

2018 Schedule of Benefits

Plan Name: CareSource HSA Bronze



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: \$4,000 Family: \$8,000
Coinsurance	50%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays)	Individual: \$6,550 Family: \$13,100

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 \$4,000 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 \$8,000 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 towards the family deductible is the individual deductible amount, in this case \$4,000 up to the family maximum of \$8,000. 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 \$6,550.

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Office Visits (includes retail clinics) Primary Care Specialist Care	50% 50%	Yes Yes	
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	50%	Yes	May require prior authorization
X-Ray	50%	Yes	
Major Diagnostic — PET, MRI, MRA, CT, SPECT	50%	Yes	May require prior authorization
Mammograms (outpatient) Preventive	\$0	No	
Diagnostic	50%	Yes	
Inpatient Services Facility/Physician	50%	Yes	Prior authorization required
Outpatient Services Facility	50%	Yes	May require prior authorization
Physician	50%	Yes	
Maternity Care Prenatal Visit, Office Visits and Postpartum Care	50%	Yes	
Inpatient Services	50%	Yes	
Outpatient Services	50%	Yes	
Urgent Care	50%	Yes	
Emergency Services Emergency Room Services	50%	Yes	Emergency room copay or coinsurance waived if you are admitted to the hospital directly from the Emergency Department
Ambulance Services	50%	Yes	
Habilitative Services Physical Therapy	50%	Yes	30 visits per benefit period
Occupational Therapy	50%	Yes	30 visits per benefit period
Speech Therapy	50%	Yes	30 visits per benefit period
Rehabilitative Services Physical Therapy	50%	Yes	30 visits per benefit period
Occupational Therapy	50%	Yes	30 visits per benefit period
Speech Therapy	50%	Yes	30 visits per benefit period
Cardiac Rehabilitation Services	50%	Yes	36 visits per benefit period
Chiropractic Services	50%	Yes	Manipulation therapy - 30 visits per benefit period
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

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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	50%	Yes	90 day limit per benefit period
Private Duty Nursing	50%	Yes	100 combined visits per benefit period One visit equals at least 4 hours.
Home Health	50%	Yes	100 combined visits per benefit period
Hospice Care	50%	Yes	Prior authorization required
Diabetic Services			
Education	50%	Yes	
Equipment	50%	Yes	
Supplies	50%	Yes	
Durable Medical Equipment	50%	Yes	May require prior authorization
Prescription Drugs			
<i>Retail — 30-day supply</i>			
Tier 0: Preventive	\$0	No	Up to a 31 day supply
Tier 1: Generic	50%	Yes	Up to a 31 day supply
Tier 2: Preferred	50%	Yes	Up to a 31 day supply
Tier 3: Non-Preferred	50%	Yes	Up to a 31 day supply
Tier 4: Specialty Preferred	50%	Yes	Up to a 31 day supply
Tier 5: Specialty Non-Preferred	50%	Yes	Up to a 31 day supply
<i>Mail Order — 90-day supply</i>			
Tier 0: Preventive	\$0	No	Up to a 90 day supply
Tier 1: Generic	50%	Yes	Up to a 90 day supply
Tier 2: Preferred	50%	Yes	Up to a 90 day supply
Tier 3: Non-Preferred	50%	Yes	Up to a 90 day supply
Tier 4: Specialty Preferred	50%	Yes	Up to a 90 day supply
Tier 5: Specialty Non-Preferred	50%	Yes	Up to a 90 day supply
Vision (pediatric)			
Eye Exam for Children	\$0	No	One routine eye exam per benefit period
Eye Wear	\$0	No	Limited to one pair per benefit period and one replacement pair if medically necessary
Dental (accidental injury)	50%	Yes	
Dental (pediatric)			
Preventive	50%	Yes	2 dental check-ups per benefit period
Major	50%	Yes	
Orthodontic	50%	Yes	No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of \$1,700

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.

Your CareSource marketplace plan was designed to meet certain requirements set by the Internal Revenue Service and qualifies as a high deductible health plan (HDHP). As such, your CareSource marketplace plan is compatible for use with a Health Savings Account (HSA). However, please be aware that CareSource is not offering or administering an HSA in conjunction with your CareSource marketplace HDHP. In addition, your enrollment in a CareSource marketplace HDHP is only one of the eligibility requirements for establishing and maintaining an HSA. You are responsible for determining whether you are eligible to establish an HSA. You should consult your financial, tax or legal advisor for more information regarding your obligations and eligibility for establishing and maintaining an HSA.