2018 Schedule of Benefits
Plan Name: CareSource Low Premium Silver 3 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: $600 Family: $1,200
Coinsurance	5%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays)	Individual: $700 Family: $1,400

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 $600 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 $1,200 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 $600 up to the family maximum of $1,200. 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 $700.

Covered Service	**You Pay** (Network Providers Only)	**Subject to Deductible**	**Limit** (If Applicable)
Office Visits (includes retail clinics)			
Primary Care	$5	No	
Specialist Care	$25	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	5%	Yes	May require prior authorization
X-Ray	5%	Yes	
Major Diagnostic — PET, MRI, MRA, CT, SPECT	$150	Yes	May require prior authorization
Mammograms (outpatient)			
Preventive	$0	No	
Diagnostic	5%	Yes	
Inpatient Services			
Facility/Physician	$275	Yes	Prior authorization required
Outpatient Services			
Facility	5%	Yes	May require prior authorization
Physician	5%	Yes	
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	$25	No	
Inpatient Services	$275	Yes	Prior authorization required
Outpatient Services	5%	Yes	
Urgent Care	$75	No	
Emergency Services			
Emergency Room Services	$275	Yes	Emergency room copay or coinsurance waived if you are admitted to the hospital directly from the Emergency Department
Ambulance Services	5%	Yes	
Autism			
Occupational Therapy	5%	Yes	20 visits per benefit year
Speech Therapy	5%	Yes	20 visits per benefit year
Behavioral Therapy	$5	No	
Habilitative Services			
Physical Therapy	5%	Yes	20 visits per benefit year
Occupational Therapy	5%	Yes	20 visits per benefit year
Speech Therapy	5%	Yes	20 visits per benefit year
Rehabilitative Services			
Physical Therapy	5%	Yes	20 visits per benefit year
Occupational Therapy	5%	Yes	20 visits per benefit year
Speech Therapy	5%	Yes	20 visits per benefit year
Cardiac Rehabilitation Services	5%	Yes	36 visits per benefit year
Chiropractic Services	5%	Yes	Manipulation therapy - 12 visits per benefit year
Behavioral Health Services	Covered the same as office visits, inpatient services and outpatient services		Prior authorization required for all inpatient stays, partial hospitalization programs and intensive outpatient services
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	$125	Yes	90 day limit per benefit year
Private Duty Nursing	5%	Yes	100 combined visits per benefit year. A visit equals 15 minutes to 8 hours of service.
Home Health	5%	Yes	100 combined visits per benefit year
Hospice Care	5%	Yes	Prior authorization required
Diabetic Services			
Education	5%	Yes	
Equipment	5%	Yes	
Supplies	5%	Yes	
Durable Medical Equipment	5%	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	$5	No	Up to a 31 day supply
Tier 2: Preferred	$20	No	Up to a 31 day supply
Tier 3: Non-Preferred	5%	Yes	Up to a 31 day supply
Tier 4: Specialty Preferred	5%	Yes	Up to a 31 day supply
Tier 5: Specialty Non-Preferred	5%	Yes	Up to a 31 day supply
Mail Order — 90-day supply			
Tier 0: Preventive	$0	No	Up to a 90 day supply
Tier 1: Generic	$12.50	No	Up to a 90 day supply
Tier 2: Preferred	$50	No	Up to a 90 day supply
Tier 3: Non-Preferred	5%	Yes	Up to a 90 day supply
Tier 4: Specialty Preferred	5%	Yes	Up to a 90 day supply
Tier 5: Specialty Non-Preferred	5%	Yes	Up to a 90 day supply
Vision (pediatric)			
Eye Exam for Children	$0	No	One routine eye exam per benefit year
Low Vision Exam	5%	Yes	1 exam and follow-up visit every 5 years
Eye Wear	$0	No	Limited to one pair per benefit year and one replacement pair if medically necessary
Enhanced Vision (adults)	$0	No	$250 limit per year One routine eye exam per benefit year at no charge
Dental (accidental injury)	5%	Yes	
Dental (pediatric)			
Preventive	5%	Yes	2 dental check-ups per benefit year
Major	5%	Yes	
Orthodontic	5%	Yes	No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of $3,000
Enhanced Dental (adults)			
Preventive and Diagnostic (2 check-ups per year)	$0	No	$800 limit for all services combined
Basic Restorative	5%	No	
Major Restorative	5%	No	

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.