

2018 Schedule of Benefits

Plan Name: CareSource Gold Dental and Vision



Plan Information

| | |
|---------------------------|--------------|
| Primary Member | [John Doe] |
| Member ID | [104000000] |
| Date of Birth | [01/01/1965] |
| Effective Date | [01/01/2018] |
| Last Coverage Change Date | [01/01/2017] |

Dependent Information

| | |
|---------------------|--------------|
| Dependent Name | [Nancy Doe] |
| Relationship to You | [Spouse] |
| Date of Birth | [01/01/1966] |
| Effective Date | [01/01/2018] |

Highlights

| | |
|---------------------------------------------------------------------------------|-----------------------------------------|
| Annual Deductible* | Individual: \$1,500 Family: \$3,000 |
| Coinsurance | 20% |
| Annual Out-of-Pocket Maximum** (includes deductible, coinsurance and copays) | Individual: \$5,000 Family: \$10,000 |



* See Section 13: *Evidence of Coverage Glossary* for the definition of annual deductible. For individual coverage, you are responsible for paying the first \$1,500 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 \$3,000 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 \$1,500 up to the family maximum of \$3,000. 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 \$5,000.

| Covered Service | You Pay (Network Providers Only) | Subject to Deductible | Limit (If Applicable) |
|-----------------------------------------------------------------------------------|-------------------------------------|-----------------------|--------------------------|
| Office Visits (includes retail clinics) Primary Care Specialist Care | \$10 \$50 | No No | |
| Preventive Care As defined by federal law | \$0 | No | |

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

| Covered Service | You Pay (Network Providers Only) | Subject to Deductible | Limit (If Applicable) |
|----------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------|
| Diagnostic Lab | 20% | Yes | May require prior authorization |
| X-Ray | 20% | Yes | |
| Major Diagnostic — PET, MRI, MRA, CT, SPECT | 20% | Yes | May require prior authorization |
| Mammograms (outpatient) Preventive | \$0 | No | |
| Diagnostic | 20% | Yes | |
| Inpatient Services Facility/Physician | 20% | Yes | Prior authorization required |
| Outpatient Services Facility | 20% | Yes | May require prior authorization |
| Physician | 20% | Yes | |
| Maternity Care Prenatal Visit, Office Visits and Postpartum Care | \$50 | No | Prior authorization required |
| Inpatient Services | 20% | Yes | |
| Outpatient Services | 20% | Yes | |
| Urgent Care | \$75 | No | |
| Emergency Services Emergency Room Services | 20% | Yes | Emergency room copay or coinsurance waived if you are admitted to the hospital directly from the Emergency Department |
| Ambulance Services | 20% | Yes | |
| Autism Occupational Therapy | \$50 | No | 20 visits per benefit year |
| Speech Therapy | \$50 | No | 20 visits per benefit year |
| Behavioral Therapy | \$10 | No | |
| Habilitative Services Physical Therapy | \$50 | No | 20 visits per benefit year |
| Occupational Therapy | \$50 | No | 20 visits per benefit year |
| Speech Therapy | \$50 | No | 20 visits per benefit year |
| Rehabilitative Services Physical Therapy | \$50 | No | 20 visits per benefit year |
| Occupational Therapy | \$50 | No | 20 visits per benefit year |
| Speech Therapy | \$50 | No | 20 visits per benefit year |
| Cardiac Rehabilitation Services | 20% | Yes | 36 visits per benefit year |
| Chiropractic Services | 20% | Yes | Manipulation therapy - 12 visits per benefit year |
| 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 | | Prior authorization required |

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| Covered Service | You Pay (Network Providers Only) | Subject to Deductible | Limit (If Applicable) |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------|
| Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder | Covered the same as office visits, inpatient services and outpatient services | | |
| Skilled Nursing | 20% | Yes | 90 day limit per benefit year |
| Private Duty Nursing | 20% | Yes | 100 combined visits per benefit year. A visit equals 15 minutes to 8 hours of service. |
| Home Health | 20% | Yes | 100 combined visits per benefit year |
| Hospice Care | 20% | Yes | Prior authorization required |
| Diabetic Services | | | |
| Education | 20% | Yes | |
| Equipment | 20% | Yes | |
| Supplies | 20% | Yes | |
| Durable Medical Equipment | 20% | Yes | May require prior authorization |
| Prescription Drugs | | | |
| <i>Retail — 30-day supply</i> | | | |
| Tier 0: Preventive | \$0 | No | Up to a 31 day supply |
| Tier 1: Generic | \$10 | No | Up to a 31 day supply |
| Tier 2: Preferred | \$50 | No | Up to a 31 day supply |
| Tier 3: Non-Preferred | \$200 | No | Up to a 31 day supply |
| Tier 4: Specialty Preferred | 40% (up to \$300) | Yes | Up to a 31 day supply |
| Tier 5: Specialty Non-Preferred | 50% (up to \$300) | Yes | Up to a 31 day supply |
| <i>Mail Order — 90-day supply</i> | | | |
| Tier 0: Preventive | \$0 | No | Up to a 90 day supply |
| Tier 1: Generic | \$25 | No | Up to a 90 day supply |
| Tier 2: Preferred | \$125 | No | Up to a 90 day supply |
| Tier 3: Non-Preferred | \$500 | No | Up to a 90 day supply |
| Tier 4: Specialty Preferred | 40% (up to \$300) | Yes | Up to a 90 day supply |
| Tier 5: Specialty Non-Preferred | 50% (up to \$300) | Yes | Up to a 90 day supply |
| Vision (pediatric) | | | |
| Eye Exam for Children | \$0 | No | One routine eye exam per benefit year |
| Low Vision Exam | 20% | Yes | 1 exam and follow-up visit every 5 years |
| Eye Wear | \$0 | No | Limited to one pair per benefit year and one replacement pair if medically necessary |
| Enhanced Vision (adults) | \$0 | No | \$250 limit per year One routine eye exam per benefit year at no charge |
| Dental (accidental injury) | 20% | Yes | |
| Dental (pediatric) | | | |
| Preventive | \$35 | No | 2 dental check-ups per benefit year |
| Major | 40% | No | |
| Orthodontic | 50% | No | No limit for medically necessary orthodontia. Cosmetic orthodontia lifetime limit of \$1,700 |
| Enhanced Dental (adults) | | | |
| Preventive and Diagnostic (2 check-ups per year) | \$35 | No | \$800 limit for all services combined |
| Basic Restorative | 40% | No | |
| Major Restorative | 40% | No | |

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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.