2020 Schedule of Benefits
Plan Name: CareSource Marketplace Low Premium Silver Limited

CareSource

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

This summary shows in-network benefits only.

* 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		40 combined visits per benefit year
Physical Therapy	$35 copay	
Occupational Therapy	$35 copay	
Speech Therapy	25% coinsurance after deductible	
Audiology	25% coinsurance after deductible	
Spinal Manipulation	25% coinsurance after deductible	
Rehabilitative Services		40 combined visits per benefit year
Physical Therapy	$35 copay	
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		
Retail		
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	
Mail Order		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

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Covered Service	**You Pay** (Network Providers Only)	**Limit** (If Applicable)
Vision (pediatric)		
Children's Eye Exam	No charge	1 routine eye exam per benefit year
Low Vision Testing and Aids	No charge	Limited to one evaluation and aid per benefit year.
Children's Eyewear	No charge	Limited to one pair of glasses or contact lenses once per benefit year. If medically necessary, a replacement pair of glasses is allowed.
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	15% coinsurance after deductible	2 dental check-ups per benefit year
Basic/Major Restorative	15% coinsurance after deductible	None
Orthodontic	15% coinsurance after deductible	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.

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.

The copays and coinsurance listed in the 'You Pay' column would only apply if the item or service is not furnished directly by a provider meeting the criteria outlined below, otherwise there would be no cost to you.
1) an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603);
2) a provider who was referred by one of the organizations listed in item 1.

CareSource®

This Notice has Important Information. This notice has important information about your application or coverage through CareSource. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-855-202-0729 TTY:711.

ARABIC
يحتوي هذا الإشعار على معلومات مهمة. يحتوي هذا الإشعار على معلومات مهمة بخصوص طلبك أو التغطية التي تحصل عليها من خلال CareSource. ابحث عن التواريخ المهمة في هذا الإشعار. قد تحتاج إلى اتخاذ إجراء معين قبل حلول أحد التواريخ للحفاظ على التغطية الصحية التي تحصل عليها أو للحصول على مساعدة بشأن التكاليف. يحق لك الحصول على مساعدة ومعلومات مجانا وباللغة التي تتحدث بها. اتصل على 1-855-202-0729 TTY:711.

AMHARIC ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ CareSource ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። 1-855-202-0729 TTY:711 ይደውሉ።

BURMESE ဤအသိပေးစာတွင် အရေးကြီးသော အချက်အလက်များ ပါဝင်ပါသည်။ ဤအသိပေးစာတွင် သင့်လျှောက်ထားမှု သို့မဟုတ် CareSource အတွင်း အကျုံးဝင်မှုအကြောင်း အရေးကြီးသော အချက်အလက်များ ပါဝင်ပါသည်။ ဤအသိပေးစာတွင်း အရေးကြီးသော ရက်စွဲများကို ရှာထားပါ။ သင့်ကျန်းမာရေး အကျုံးဝင်မှုအား ဆက်လက်ထားရှိထားရန် သို့မဟုတ် ကုန်ကျစရိတ်များနှင့် ပတ်သက်ပြီး အကူအညီရရှိရန် အချို့သော နောက်ဆုံးရက် သတ်မှတ်ချက်များဖြင့် ဆောင်ရွက်မှုပြုရန် လိုအပ်နိုင်ပါသည်။ သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ 1-855-202-0729 TTY:711 ဤတွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

CHINESE 此通知包含重要信息。 此通知包含关于您的申请以及 CareSource 医疗保险覆盖范围的重要信息。 请仔细查看本通知中的关键日期。 您可能需要在某些标注的截止日期前采取行动，以确保您的健康保险有效或者付费项目获得帮助。您有权免费获得以您的语言提供的此信息和帮助。 请致电 1-855-202-0729 TTY:711。

CUSHITE – OROMO Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa CareSource tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa1-855-202-0729 TTY:711 tii bilbilaa.

DUTCH Deze kennisgeving bevat belangrijke informatie. Deze kennisgeving bevat belangrijke informatie over uw aanvraag of dekking via CareSource. Let op belangrijke data in deze kennisgeving. Het kan nodig zijn om actie te ondernemen vóór bepaalde deadlines om uw gezondheidszorgdekking of hulp met de kosten te behouden. U hebt het recht om deze informatie en hulp kosteloos te ontvangen in uw taal. Bel 1-855-202-0729 TTY:711.

FRENCH (CANADA) Cet avis contient des renseignements importants. Cet avis contient des renseignements importants sur votre demande d'assurance auprès de CareSource ou la couverture obtenue par l'intermédiaire de CareSource. Prenez connaissance des dates clés mentionnées dans le présent avis. Assurez-vous de respecter les délais indiqués pour conserver votre protection et contribuer à réduire les coûts. Vous avez le droit d'obtenir gratuitement ces renseignements et du soutien dans votre langue. Téléphonez au 1-855-202-0729 TTY:711.

GERMAN Dieser Hinweis enthält wichtige Information. Dieser Hinweis enthält wichtige Information über Ihren Antrag oder Ihren Schutz durch CareSource. Achten Sie auf Schlüsseltermine in diesem Hinweis. Sie müssen eventuell innerhalb von bestimmten Fristen Maßnahmen ergreifen, um Ihre Gesundheitsversorgung aufrecht zu erhalten oder Hilfe mit den Kosten zu bekommen. Sie haben das Recht, kostenfrei in Ihrer eigenen Sprache diese Hilfe und Information zu bekommen. Rufen Sie die Nummer 1-855-202-0729 TTY:711an.

GUJARATI આ સૂર્ન મ ાં અગત્ની મ હહતી છે. આ સૂર્ન મ ાં તમ રી અરજી અથિ CareSource દ્વ રે સાંકળ ાની અગત્ની મ હહતી છે. આ સૂર્ન મ ાંની ખ સ ત રીખો જ ઓ. તમે તમારા આરોગ્ય કવરેજ રાખવા અથવા ખર્ચ સાથે મદદ કરવી માટે અમુક રોક્કસ મુદતો દ્વારા પગલાાં લેવાની જરૂર છે. તમને આ મ હહતી અને મદદ તમ રી ભ ષ મ ાં વિના મૂલ્ય મેળિ ાનો અવિક ર છે. આ 1-855-202-0729 TTY:711સાંપકય કરો.

HINDI इस नोटिस में महत्वपूर्ण सूचना है। इस नोटिस में आपके आवेदन या CareSource के माध्यम से आपके कवरेज के बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारिखों को देखें। आपको लागत सहित अपने हेल्थ कवरेज या सहायता को बनाए रखने के लिए विभिन्न समयसीमाओं में कार्रवाई करने की जरूरत हो सकती है। आपके पास बगैर किसी लागत के अपनी भाषा में यह जानकारी और सहायता प्राप्त करने का अधिकार है। कॉल करें, 1-855-202-0729 TTY:711.

ITALIAN Questa comunicazione contiene informazioni importanti. Questa comunicazione contiene informazioni importanti circa la sua iscrizione o copertura tramite CareSource. Cerchi le date principali in questa comunicazione. Potrebbe dover intraprendere delle azioni entro certe scadenze per mantenere la Sua copertura sanitaria o per contribuire ai costi. Ha il diritto di avere queste informazioni e supporto nella Sua lingua, senza alcun costo. Chiami il 1-855-202-0729 TTY:711.

JAPANESE この通知には重要な情報が含まれています。 この通知には、CareSource の申請または補償範囲に関する重要な情報が含まれています。 この通知に記載されている重要な日付をご確認ください。 健康保険や有料サポートを維持するには、特定の期日までに措置を講じていただく必要があります。 ご希望の言語による情報とサポートが無料で提供されます。 1-855-202-0729 TTY:711 にご連絡ください。

KOREAN 본 통지서는 중요한 정보를 담고 있습니다. CareSource 가입이나 혜택에 대한 중요한 정보가 안내되어 있습니다. 본 통지서에 나와 있는 주요 날짜들을 확인해 주십시오. 의료 혜택을 받거나 비용을 절약하시려면 특정 기한까지 조치를 취하셔야 할 수 있습니다. 원하는 언어로 별도 비용 없이 관련 정보와 안내를 받으실 수 있습니다. 다음 번호로 전화해 주십시오: 1-855-202-0729 TTY:711.

PENNSYLVANIA DUTCH Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit CareSource. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. 1-855-202-0729 TTY:711

RUSSIAN Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком, позвоните по номеру 1-855-202-0729 TTY:711.

SPANISH Este aviso incluye información importante. Este aviso incluye información importante sobre su solicitud o su cobertura de CareSource. Busque las fechas clave en este aviso. Es probable que deba realizar acciones dentro de determinado plazo para mantener su cobertura médica o recibir ayuda con los costos. Tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Llame al 1-855-202-0729 TTY:711.

UKRAINIAN Це Повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про вашу заяву чи відшкодування через CareSource. Шукайте важливі дати у цьому повідомленні. Вам може знадобитися вжити заходів у певні терміни, щоб отримати медичне страхування чи допомогу з витратами. Ви маєте право на безкоштовне отримання цієї інформації та допомоги вашою мовою. Зателефонуйте за номером 1-855-202-0729 TTY:711.

VIETNAMESE Thông báo này có thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin hoặc bảo hiểm của bạn thông qua CareSource. Hãy xem những ngày quan trọng trong thông báo này. Bạn có thể cần phải hành động trước một số thời hạn nhất định để duy trì bảo hiểm sức khỏe của mình hay được trợ giúp có trả phí. Bạn có quyền được nhận thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Vui lòng gọi số 1-855-202-0729 TTY:711.

Notice of Non-Discrimination

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.