2018 Schedule of Benefits
Plan Name: CareSource Federal Simple Choice Silver Limited
Dental and Vision

CareSource

Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2018]
Last Coverage Change Date	[01/01/2017]

Dependent Information

Dependent Name	[Nancy Doe]
Relationship to You	[Spouse]
Date of Birth	[01/01/1966]
Effective Date	[01/01/2018]

Highlights

Annual Deductible*	Individual: $3,500 Medical/$500 Pharmacy Family: $7,000 Medical/$1,000 Pharmacy
Coinsurance	20%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays)	Individual: $7,350 Family: $14,700

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 $3,500 Medical/$500 Pharmacy 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 $7,000 Medical/$1,000 Pharmacy 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 towards the family deductible is the individual deductible amount, in this case $3,500 Medical/$500 Pharmacy up to the family maximum of $7,000 Medical/$1,000 Pharmacy. The annual deductible does not apply to covered services identified with "No" in the Subject to Deductible column 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 towards the family annual out-of-pocket maximum. However, for each individual covered member within your family, the maximum amount each member would pay towards the family annual out-of-pocket maximum is the individual out-of-pocket maximum, which is $7,350.

Covered Service	**You Pay** (Network Providers Only)	**Subject to Deductible**	**Limit** (If Applicable)
Office Visits (includes retail clinics)			
Primary Care	$30	No	
Specialist Care	$65	No	
Preventive Care			
As defined by federal law	$0	No	

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

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Diagnostic			
Lab	20%	Yes	May require prior authorization
X-Ray	20%	Yes	
Major Diagnostic — PET, MRI, MRA, CT, SPECT	20%	Yes	May require prior authorization
Mammograms (outpatient)			
Preventive	$0	No	
Diagnostic	20%	Yes	
Inpatient Services			
Facility/Physician	20%	Yes	Prior authorization required
Outpatient Services			
Facility	20%	Yes	May require prior authorization
Physician	20%	Yes	
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	$65	No	
Inpatient Services	20%	Yes	
Outpatient Services	20%	Yes	
Urgent Care	$75	No	
Emergency Services			
Emergency Room Services	20%	Yes	Emergency room copay or coinsurance waived if you are admitted to the hospital directly from the Emergency Department
Ambulance Services	20%	Yes	
Habilitative Services			
Physical Therapy	$30	No	25 visits per benefit year
Occupational Therapy	$30	No	25 visits per benefit year
Speech Therapy	$30	No	25 visits per benefit year
Rehabilitative Services			
Physical Therapy	$30	No	25 visits per benefit year
Occupational Therapy	$30	No	25 visits per benefit year
Speech Therapy	$30	No	25 visits per benefit year
Pulmonary Rehabilitation	20%	Yes	25 visits per benefit year
Cardiac Rehabilitation Services	20%	Yes	36 visits per benefit year
Chiropractic Services	20%	Yes	Manipulation therapy - 20 visits per benefit year
Post-Cochlear Implant Aural Therapy	20%	Yes	30 visits per benefit year
Cognitive Rehabilitation Therapy	20%	Yes	20 visits per benefit year
Behavioral Health Services	Covered the same as office visits, inpatient services and outpatient services		Prior authorization is required for all inpatient stays. Partial hospitalization and intensive outpatient services may require prior authorization
Transplant Services	Covered the same as office visits, inpatient services and outpatient services		Prior authorization required

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services and outpatient services		
Skilled Nursing	20%	Yes	90 day limit per benefit year
Private Duty Nursing	20%	Yes	250 visits per benefit year. One visit equals 8 hours.
Home Health	20%	Yes	100 visits per benefit year. One visit equals at least 4 hours.
Hospice Care	0%	No	Prior authorization required
Diabetic Services			
Education	20%	Yes	
Equipment	20%	Yes	
Supplies	20%	Yes	
Durable Medical Equipment	20%	Yes	May require prior authorization
Prescription Drugs			
Retail — 30-day supply			
Tier 0: Preventive	$0	No	Up to a 31 day supply
Tier 1: Generic	$15	No	Up to a 31 day supply
Tier 2: Preferred	$50	No	Up to a 31 day supply
Tier 3: Non-Preferred	$100	No	Up to a 31 day supply
Tier 4: Specialty Preferred	$150	Yes	Up to a 31 day supply
Tier 5: Specialty Non-Preferred	Not Applicable	N/A	
Mail Order — 90-day supply			
Tier 0: Preventive	$0	No	Up to a 90 day supply
Tier 1: Generic	$37.50	No	Up to a 90 day supply
Tier 2: Preferred	$125	No	Up to a 90 day supply
Tier 3: Non-Preferred	$250	No	Up to a 90 day supply
Tier 4: Specialty Preferred	$375	Yes	Up to a 90 day supply
Tier 5: Specialty Non-Preferred	Not Applicable	N/A	
Vision (pediatric)			
Eye Exam for Children	$0	No	One routine eye exam per benefit year
Eye Wear	$0	No	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
Enhanced Vision (adults)	$0	No	$250 limit per year One routine eye exam per benefit year at no charge
Dental (accidental injury)	20%	Yes	
Dental (pediatric)			
Preventive/Diagnostic	$30	No	2 dental check-ups per benefit year
Minor/Major	20%	No	
Orthodontic	40%	No	No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of $2,000
Enhanced Dental (adults)			
Preventive/Diagnostic (2 check-ups per year)	$30	No	$800 limit for all services combined
Basic Restorative	25%	No	
Major Restorative	25%	No	

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

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 Chapter 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.

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.