2018 Schedule of Benefits
Plan Name: CareSource Silver 1 Dental and Vision

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: $3,900 Family: $7,800
Coinsurance	30%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays)	Individual: $5,850 Family: $11,700

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 $3,900 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 $7,800 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 $3,900 up to the family maximum of $7,800. 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 $5,850.

Covered Service	**You Pay** (Network Providers Only)	**Subject to Deductible**	**Limit** (If Applicable)
Office Visits (includes retail clinics)			
Primary Care	$10	No	
Specialist Care	$40	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	$75	Yes	May require prior authorization
X-Ray	$150	Yes	
Major Diagnostic — PET, MRI, MRA, CT, SPECT	$200	Yes	May require prior authorization
Mammograms (outpatient)			
Preventive	$0	No	
Diagnostic	$150	Yes	
Inpatient Services			
Facility/Physician	$300 per day for days 1-5, $0 per day for days 6-100	No	Prior authorization required
Outpatient Services			
Facility	30%	Yes	May require prior authorization
Physician	30%	Yes	
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	$40	No	
Inpatient Services	$300 per day for days 1-5, $0 per day for days 6-100	No	
Outpatient Services	30%	Yes	
Urgent Care	$75	No	
Emergency Services			
Emergency Room Services	$500	Yes	Emergency room copay or coinsurance waived if you are admitted to the hospital directly from the Emergency Department
Ambulance Services	30%	Yes	
Habilitative Services			
Physical Therapy	$40	No	30 visits per benefit period
Occupational Therapy	$40	No	30 visits per benefit period
Speech Therapy	$40	No	30 visits per benefit period
Rehabilitative Services			
Physical Therapy	$40	No	30 visits per benefit period
Occupational Therapy	$40	No	30 visits per benefit period
Speech Therapy	$40	No	30 visits per benefit period
Cardiac Rehabilitation Services	30%	Yes	36 visits per benefit period
Chiropractic Services	30%	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

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	$300 per day for days 1-5, $0 per day for days 6-90	No	90 day limit per benefit period
Private Duty Nursing	30%	Yes	100 combined visits per benefit period One visit equals at least 4 hours.
Home Health	30%	Yes	100 combined visits per benefit period
Hospice Care	30%	Yes	Prior authorization required
Diabetic Services			
Education	30%	Yes	
Equipment	30%	Yes	
Supplies	30%	Yes	
Durable Medical Equipment	30%	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	$10	No	Up to a 31 day supply
Tier 2: Preferred	$50	No	Up to a 31 day supply
Tier 3: Non-Preferred	$200	No	Up to a 31 day supply
Tier 4: Specialty Preferred	40% (up to $300)	Yes	Up to a 31 day supply
Tier 5: Specialty Non-Preferred	50% (up to $300)	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	$25	No	Up to a 90 day supply
Tier 2: Preferred	$125	No	Up to a 90 day supply
Tier 3: Non-Preferred	$500	No	Up to a 90 day supply
Tier 4: Specialty Preferred	40% (up to $300)	Yes	Up to a 90 day supply
Tier 5: Specialty Non-Preferred	50% (up to $300)	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
Enhanced Vision (adults)	$0	No	$250 limit per year One routine eye exam per benefit year at no charge
Dental (accidental injury)	30%	Yes	
Dental (pediatric)			
Preventive	$0	No	2 dental check-ups per benefit period
Major	20%	No	
Orthodontic	30%	No	No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of $2,000
Enhanced Dental (adults)			
Preventive and Diagnostic (2 check-ups per year)	$0	No	$800 limit for all services combined
Basic Restorative	$0	No	
Major Restorative	20%	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.