

2019 Schedule of Benefits

Plan Name: CareSource Marketplace Low Deductible Silver



Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2019]
Last Coverage Change Date	[01/01/2018]

Dependent Information

Dependent Name	[Nancy Doe]
Relationship to You	[Spouse]
Date of Birth	[01/01/1966]
Effective Date	[01/01/2019]

Highlights

Annual Deductible*	Individual: \$4,400 Family: \$8,800
Coinsurance	30%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays)	Individual: \$7,500 Family: \$15,000

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 \$4,400 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 \$8,800 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 \$4,400 up to the family maximum of \$8,800. The annual deductible applies to covered services not 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 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 \$7,500.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Office Visits (includes retail clinics)		
Primary Care	\$10 copay	None
Specialist Care	\$60 copay	None
Preventive Care		
As defined by federal law	No charge	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)
Diagnostic Lab	30% coinsurance after deductible	May require prior authorization
X-Ray	\$150 copay after deductible	May require prior authorization
Major Diagnostic — PET, MRI, MRA, CT, SPECT	\$250 copay after deductible	May require prior authorization
Mammograms (outpatient) Preventive	No charge	None
Diagnostic	\$150 copay after deductible	May require prior authorization
Inpatient Services Facility/Physician	\$500 copay after deductible	Prior authorization required
Outpatient Services Facility/Physician	30% coinsurance after deductible	May require prior authorization
Maternity Care Prenatal Visit, Office Visits and Postpartum Care	\$60 copay	None
Inpatient Services	\$500 copay after deductible	Prior authorization required
Outpatient Services	30% coinsurance after deductible	May require prior authorization
Urgent Care	\$75 copay	None
Emergency Services Emergency Room Services	\$500 copay after deductible	Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department.
Ambulance Services	30% coinsurance after deductible	Ambulance transports must be made to the closest local facility that can provide you with covered services appropriate for your medical condition.
Habilitative Services Physical Therapy	\$10 copay	20 visits per benefit year
Occupational Therapy	\$10 copay	20 visits per benefit year
Speech Therapy	30% coinsurance after deductible	20 visits per benefit year
Rehabilitative Services Physical Therapy	\$10 copay	20 visits per benefit year
Occupational Therapy	\$10 copay	20 visits per benefit year
Speech Therapy	30% coinsurance after deductible	20 visits per benefit year
Cardiac Rehabilitation Services	30% coinsurance after deductible	36 visits per benefit year
Chiropractic Services	30% coinsurance after deductible	Manipulation therapy - 12 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, residential treatment programs, partial hospitalization programs and intensive outpatient services.

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
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
Skilled Nursing	\$400 copay after deductible	90 day limit per benefit year
Private Duty Nursing	30% coinsurance after deductible	100 combined visits per benefit year. A visit equals 8 hours or less.
Home Health	30% coinsurance after deductible	100 combined visits per benefit year. A visit equals at least 4 hours.
Hospice Care	30% coinsurance after deductible	Prior authorization is required for inpatient, respite or continuous care levels of care.
Diabetic Services		
Education	30% coinsurance after deductible	None
Equipment	30% coinsurance after deductible	None
Supplies	30% coinsurance after deductible	None
Durable Medical Equipment	30% coinsurance after deductible	May require prior authorization
Prescription Drugs		
<i>Retail — 30-day supply</i>		
Tier 0: Preventive	No charge	Up to a 30-day supply May require prior authorization
Tier 1: Generic	\$10 copay	
Tier 2: Preferred	\$60 copay	
Tier 3: Non-Preferred	30% coinsurance after deductible	
Tier 4: Specialty Preferred	30% coinsurance after deductible	
Tier 5: Specialty Non-Preferred	50% coinsurance after deductible	
<i>Mail Order — 90-day supply</i>		
Tier 0: Preventive	No charge	Up to a 90-day supply May require prior authorization
Tier 1: Generic	\$25 copay	
Tier 2: Preferred	\$150 copay	
Tier 3: Non-Preferred	30% coinsurance after deductible	
Tier 4: Specialty Preferred	30% coinsurance after deductible	
Tier 5: Specialty Non-Preferred	50% coinsurance after deductible	
Vision (pediatric)		
Children's Eye Exam	No charge	1 routine eye exam per benefit year
Low Vision Exam	30% coinsurance after deductible	May require prior authorization
Children's Glasses	No charge	Limited to one pair of glasses or a 12-month supply of contact lenses per benefit year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Dental (accidental injury)	30% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental (pediatric) Children's Dental Check-up Basic/Major Restorative Orthodontic	\$30 copay 20% coinsurance 40% coinsurance	2 dental check-ups per benefit year None 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 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.

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, religion 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, religion 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 call the member services number on your member ID card.

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, religion 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>.