2020 Schedule of Benefits
Plan Name: CareSource Marketplace Standard Silver 2

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: $1,000 Family: $2,000
Coinsurance	10%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $2,000 Family: $4,000

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 $1,000 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 $2,000 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 $1,000 up to the family maximum of $2,000. 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 $2,000. 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	$10 copay	None
Chiropractor (office visit only)	$10 copay	None
Specialist Care	$30 copay	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)
Preventive Care As defined by federal law	No charge	None
Diagnostic Services		
Lab	10% coinsurance after deductible	May require prior authorization
X-Ray/Radiology	$150 copay after deductible	May require prior authorization
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	$200 copay after deductible	Prior authorization required
Mammograms (outpatient)		
Preventive	No charge	None
Diagnostic	$150 copay after deductible	Prior authorization required
Inpatient Services		
Facility/Physician	$250 copay after deductible	Prior authorization required
Skilled Nursing Facility	$250 copay after deductible	Prior authorization required 90 day limit per benefit year
Outpatient Services		
Facility/Physician	10% coinsurance after deductible	May require prior authorization
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$30 copay	None
Inpatient Services	$250 copay after deductible	Prior authorization required
Outpatient Services	10% coinsurance after deductible	May require prior authorization
Urgent Care	$75 copay	None
Ambulance Services	10% 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	$250 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	$10 copay	25 visits per benefit year
Occupational Therapy	$10 copay	25 visits per benefit year
Speech Therapy	10% coinsurance after deductible	25 visits per benefit year
Rehabilitative Services		
Physical Therapy	$10 copay	25 visits per benefit year
Occupational Therapy	$10 copay	25 visits per benefit year
Speech Therapy	10% coinsurance after deductible	25 visits per benefit year
Pulmonary Rehabilitation	10% coinsurance after deductible	25 visits per benefit year
Cardiac Rehabilitation Services	10% coinsurance after deductible	36 visits per benefit year
Manipulation Therapy	10% coinsurance after deductible	Manipulation therapy - 20 visits per benefit year
Post-Cochlear Implant Aural Therapy	10% coinsurance after deductible	30 visits per benefit year
Cognitive Rehabilitation Therapy	10% coinsurance after deductible	20 visits per benefit year

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		**Prior authorization required**
Private Duty Nursing	10% coinsurance after deductible	250 visits per benefit year A visit equals 8 hours
All Other Services	10% coinsurance after deductible	100 combined visits per benefit year A visit equals at least 4 hours
Hospice Care	No charge for both in-network and out-of-network by Medicare-approved providers.	Prior authorization is required for inpatient, respite, or continuous care levels of care.
Diabetic Services		
Education	10% coinsurance after deductible	None
Equipment	10% coinsurance after deductible	None
Supplies	10% coinsurance after deductible	None
Medical Supplies, Durable Medical Equipment, and Appliances	10% coinsurance after deductible	May require prior authorization
Hearing Aids	15% coinsurance after deductible	1 hearing aid per hearing-impaired ear every 36 months
Prescription Drugs		
Retail		
Tier 0 (Preventive)	No charge	Up to a 30-day supply May require prior authorization
Tier 1 (Low Cost)	$15 copay	
Tier 2 (Preferred)	$40 copay	
Tier 3 (Non-Preferred)	10% coinsurance after deductible	
Tier 4 (Specialty Preferred)	10% 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)	$37.50 copay	Up to a 90-day supply
Tier 2 (Preferred)	$100 copay	Up to a 90-day supply
Tier 3 (Non-Preferred)	10% coinsurance after deductible	Up to a 90-day supply
Tier 4 (Specialty Preferred)	10% 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	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 a 12-month supply of contact lenses per benefit year. If medically necessary, a replacement pair of glasses is allowed.
Dental (accidental injury)	10% 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 copay	2 dental check-ups per benefit year
Basic/Major Restorative	20% coinsurance	None
Orthodontic	30% coinsurance	Prior authorization is required for medically necessary orthodontia. No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of $2,000.

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.

If you, or someone you're helping, have questions about CareSource, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-888-815-6446 TTY:711.

ARABIC
إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، اتصل على 1-888-815-6446 TTY:711.

AMHARIC
እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ CareSource ጥያቄ ካላቸሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-888-815-6446 TTY:711 ይደውሉ።

BURMESE
CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား စကားပြောဆိုရန် 1-888-815-6446 TTY:711 ကျေတွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

CHINESE
如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请致电 1-888-815-6446 TTY:711。

CUSHITE – OROMO
Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-888-815-6446 TTY:711 tiin bilbilaa.

DUTCH
Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk, bel dan naar 1-888-815-6446 TTY:711.

FRENCH (CANADA)
Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète, veuillez téléphoner au 1-888-815-6446 TTY:711.

GERMAN
Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, rufen Sie die Nummer 1-888-815-6446 TTY:711 an.

GUJARATI જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તેમ ાંથી કોઈને CareSource વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિિ નો અવિક ર છે. તે ખર્ે વિન તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર છે. ૬ ભ વખરો િ ત કરિ મ ટે,આ 1-888-815-6446 TTY:711 પર કોલ કરો.

HINDI
यदि आपके, या आप जिसकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल हैं तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, 1-888-815-6446 TTY:711.

ITALIAN
Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete, chiami il 1-888-815-6446 TTY:711.

JAPANESE
ご本人様、または身の回りの方で、CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます（無償）。通訳をご利用の場合は、1-888-815-6446 TTY:711 にご連絡ください。

KOREAN
귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 주십시오: 1-888-815-6446 TTY:711.

PENNSYLVANIA DUTCH
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-888-815-6446 TTY:711 uffrufe.

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 1-888-815-6446 TTY:711.

SPANISH
Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-888-815-6446 TTY:711.

UKRAINIAN
Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, зателефонуйте за номером 1-888-815-6446 TTY:711.

VIETNAMESE
Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi số 1-888-815-6446 TTY:711.

Notice of Non-Discrimination

CareSource

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 1-888-815-6446 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.