**2019 Schedule of Benefits**
Plan Name: CareSource Marketplace 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 | [01/01/2019] |
| 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: $600<br>Family: $1,200 |
| Coinsurance | 5% |
| Annual Out-of-Pocket Maximum**<br>(includes deductible, coinsurance and copays) | Individual: $800<br>Family: $1,600 |

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 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 $800.

| **Covered Service** | **You Pay**<br>(Network Providers Only) | **Limit**<br>(If Applicable) |
|---|---|---|
| **Office Visits** (includes retail clinics) | | |
| Primary Care | $5 copay | None |
| Specialist Care | $25 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 | 5% coinsurance after deductible | May require prior authorization |
| X-Ray | $50 copay after deductible | May require prior authorization |
| **Major Diagnostic** — PET, MRI, MRA, CT, SPECT | $100 copay after deductible | May require prior authorization |
| **Mammograms** (outpatient) | | |
| Preventive | No charge | None |
| Diagnostic | $50 copay after deductible | May require prior authorization |
| **Inpatient Services** | | |
| Facility/Physician | $200 copay after deductible | Prior authorization required |
| **Outpatient Services** | | |
| Facility/Physician | 5% coinsurance after deductible | May require prior authorization |
| **Maternity Care** | | |
| Prenatal Visit, Office Visits and Postpartum Care | $25 copay | None |
| Inpatient Services | $200 copay after deductible | Prior authorization required |
| Outpatient Services | 5% coinsurance after deductible | May require prior authorization |
| **Urgent Care** | $75 copay | None |
| **Emergency Services** | | |
| Emergency Room Services | $200 copay after deductible | Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department. |
| Ambulance Services | 5% 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 | $5 copay | 20 visits per benefit year |
| Occupational Therapy | $5 copay | 20 visits per benefit year |
| Speech Therapy | 5% coinsurance after deductible | 20 visits per benefit year |
| **Rehabilitative Services** | | |
| Physical Therapy | $5 copay | 20 visits per benefit year |
| Occupational Therapy | $5 copay | 20 visits per benefit year |
| Speech Therapy | 5% coinsurance after deductible | 20 visits per benefit year |
| Cardiac Rehabilitation Services | 5% coinsurance after deductible | 36 visits per benefit year |
| Chiropractic Services | 5% 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. |

| 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** | $100 copay after deductible | 90 day limit per benefit year |
| **Private Duty Nursing** | 5% coinsurance after deductible | 100 combined visits per benefit year. A visit equals 8 hours or less. |
| **Home Health** | 5% coinsurance after deductible | 100 combined visits per benefit year. A visit equals at least 4 hours. |
| **Hospice Care** | 5% coinsurance after deductible | Prior authorization is required for inpatient, respite or continuous care levels of care. |
| **Diabetic Services** | | |
| Education | 5% coinsurance after deductible | None |
| Equipment | 5% coinsurance after deductible | None |
| Supplies | 5% coinsurance after deductible | None |
| **Durable Medical Equipment** | 5% coinsurance after deductible | May require prior authorization |
| **Prescription Drugs** | | |
| *Retail — 30-day supply* | | |
| Tier 0: Preventive | No charge | Up to a 30-day supply<br>May require prior authorization |
| Tier 1: Generic | $5 copay | |
| Tier 2: Preferred | $20 copay | |
| Tier 3: Non-Preferred | 5% coinsurance after deductible | |
| Tier 4: Specialty Preferred | 5% coinsurance after deductible | |
| Tier 5: Specialty Non-Preferred | 50% coinsurance after deductible | |
| *Mail Order — 90-day supply* | | |
| Tier 0: Preventive | No charge | Up to a 90-day supply<br>May require prior authorization |
| Tier 1: Generic | $12.50 copay | |
| Tier 2: Preferred | $50 copay | |
| Tier 3: Non-Preferred | 5% coinsurance after deductible | |
| Tier 4: Specialty Preferred | 5% 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 | 5% 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 |
| **Enhanced Vision** (adults) | | |
| Eye Exam | $25 copay | $250 limit per benefit year for glasses/contacts |

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Dental** (accidental injury) | 5% coinsurance after deductible | Injury as a result of chewing or biting is not considered an accidental injury. |
| **Dental** (pediatric) | | |
| Children's Dental Check-up | 5% coinsurance after deductible | 2 dental check-ups per benefit year |
| Basic/Major Restorative | 5% coinsurance after deductible | None |
| Orthodontic | 5% coinsurance after deductible | Prior authorization is required for medically necessary orthodontia. No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of $3,000. |
| **Enhanced Dental** (adults) | | |
| Preventive and Diagnostic (2 check-ups per year) | No charge | $800 limit per benefit year |
| Basic/Major Restorative | 5% coinsurance | |

**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**.

If you, or someone you're helping, have questions about CareSource, you have the right to get help and information in your language at no cost. Please call the member services number on your member ID card.

**ARABIC**
إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدةٍ ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، رجى الاتصال على رقم خدمة الأعضاء الموجود على بطاقة تعريف العضو الخاصة بك.

**AMHARIC**
እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ CareSource ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር አባክዎን በመታወቂያ ካርዱ ላይ ባለው የአገልግሎቶች ቁጥር ይደውሉ።

**BURMESE**
CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား ခြေးဖျက၊ ပါပြူ သက်၏ အသက်ကြီ ကြ်ကြက်ပေါ်ရှိ အသက်ကြီ ကြ် ဝက်ဇ ငြင်မှုဝက်ျဝ်ံနံက်သို့သို့ ဓာဇ်ူန်။

**CHINESE**
如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请拨打您的会员 ID 卡上的会员服务电话号码。

**CUSHITE – OROMO**
Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, Maaloo lakkoofsa bilbilaa isa waraqaa eenyummaa keessan irra jiruun tajaajila miseensaatiif bilbilaa.

**DUTCH**
Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk. Bel naar het nummer voor ledendiensten op uw lidkaart

**FRENCH (CANADA)**
Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète. Veuillez communiquer avec les services aux membres au numéro indiqué sur votre carte de membre.

**GERMAN**
Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, Bitte rufen Sie die Mitglieder-Servicenummer auf Ihrer Mitglieder-ID-Karte an

**GUJARATI** જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તેમ ાંથી કોઈને [એસબીએમ ક ૃયક્ૃરમન ાં ન મ મ કો] વશિ પ્ૂરશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળાિનો અવકિ ર છે. તે ખર્ૂય વનિ તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષર્ો ાંત કરમિ ટે,કૃપા કરીને તમારા સભ્ય આઈડી કાર્ડ પર સભ્ય સેવા માટે ના નંબર પર ફોન કરો.

**HINDI**
यदआपके, या आप जसिकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल हैं तो आपके पास बगैर कसिी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधकिार है। एक दुभाषए से बात करने के लए कॉल करें, कृपया अपने सदस्य आईडी कार्ड पर दयि सदस्य सेवा नंबर पर कॉल करें।

**ITALIAN**
Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete. Chiamare il numero dei servizi ai soci riportato sulla tessera di iscrizione.

**JAPANESE**
ご本人様、または身の回りの方で、CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます（無償）。 通訳をご利用の場合は、お持ちの会員IDカードにある、会員サービスの電話番号までお問い合わせ下さい。

**KOREAN**
귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 귀하의 회원 ID 카드에 적힌 회원 서비스 팀 번호로 전화하십시오.

**PENNSYLVANIA DUTCH**
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, Bel alstublieft met het Ledenservice nummer op uw lid ID -kaart.

**RUSSIAN**
Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно Caresource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком. Пожалуйста, позвоните по телефону отдела обслуживания клиентов, указанному на вашей идентификационной карточке клиента.

**SPANISH**
Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete. Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

**UKRAINIAN**
Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, Зателефонуйте за номером обслуговування учасників, який вказано на вашому посвідченні учасника

**VIETNAMESE**
Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên. Vui lòng gọi số dịch vụ thành viên trên thẻ ID thành viên của bạn.

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# Notice of Non-Discrimination

CareSource

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.