

his summary bws in-network benefits only.

Plan Information

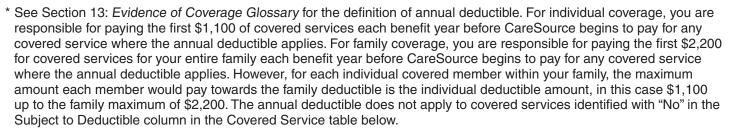
Primary Member	
Member ID	
Date of Birth	
Effective Date	
Last Coverage Change Date	

Dependent Information

Dependent Name	
Relationship to You	
Date of Birth	
Effective Date	

Highlights

Annual Deductible*	Individual: \$1,100 Family: \$2,200	Th
Coinsurance	10%	sho
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copay	Individual: \$2,000 /s) Family: \$4,000	be



** 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 \$2,000.

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Office Visits (includes retail clinics) Primary Care Specialist Care	\$15 \$30	No 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	10%	Yes	
X-Ray	10%	Yes	
Major Diagnostic — PET, MRI, MRA, CT, SPECT	10%	Yes	
Mammograms (outpatient)			
Preventive	\$0	No	
Diagnostic	10%	Yes	
Inpatient Services			
Facility	10%	Yes	Prior authorization required
Physician	10%	Yes	
Outpatient Services			
Facility	10%	Yes	
Physician	10%	Yes	
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	\$30	No	
Inpatient Services	10%	Yes	
Outpatient Services	10%	Yes	
Urgent Care	\$100	No	
Emergency Services			
Emergency Room Services	10%	Yes	Emergency room copay or
			coinsurance waived if you
			are admitted to the hospital
			directly from the Emergency
Ambulance Services	10%	Yes	Department.
	1070	100	
Therapy Services Physical Therapy	10%	Yes	20 visits per benefit period
Occupational Therapy	10%	Yes	20 visits per benefit period
Speech Therapy	10%	Yes	20 visits per benefit period
Cardiac Rehabilitation Services	10%	Yes	36 visits per benefit period
Chiropractic Services	10%	Yes	Manipulation therapy - 12
			visits per benefit period
Behavioral Health Services	Covered the same as office	e visits, inpatient	Prior authorization required
	services and outpatie		for all inpatient stays, partial
			hospitalization programs and
			intensive outpatient services.
Transplant Services	Covered the same as office	e visits, inpatient	
•	services and outpatie		
Temporomandibular/Craniomandibular	Covered the same as office	e visits, inpatient	
Joint Disorder and Craniomandibular	services and outpatie		
Jaw Disorder		1	
Skilled Nursing	10%	Yes	90 day limit per benefit period
Home Health	10%	Yes	100 combined visits per
			benefit year
Hospice Care	10%	Yes	Prior authorization required

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Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
Diabetic Services			
Education	10%	Yes	
Equipment	10%	Yes	
Supplies	10%	Yes	
Durable Medical Equipment	10%	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	\$45	No	Up to a 31 day supply
Tier 3: Non-Preferred	10%	Yes	Up to a 31 day supply
Tier 4: Specialty Preferred	10%	Yes	Up to a 31 day supply
Tier 5: Specialty Non-Preferred	10%	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	\$0	No	Up to a 90 day supply
Tier 2: Preferred	\$112.50	No	Up to a 90 day supply
Tier 3: Non-Preferred	10%	Yes	Up to a 90 day supply
Tier 4: Specialty Preferred	10%	Yes	Up to a 90 day supply
Tier 5: Specialty Non-Preferred	10%	Yes	Up to a 90 day supply
Vision (pediatric)			
Eye Exam for Children	\$0	No	One routine eye exam per benefit year.
Eye Glasses	10%	Yes	Limited to one pair per benefit year and one replacement pair if medically necessary.
Dental (accidental injury)	10%	Yes	
Dental (pediatric)			
Preventive	Not Applicable	N/A	
Major	Not Applicable	N/A	
Orthodontic	Not Applicable	N/A	

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.

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Spanish

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Chinese

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