Plan Name: CareSource Hoosier Choice Silver 1 Dental and Vision



This summary nows in-network benefits only.

Plan Information

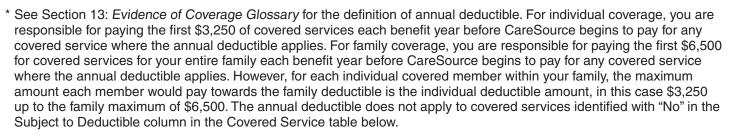
Primary Member	
Member ID	
Date of Birth	
Effective Date	
Last Coverage Change Date	

Dependent Information

Dependent Name	
Relationship to You	
Date of Birth	
Effective Date	

Highlights

Annual Deductible*	Individual: \$3,250 Family: \$6,500	
Coinsurance	30%	sh
Annual Out-of-Pocket Maximum**	Individual: \$5,500	
(includes deductible, coinsurance and copays)	Family: \$11,000	



** 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 \$5,500.

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Office Visits (includes retail clinics) Primary Care Specialist Care	\$0 \$40	No No	
Preventive Care As defined by federal law	\$0	No	

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Diagnostic Lab X-RaySileYesSileMajor Diagnostic PET, MRI, MRA, CT, SPECTS160YesIntermediationMarmograms (outpatient) PreventiveS0No S125SileSileInpatient Services FacilityS00 per day for days 1-5 S00 per day for days 1-5 S00 per day for days 1-5 S00 per day for days 5-10 S00 per day for days 5-10 NoPrior authorization requiredMaternity Care Pronatal Visit, Office Visits and Postpartum Care Inpatient ServicesS40 S00 per day for days 6-10 S00 per day for days 6-10 No S00 per day for days 6-10 S00 per day for days 6-10 No S00 per day for days 6-10 No No S00 per day for days 6-10 No No No No No S00 per day for days 6-10 No No No No No No S00 per day for days 6-10 No<	Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
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\$0 per day for days 6-100 Image: Solution of the	Joint Disorder and Craniomandibular			
benefit year	Skilled Nursing		No	90 day limit per benefit period
Hospice Care 30% Yes Prior authorization required	Home Health	30%	Yes	
	Hospice Care	30%	Yes	Prior authorization required

Learn more about CareSource and all our plan options at CareSource.com/marketplace.

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Diabetic Services Education Equipment Supplies	30% 30% 30%	Yes Yes Yes	
Durable Medical Equipment	30%	Yes	May require prior authorization
Prescription Drugs Retail — 30-day supply Tier 0: Preventive Tier 1: Generic Tier 2: Preferred Tier 3: Non-Preferred Tier 4: Specialty Preferred Tier 5: Specialty Non-Preferred	\$0 \$0 \$50 \$130 40% 50%	No No No No No	Up to a 31 day supply Up to \$300 and up to a 31 day supply Up to \$300 and up to a 31 day supply
Mail Order — 90-day supply Tier 0: Preventive Tier 1: Generic Tier 2: Preferred Tier 3: Non-Preferred Tier 4: Specialty Preferred Tier 5: Specialty Non-Preferred	\$0 \$0 \$125 \$325 40% 50%	No No No No No	Up to a 90 day supply Up to \$300 and up to a 90 day supply Up to \$300 and up to a 90 day supply
Vision (pediatric) Eye Exam for Children Eye Glasses	\$0 30%	No Yes	One routine eye exam per benefit year. Limited to one pair per benefit year and one replacement pair if medically necessary.
Enhanced Vision (adults)	\$25	Yes	\$150 limit per year
Dental (accidental injury)	30%	Yes	
Dental (pediatric) Preventive Major Orthodontic	\$0 30% 40%	No No No	2 dental check-ups per benefit period Orthodontia lifetime limit \$2,000
Enhanced Dental (adults) Preventive and Diagnostic (2 check-ups per year) Basic Restorative Major Restorative	\$0 \$0 30%	No No No	\$800 limit for all services combined

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 evidencebased criteria for medical necessity and are covered services under the Plan prior to the health care service being provided. The provider 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 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 CareSource.com/marketplace.

Non-Discrimination Statement:

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.

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.

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。