2017 Schedule of Benefits
Plan Name: CareSource Hoosier Choice Silver 1 Dental and Vision

CareSource

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%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays)	Individual: $5,500 Family: $11,000

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 $3,250 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 $6,500 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 $3,250 up to the family maximum of $6,500. 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 $5,500.

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

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)
Diagnostic			
Lab	30%	Yes	
X-Ray	$125	Yes	
Major Diagnostic — PET, MRI, MRA, CT, SPECT	$160	Yes	
Mammograms (outpatient)			
Preventive	$0	No	
Diagnostic	$125	Yes	
Inpatient Services			
Facility	$200 per day for days 1-5, $0 per day for days 6-100	No	Prior authorization required
Physician	30%	Yes	
Outpatient Services			
Facility	30%	Yes	
Physician	30%	Yes	
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	$40	No	
Inpatient Services	$200 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	$350	Yes	Emergency room copay or coinsurance waived if you are admitted to the hospital directly from the Emergency Department.
Ambulance Services	30%	Yes	
Therapy Services			
Physical Therapy	30%	Yes	20 visits per benefit period
Occupational Therapy	30%	Yes	20 visits per benefit period
Speech Therapy	30%	Yes	20 visits per benefit period
Cardiac Rehabilitation Services	30%	Yes	36 visits per benefit period
Chiropractic Services	30%	Yes	Manipulation therapy - 12 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		
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services and outpatient services		
Skilled Nursing	$100 per day for days 1-5, $0 per day for days 6-100	No	90 day limit per benefit period
Home Health	30%	Yes	100 combined visits per benefit year
Hospice Care	30%	Yes	Prior authorization required

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
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	$0	No	Up to a 31 day supply
Tier 2: Preferred	$50	No	Up to a 31 day supply
Tier 3: Non-Preferred	$130	No	Up to a 31 day supply
Tier 4: Specialty Preferred	40%	No	Up to $300 and up to a 31 day supply
Tier 5: Specialty Non-Preferred	50%	No	Up to $300 and 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	$0	No	Up to a 90 day supply
Tier 2: Preferred	$125	No	Up to a 90 day supply
Tier 3: Non-Preferred	$325	No	Up to a 90 day supply
Tier 4: Specialty Preferred	40%	No	Up to $300 and up to a 90 day supply
Tier 5: Specialty Non-Preferred	50%	No	Up to $300 and up to a 90 day supply
Vision (pediatric)			
Eye Exam for Children	$0	No	One routine eye exam per benefit year.
Eye Glasses	30%	Yes	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	$0	No	2 dental check-ups per benefit period
Major	30%	No	
Orthodontic	40%	No	Orthodontia lifetime limit $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	30%	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 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.

Learn more about CareSource and all our plan options 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。