, speech therapy, and pulmonary rehab. There is a 36 visit limit for cardiac rehab, and a 12 visit limit for spinal manipulation. If different types of therapy services are performed during one Physician office service or Outpatient Service, then each different type of therapy service will be considered a separate therapy visit. Each therapy visit will count against the applicable maximum visits listed below. For example, if both a physical therapy service and a spinal manipulation service are performed during a Physician office service or Outpatient Service, they will count as both one physical therapy visit and one spinal manipulation visit.	Physical Therapy: Excludes maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening. Occupational Therapy: Excludes diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Also excludes supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment. Cardiac Rehab: Excludes home programs, on-going conditioning and maintenance are not covered. Pulmonary Rehab: Excludes pulmonary rehabilitation in the acute inpatient rehabilitation setting. Additional exclusions: admission to a Hospital mainly for physical therapy; long term rehabilitation in an inpatient setting.
	Rehabilitative Speech Therapy	-	-	Speech and language therapy and/or occupational therapy, total limit of 20 visits per benefit year.
	Rehabilitative Occupational and Rehabilitative Physical Therapy			
Surgical Procedures				
	Bariatric Surgery	NOT COVERED		
	Cosmetic Surgery	NOT COVERED except as noted in the EOC under Reconstructive Surgery	See "Reconstructive Surgery," "Inpatient Services," and "Outpatient Services" for services normally considered cosmetic but which are covered as medically necessary.	
	Transplant	PA required prior to evaluation and work up for a tansplant, and prior to receiving surgery	Coverage is subject to office visit copays, facility visit copays, and deductibles prior to coinsurance for services. Medically necessary human organ and tissue transplant services are covered. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan. Coverage includes reimbursement for transportation and lodging expenses described above up to a maximum of $10,000. Coverage also includes reimbursement of up to $30,000 for expenses related to finding a donor who is not related to the member and who will be a donor for a bone marrow/stem cell covered transplant procedures. Refer to the Explanation of Coverage, Section 4-27 ("Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services" for specific details regarding the benefit year as defined for a transplant, precertification requirements, and additional limitations and conditions around transportation and lodging.	Excludes corneal and kidney transplants. For a list of the specifically excluded services under this benefit, see the Explanation of Coverage, Section 4, #27, pages 47-48.
	Reconstructive Surgery	PA required prior to receiving surgery	Covered services include necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child; Breast reconstruction resulting from a mastectomy; Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger; Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia; Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect; Tongue release for diagnosis of tongue-tied; Congenital disorders that cause skull deformity such as Crouzon's disease; Cleft lip; Cleft palate; and services normally considered cosmetic but which are covered as medically necessary services. Coverage is subject to office visit copays, facility visit copays, and deductibles prior to coinsurance for services.	
Vision				
	Routine Eye Exam (Adult)	-	**1 Routine eye exam per year** covered for adults as preventive health service, no copay or coinsurance. Enhanced plan benefits are listed below- Limit 1 per year	**Excludes services for vision training and orthoptics.**
	Routine Eye Exam for Children	-	There are no copayments, coinsurance or deductibles for **1 annual pediatric vision exam, 1 pair of frames, or lenses**. Covered frames are available from a limited selection of frames; provider will show the member the selection of covered frames. Replacement is covered 1 time in any 12-month period. Contact lenses are limited to a single purchase of up to a 3-month supply of daily disposables, or a 6-month supply of nondaily disposables, once per member in any 12-month period. Covered contact lenses are available from a selection of contact lenses; provider will show the covered person the selection of covered contact lenses. Replacement is limited to once in any 12 month period. For additional exams beyond one per year, a copayment (shown in table to the right) applies. For additional pair of eyeglasses or contacts lenses beyond the annual limits described above, coinsurance (shown in table to the right) applies.	-
	Eyeglasses for Children	Medically necessary contact lenses can be dispensed in lieu of other eyewear with PA; PA is also required for expenses in excess of $600 for medically necessary contact lenses.		
	Eyeglasses	Medically necessary contact lenses can be dispensed in lieu of other eyewear with PA; PA is also required for expenses in excess of $600 for medically necessary contact lenses.	Basic Plans: Not covered. Enhanced Plans: Covered up to $150 per year for frames and lenses, specific selection of frames.	
	Low Vision Care for Children	PA required; maximum allowances are listed in the EOC under Section 15, "Pediatric Vision, Low Vision Care." See also "Durable Medical Equipment." PA also required for DME of any dollar value associated with the treatment of low vision, such as lamps, magnifying glasses, etc.	For 18 and under only.	

Note: Copays and coinsurance may be subject to deductibles with the exception of copays for primary care and specialty care office visits, preventive health services, urgent care visits, prescription drugs, and vision services - pediatric.

Category of Service	Service/Procedure	Prior Auth Required?	Limits & Comments	Specific Exclusions
Disease Management Programs by CareSource	**Asthma** **Depression** **Diabetes Education** **Fitness** **Heart Disease** **High Blood Pressure & Cholesterol** **Low Back Pain** **Nutrition** **Pain Management** **Pregnancy** **Smoking Cessation** **Stress Management** **Weight Loss**	**Prior Authorization is required for Pain Management only.**	These benefit programs are educational in nature and may be accompanied by informational materials from CareSource. They are focused on clinical health and wellness conditions and are designed to enrich the health and lifestyles of members.	**Weight loss programs are not a covered benefit and are excluded whether or not they are pursued under medical or physician supervision.**
Enhanced Dental + Vision Benefits				
Enhanced Dental				
	Routine Dental Services (Adult)	-	The enhanced dental benefits are offered at an extra cost and include preventive and diagnostic (cleanings and exams), x-rays, basic restorative (fillings) and major restorative (extractions, dentures and crowns)services. Two preventive visits are allowed each year for cleanings and oral exams.	-
	Major Dental Services (Adult)	-	The enhanced dental benefits are offered at an extra cost and include preventive and diagnostic (cleanings and exams), x-rays, basic restorative (fillings) and major restorative (extractions, dentures and crowns)services. Two preventive visits are allowed each year for cleanings and oral exams.	-
	Orthodontia – Adult	**NOT COVERED**		**Orthodontia for adults age 19 and older is excluded.**
	Accidental Dental	-	All plans: Coverage is provided for for all Adults and Children under the basic plan. See above for specific accidental benefits that are covered.	-
Enhanced Vision				
	Routine Eye Exams, Glasses & Contact Lenses (Adult)	-	The enhanced vision plan supplements the vision exam benefit of our basic plan covering an additional routine eye exam for adults and coverage also includes eyeglasses (lenses and specifically selected frames) or contact lenses up to $150 per year with $25 copay required.	All plans: Excludes services for vision training and orthoptics.