

2020 Schedule of Benefits

Plan Name: CareSource Marketplace Low Premium Silver
Dental and Vision



Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2020]
Last Coverage Change Date	[01/01/2019]

Dependent Information

Dependent Name	[Nancy Doe]
Relationship to You	[Spouse]
Date of Birth	[01/01/1966]
Effective Date	[01/01/2020]

Highlights

Annual Deductible*	Individual: \$6,800 Family: \$13,600
Coinsurance	25%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$7,300 Family: \$14,600



* See Section 13: *Evidence of Coverage Glossary* for the definition of annual deductible. For individual coverage, you are responsible for paying the first \$6,800 of covered services each benefit year before CareSource begins to pay for any covered service where the annual deductible applies. For family coverage, you are responsible for paying the first \$13,600 for covered services for your entire family each benefit year before CareSource begins to pay for any covered service where the annual deductible applies. However, for each individual covered member within your family, the maximum amount each member would pay toward the family deductible is the individual deductible amount, in this case \$6,800 up to the family maximum of \$13,600. The annual deductible applies to covered services identified as “after deductible” in the Covered Service table below.

** See Section 13: *Evidence of Coverage Glossary* for the definition of annual out-of-pocket maximum. For family coverage, each individual covered member within your family is contributing toward the family annual out-of-pocket maximum. However, for each individual covered member within your family, the maximum amount each member would pay toward the family annual out-of-pocket maximum is the individual out-of-pocket maximum, which is \$7,300. Your Evidence of Coverage explains which benefits accrue to your out-of-pocket maximum.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Office Visits (includes retail clinics)		
Primary Care	\$35 copay	None
Specialist Care	\$70 copay	None
Preventive Care		
As defined by federal law	No charge	None

Learn more about CareSource and all our plan options at www.caresource.com/marketplace.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	25% coinsurance after deductible	May require prior authorization
X-Ray/Radiology	\$200 copay after deductible	May require prior authorization
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$250 copay after deductible	Prior authorization required
Mammograms (outpatient)		
Preventive	No charge	None
Diagnostic	\$200 copay after deductible	Prior authorization required
Inpatient Services		
Facility/Physician	\$500 copay after deductible	Prior authorization required
Skilled Nursing Facility	\$500 copay after deductible	Prior authorization required 60 day limit per benefit year
Outpatient Services		
Facility/Physician	25% coinsurance after deductible	May require prior authorization
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	\$70 copay	None
Inpatient Services	\$500 copay after deductible	Prior authorization required
Outpatient Services	25% coinsurance after deductible	May require prior authorization
Urgent Care	\$75 copay	None
Ambulance Services	25% coinsurance after deductible	Prior authorization is not required for emergency ambulance transportation or for facility to facility transfers. All other ambulance transportation requires prior authorization.
Emergency Health Care Services	\$500 copay after deductible	If admitted to the hospital directly from the Emergency Department, these services will be covered the same as inpatient services and the applicable Copayment and Coinsurance will apply.
Habilitative Services		
Physical Therapy	\$35 copay	40 combined visits per benefit year
Occupational Therapy	\$35 copay	
Speech Therapy	25% coinsurance after deductible	
Audiology	25% coinsurance after deductible	
Spinal Manipulation	25% coinsurance after deductible	
Rehabilitative Services		
Physical Therapy	\$35 copay	40 combined visits per benefit year
Occupational Therapy	\$35 copay	
Speech Therapy	25% coinsurance after deductible	
Audiology	25% coinsurance after deductible	
Cognitive Rehabilitation	25% coinsurance after deductible	
Spinal Manipulation	25% coinsurance after deductible	

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Behavioral Health Services	Covered the same as office visits, inpatient services, and outpatient services	Prior authorization is required for all inpatient stays and residential treatment programs. Partial hospitalization programs and intensive outpatient services may require prior authorization.
Transplant Services	Covered the same as office visits, inpatient services, and outpatient services	Prior authorization required
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services, and outpatient services	Prior authorization required
Home Health	25% coinsurance after deductible	Prior authorization required 120 combined visits per benefit year A visit equals at least 4 hours
Hospice Care	25% coinsurance after deductible	Prior authorization is required for inpatient, respite, or continuous care levels of care.
Diabetic Services		
Education	25% coinsurance after deductible	None
Equipment	25% coinsurance after deductible	None
Supplies	25% coinsurance after deductible	None
Medical Supplies, Durable Medical Equipment, and Appliances	25% coinsurance after deductible	May require prior authorization
Prescription Drugs		
<i>Retail</i>		
Tier 0 (Preventive)	No charge	Up to a 30-day supply May require prior authorization
Tier 1 (Low Cost)	\$30 copay	
Tier 2 (Preferred)	\$60 copay	
Tier 3 (Non-Preferred)	25% coinsurance after deductible	
Tier 4 (Specialty Preferred)	25% coinsurance after deductible	
Tier 5 (Specialty Non-Preferred)	50% coinsurance after deductible	
<i>Mail Order</i>		May require prior authorization
Tier 0 (Preventive)	No charge	Up to a 90-day supply
Tier 1 (Low Cost)	\$75 copay	Up to a 90-day supply
Tier 2 (Preferred)	\$150 copay	Up to a 90-day supply
Tier 3 (Non-Preferred)	25% coinsurance after deductible	Up to a 90-day supply
Tier 4 (Specialty Preferred)	25% coinsurance after deductible	Up to a 30-day supply
Tier 5 (Specialty Non-Preferred)	50% coinsurance after deductible	Up to a 30-day supply

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Vision (pediatric) Children's Eye Exam Low Vision Testing and Aids Children's Eyewear	No charge No charge No charge	1 routine eye exam per benefit year Limited to one evaluation and aid per benefit year. Limited to one pair of glasses or contact lenses once per benefit year. If medically necessary, a replacement pair of glasses is allowed.
Enhanced Vision (adults) Eye Exam Low Vision Testing and Aids Eyewear	\$40 copay No charge No charge	1 routine eye exam per benefit year Limited to one evaluation and aid per benefit year. 1 pair of glasses/contacts per benefit year up to a \$250 allowance
Dental (accidental injury)	25% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental (pediatric) Children's Dental Check-up Basic/Major Restorative Orthodontic	15% coinsurance after deductible 15% coinsurance after deductible 15% coinsurance after deductible	2 dental check-ups per benefit year None Prior authorization is required. Only covers orthodontic treatment for a congenital anomaly related to or developed as a result of cleft palate, with or without cleft lip.
Enhanced Dental (adults) Preventive and Diagnostic (2 check-ups per year) Basic/Major Restorative	\$25 copay 30% coinsurance	\$800 limit per benefit year

Prior Authorization: Some health care services require prior authorization from the Plan. Prior authorization is the process used by the Plan to determine those health care services listed on the Plan's prior authorization list that meet evidence-based criteria for medical necessity and are covered services under the Plan prior to the health care service being provided. The provider (in-network or out-of-network) is responsible for obtaining prior authorization for the health care services described on the prior authorization list. Please refer to Section 2 of the Evidence of Coverage at www.caresource.com/marketplace for complete details after you are enrolled.

This Schedule of Benefits is a summary of your financial responsibility when you receive health care services from a physician, pharmacy, facility, or other provider. All covered services are subject to the conditions, exclusions, limitations, terms, and rules of the Evidence of Coverage including any rider/enhancements or amendments. Except as otherwise provided in the Evidence of Coverage, covered services must be provided to you by a network provider and medically necessary. The Plan does not cover all health care service expenses. In the event of any discrepancy between this Schedule of Benefits and your Evidence of Coverage, the Evidence of Coverage shall control. For more detailed information about your covered services, please refer to the Evidence of Coverage at www.caresource.com/marketplace.

For covered services listed in the Evidence of Coverage that are not specifically listed on this Schedule of Benefits, the cost sharing is equal to the coinsurance after the deductible.

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-855-202-0729 TTY:711.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.