

This summary hows in-network benefits only.

## **Plan Information**

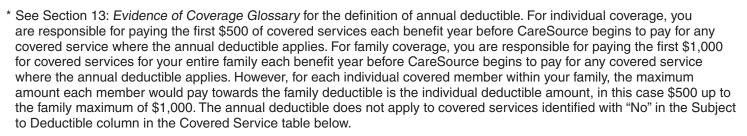
Primary Member	
Member ID	
Date of Birth	
Effective Date	
Last Coverage Change Date	

# **Dependent Information**

Dependent Name	
Relationship to You	
Date of Birth	
Effective Date	

# **Highlights**

Annual Deductible*	Individual: \$500 Family: \$1,000		
Coinsurance	5%	s	sI
Annual Out-of-Pocket Maximum**	Individual: \$900		
(includes deductible, coinsurance and copays)	Family: \$1,800		



\*\* 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 \$900.

Covered Service	You Pay (Network Providers Only)	Subject to Deductible	Limit (If Applicable)
<b>Office Visits</b> (includes retail clinics) Primary Care Specialist Care	\$5 \$10	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	<b>You Pay</b> (Network Providers Only)	Subject to Deductible	<b>Limit</b> (If Applicable)
Diagnostic			
Lab	5%	Yes	
X-Ray	5%	Yes	
Major Diagnostic — PET, MRI, MRA, CT, SPECT	5%	Yes	
Mammograms (outpatient)			
Preventive	\$0	No	
Diagnostic	5%	Yes	
Inpatient Services			
Facility	5%	Yes	Prior authorization required
Physician	5%	Yes	
Outpatient Services			
Facility	5%	Yes	
Physician	5%	Yes	
Maternity Care			
Prenatal Visit, Office Visits and Postpartum Care	\$10	No	
Inpatient Services	5%	Yes	
Outpatient Services	5%	Yes	
Urgent Care	\$100	No	
	<b> </b>		
Emergency Services Emergency Room Services	5%	Yes	Emergency room copay or coinsurance waived if you are admitted to the hospital directly from the Emergency Department.
Ambulance Services	5%	Yes	Department
<b>Therapy Services</b> Physical Therapy Occupational Therapy Speech Therapy Cardiac Rehabilitation Services Chiropractic Services	5% 5% 5% 5% 5%	Yes Yes Yes Yes Yes	20 visits per benefit period 20 visits per benefit period 20 visits per benefit period 36 visits per benefit period Manipulation therapy - 12 visits per benefit period
Behavioral Health Services	Covered the same as office services and outpatien		Prior authorization required for all inpatient stays, partial hospitalization programs and intensive outpatient services.
Transplant Services	Covered the same as office services and outpatien		
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office services and outpatier		
Skilled Nursing	5%	Yes	90 day limit per benefit period
Home Health	5%	Yes	100 combined visits per benefit year

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Covered Service	You Pay (Network Providers Only)	Subject to Deductible	<b>Limit</b> (If Applicable)
Diabetic Services			
Education	5%	Yes	
Equipment	5%	Yes	
Supplies	5%	Yes	
Durable Medical Equipment	5%	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	\$20	No	Up to a 31 day supply
Tier 3: Non-Preferred	5%	Yes	Up to a 31 day supply
Tier 4: Specialty Preferred	5%	Yes	Up to a 31 day supply
Tier 5: Specialty Non-Preferred	5%	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	\$50	No	Up to a 90 day supply
Tier 3: Non-Preferred	5%	Yes	Up to a 90 day supply
Tier 4: Specialty Preferred	5%	Yes	Up to a 90 day supply
Tier 5: Specialty Non-Preferred	5%	Yes	Up to a 90 day supply
Vision (pediatric)			
Eye Exam for Children	\$0	No	One routine eye exam per benefit year.
Eye Glasses	5%	Yes	Limited to one pair per benefit year
-			and one replacement pair if medically
			necessary.
Dental (accidental injury)	5%	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.

## **Non-Discrimination Statement:**

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#### Spanish

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### Chinese

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