CareSource®

MARKETPLACE PLANS

AFFORDABLE HEALTH PLANS

2017

OHIO

CareSource is a Qualified Health Plan issuer in the Health Insurance Marketplace

ADV-SOLICIT(OH000/OH2017)-0336

CARESOURCE GOLD

This may be a good choice for you if you expect to have a lot of doctor appointments, need many prescription medicines, or need other health services. Gold plans have:

- **Higher premiums.** You pay more each month for a gold plan than you would for another metal level.
- **Lower out-of-pocket costs.** With a gold plan, the amount you pay each time you get a health service, such as seeing a doctor or filling a prescription, is less than what you'd pay if you have a bronze or silver plan.

Plan Costs

Plan Type	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Emergency Copay
Individual	$1,000	Medical $2,500 Pharmacy $2,000	20%	$0	$0	$40	$250 after deductible
Family	$2,000	Medical $5,000 Pharmacy $4,000	20%	$0	$0	$40	$250 after deductible

Prescription Drug Coverage

Plan Type	Preventive	Generic	Preferred Brand	Non-preferred Brand	Preferred Specialty	Non-preferred Specialty
Individual/ Family	$0	$0	$120	$160	40% Coinsurance (up to $300)	50% Coinsurance (up to $300)

Coinsurance

Service/Supply Examples	Coinsurance after Deductible
Ambulance Services, Dental Services (related to accident or injury), Laboratory Services, Diagnostic Mammogram, X-Rays, Home Health Care Services, Home Infusion Services, Hospice Services, Inpatient Professional Services, Medical Supplies, Durable Medical Equipment and Appliances, Outpatient Services, Therapy Services, etc.	20%

Required Copays

Service	Copay
Outpatient Advanced Imaging (CT/PET Scans, MRI)	$150 after deductible
Inpatient Facility Services	$150 copay per day for 5 days, $0 days 6 and beyond
Skilled Nursing Facility for Physical Medicine and Rehabilitation	$150 copay per day for 5 days, $0 days 6 and beyond
Urgent Care Services	$75
Pediatric Vision Services – an annual exam is provided at no charge. Copayments apply ONLY if additional office visits are needed.	$40

Pediatric vision and dental (including orthodontia) is included. Please see page 6 for details. For vision and dental for adults, see page 7.

CARESOURCE SILVER

These are the only plans that offer cost sharing reductions in addition to tax credits.

› Eligibility for different levels of Silver plans is based on your reported income.

Cost sharing reductions are calculated by the Health Insurance Marketplace when you submit your household income information to healthcare.gov.

Plan Costs (Silver)

Plan Type	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Emergency Copay
Individual	$3,300	$6,400	30%	$0	$0	$50	$500 after deductible
Family	$6,600	$12,800	30%	$0	$0	$50	$500 after deductible

Prescription Drug Coverage

Plan Type	Preventive	Generic	Preferred Brand	Non-preferred Brand	Preferred Specialty	Non-preferred Specialty
Individual/ Family	$0	$0	$60	$130	40% Coinsurance (up to $300)	50% Coinsurance (up to $300)

Coinsurance

Service/Supply Examples	Coinsurance after Deductible
Ambulance Services, Dental Services (related to accident or injury), Laboratory Services, Diagnostic Mammogram, X-Rays, Home Health Care Services, Home Infusion Services, Hospice Services, Inpatient Professional Services, Medical Supplies, Durable Medical Equipment and Appliances, Outpatient Services, Therapy Services, etc.	30%

Required Copays

Service	Copay
Outpatient Advanced Imaging (CT/PET Scans, MRI)	$175 after deductible
Inpatient Facility Services	$250 copay per day for 5 days, $0 days 6 and beyond
Skilled Nursing Facility for Physical Medicine and Rehabilitation	$100 copay per day for 5 days, $0 days 6 and beyond
Urgent Care Services	$75
Pediatric Vision Services – an annual exam is provided at no charge. Copayments apply ONLY if additional office visits are needed.	$40

Pediatric vision and dental (including orthodontia) is included. Please see page 6 for details. For vision and dental for adults, see page 7.

CARESOURCE SILVER (continued)

These are the only plans that offer cost sharing reductions in addition to tax credits.

Eligibility for different levels of Silver plans is based on your reported income.

Cost sharing reductions are calculated by the Health Insurance Marketplace when you submit your household income information to healthcare.gov.

Silver 1 has an actuarial value of 73%. This is the total percentage of average costs for covered benefits that the plan covers. To qualify for this plan your household income would be between 201-250% of the Federal Poverty Level (FPL). For additional details about eligibility for cost sharing reductions, visit healthcare.gov.

Plan Costs (Silver 1)

Plan Type	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Emergency Copay
Individual	$3,250	$5,500	30%	$0	$0	$40	$350 after deductible
Family	$6,500	$10,000	30%	$0	$0	$40	$350 after deductible

Prescription Drug Coverage

Plan Type	Preventive	Generic	Preferred Brand	Non-preferred Brand	Preferred Specialty	Non-preferred Specialty
Individual/ Family	$0	$0	$50	$130	40% Coinsurance (up to $300)	50% Coinsurance (up to $300)

Coinsurance

Service/Supply Examples	Coinsurance after Deductible
Ambulance Services, Dental Services (related to accident or injury), Laboratory Services, Diagnostic Mammogram, X-Rays, Home Health Care Services, Home Infusion Services, Hospice Services, Inpatient Professional Services, Medical Supplies, Durable Medical Equipment and Appliances, Outpatient Services, Therapy Services, etc.	30%

Required Copays

Service	Copay
Outpatient Advanced Imaging (CT/PET Scans, MRI)	$150 after deductible
Inpatient Facility Services	$200 copay per day for 5 days, $0 days 6 and beyond
Skilled Nursing Facility for Physical Medicine and Rehabilitation	$100 copay per day for 5 days, $0 days 6 and beyond
Urgent Care Services	$75
Pediatric Vision Services – an annual exam is provided at no charge. Copayments apply ONLY if additional office visits are needed.	$40

Pediatric vision and dental (including orthodontia) is included. Please see page 6 for details. For vision and dental for adults, see page 7.

CARESOURCE SILVER (continued)

These are the only plans that offer cost sharing reductions in addition to tax credits.

Eligibility for different levels of Silver plans is based on your reported income.

Cost sharing reductions are calculated by the Health Insurance Marketplace when you submit your household income information to healthcare.gov.

Silver 2 has an actuarial value of 87%. This is the total percentage of average costs for covered benefits that the plan covers. To qualify for this plan your household income would be between 151-200% of the Federal Poverty Level (FPL). For additional details about eligibility for cost sharing reductions, visit healthcare.gov.

Plan Costs (Silver 2)

Plan Type	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Emergency Copay
Individual	$950	$1,900	15%	$0	$0	$10	$350 after deductible
Family	$1,900	$3,800	15%	$0	$0	$10	$350 after deductible

Prescription Drug Coverage

Plan Type	Preventive	Generic	Preferred Brand	Non-preferred Brand	Preferred Specialty	Non-preferred Specialty
Individual/ Family	$0	$0	$30	$130	40% Coinsurance (up to $150)	50% Coinsurance (up to $150)

Coinsurance

Service/Supply Examples	Coinsurance after Deductible
Ambulance Services, Dental Services (related to accident or injury), Laboratory Services, Diagnostic Mammogram, X-Rays, Home Health Care Services, Home Infusion Services, Hospice Services, Inpatient Professional Services, Medical Supplies, Durable Medical Equipment and Appliances, Outpatient Services, Therapy Services, etc.	15%

Required Copays

Service	Copay
Outpatient Advanced Imaging (CT/PET Scans, MRI)	$125 after deductible
Inpatient Facility Services	$175 copay per day for 5 days, $0 days 6 and beyond
Skilled Nursing Facility for Physical Medicine and Rehabilitation	$100 copay per day for 5 days, $0 days 6 and beyond
Urgent Care Services	$0
Pediatric Vision Services – an annual exam is provided at no charge. Copayments apply ONLY if additional office visits are needed.	$10

Pediatric vision and dental (including orthodontia) is included. Please see page 6 for details. For vision and dental for adults, see page 7.

CARESOURCE SILVER (continued)

These are the only plans that offer cost sharing reductions in addition to tax credits.

› Eligibility for different levels of Silver plans is based on your reported income.

Cost sharing reductions are calculated by the Health Insurance Marketplace when you submit your household income information to healthcare.gov.

Silver 3 has an actuarial value of 94%. This is the total percentage of average costs for covered benefits that the plan covers. To qualify for this plan your household income would be between 100-150% of the Federal Poverty Level (FPL). For additional details about eligibility for cost sharing reductions, visit healthcare.gov.

Plan Costs (Silver 3)

Plan Type	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Emergency Copay
Individual	$350	$650	5%	$0	$0	$0	$325 after deductible
Family	$700	$1,300	5%	$0	$0	$0	$325 after deductible

Prescription Drug Coverage

Plan Type	Preventive	Generic	Preferred Brand	Non-preferred Brand	Preferred Specialty	Non-preferred Specialty
Individual/ Family	$0	$0	$50	$20	25% Coinsurance (up to $150)	35% Coinsurance (up to $150)

Coinsurance

Service/Supply Examples	Coinsurance after Deductible
Ambulance Services, Dental Services (related to accident or injury), Laboratory Services, Diagnostic Mammogram, X-Rays, Home Health Care Services, Home Infusion Services, Hospice Services, Inpatient Professional Services, Medical Supplies, Durable Medical Equipment and Appliances, Outpatient Services, Therapy Services, etc.	5%

Required Copays

Service	Copay
Outpatient Advanced Imaging (CT/PET Scans, MRI)	$125 after deductible
Inpatient Facility Services	$75 copay per day for 5 days, $0 days 6 and beyond
Skilled Nursing Facility for Physical Medicine and Rehabilitation	$75 copay per day for 5 days, $0 days 6 and beyond
Urgent Care Services	$0
Pediatric Vision Services – an annual exam is provided at no charge. Copayments apply ONLY if additional office visits are needed.	$0

Pediatric vision and dental (including orthodontia) is included. Please see page 6 for details. For vision and dental for adults, see page 7.

CARESOURCE BRONZE

A health plan in the bronze level may be a good choice for you if you don't expect to have many doctor appointments or need many prescription drugs.

Generally, plans in the Bronze category have the lowest premiums (your monthly insurance bill) but the highest deductibles and other out-of-pocket costs.

Plan Costs

Plan Type	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Emergency Copay
Individual	$6,650	$6,850	40%	$35	$35	$75	$500 after deductible
Family	$13,300	$13,700	40%	$35	$35	$75	$500 after deductible

Prescription Drug Coverage

Plan Type	Preventive	Generic	Preferred Brand	Non-preferred Brand	Preferred Specialty	Non-preferred Specialty
Individual/ Family	$0	$25	$100	$250	40% Coinsurance (up to $300)	50% Coinsurance (up to $300)

Coinsurance

Service/Supply Examples	Coinsurance after Deductible
Ambulance Services, Dental Services (related to accident or injury), Laboratory Services, Diagnostic Mammogram, X-Rays, Home Health Care Services, Home Infusion Services, Hospice Services, Inpatient Professional Services, Medical Supplies, Durable Medical Equipment and Appliances, Outpatient Services, Therapy Services, etc.	40%

Required Copays

Service	Copay
Outpatient Advanced Imaging (CT/PET Scans, MRI)	$200 after deductible
Inpatient Facility Services	$250 copay per day for 5 days, $0 days 6 and beyond
Skilled Nursing Facility for Physical Medicine and Rehabilitation	$100 copay per day for 5 days, $0 days 6 and beyond
Urgent Care Services	$100
Pediatric Vision Services – an annual exam is provided at no charge. Copayments apply ONLY if additional office visits are needed.	$75

Pediatric vision and dental (including orthodontia) is included. Please see page 6 for details. For vision and dental for adults, see page 7.

Pediatric Dental (including Orthodontia)

Dental coverage for children is included in our CareSource Gold, Silver, and Bronze plans and our CareSource Gold, Silver, and Bronze Dental & Vision plans.

Plan	Deductible	Preventive Services	Coinsurance/Copay Comprehensive Services, Implants, & Prosthetics	Orthodontia Copay/ Coinsurance	Annual Limits	Age Limit
CareSource Gold	$0	$0	25%	20%	$3,000 lifetime limit* (Orthodontia)	Until age 19
CareSource Silver	$0	$0	30%	40%	$2,000 lifetime limit* (Orthodontia)	Until age 19
CareSource Silver (Silver 1 level)	$0	$0	30%	40%	$2,000 lifetime limit* (Orthodontia)	Until age 19
CareSource Silver (Silver 2 level)	$0	$0	15%	20%	$2,500 lifetime limit* (Orthodontia)	Until age 19
CareSource Silver (Silver 3 level)	$0	$0	5%	20%	$3,000 lifetime limit* (Orthodontia)	Until age 19
CareSource Bronze	$0	$20	40%	50%	$1,700 lifetime limit* (Orthodontia)	Until age 19

**Lifetime limit only applies to cosmetic orthodontia. There is no limit for medically necessary orthodontia.*

Pediatric Vision

Plan	Deductible	Annual Exam (Preventive Care) Copay	Glasses/Contacts Coinsurance	Additional General Exams	Exams for Medical Conditions/Low Vision	Age Limit
CareSource Gold	$0	$25	First pair $0 1st Replacement $0 2nd Replacement 20%	$40	Medical Conditions $40 Low Vision/Follow-up Care 20%	Until age 19
CareSource Silver	$0	$25	First pair $0 1st Replacement $0 2nd Replacement 30%	$50	Medical Conditions $50 Low Vision/Follow-up Care 30%	Until age 19
CareSource Silver (Silver 1 level)	$0	$25	First pair $0 1st Replacement $0 2nd Replacement 30%	$40	Medical Conditions $40 Low Vision/Follow-up Care 30%	Until age 19
CareSource Silver (Silver 2 level)	$0	$25	First pair $0 1st Replacement $0 2nd Replacement 15%	$10	Medical Conditions $10 Low Vision/Follow-up Care 15%	Until age 19
CareSource Silver (Silver 3 level)	$0	$25	First pair $0 1st Replacement $0 2nd Replacement 5%	$0	Medical Conditions $0 Low Vision/Follow-up Care 0%	Until age 19
CareSource Bronze	$0	$25	First pair $0 1st Replacement $0 2nd Replacement 5%	$80	Medical Conditions $80 Low Vision/Follow-up Care 40%	Until age 19

DENTAL & VISION

These are our metal level plans PLUS dental and vision benefits for adults over the age of 19. If you choose a Dental & Vision plan, you pay one premium for health, dental, and vision coverage. Choosing a Dental & Vision plan adds dental and vision coverage, but does not change your medical benefits.

Dental Benefits

Plan	Deductible	Preventive Services*	Coinsurance/Copay Comprehensive Services, Implants, & Prosthetics	Orthodontia Copay/ Coinsurance	Annual Limits	Age Limit
CareSource Gold Dental & Vision	$0	$0	25%	25%	$800	19 +
CareSource Silver Dental & Vision	$0	$0	30%	30%	$800	19 +
CareSource Silver Dental & Vision (Silver 1 level)	$0	$0	30%	30%	$800	19 +
CareSource Silver Dental & Vision (Silver 2 level)	$0	$0	15%	15%	$800	19 +
CareSource Silver Dental & Vision (Silver 3 level)	$0	$0	5%	5%	$800	19 +
CareSource Bronze Dental & Vision	$0	$0	$20 Copay 40% Coinsurance	$20 Copay 40% Coinsurance	$800	19 +

**Preventive services include cleanings and exams, and you receive two visits per year. All additional services require coinsurance and/or a copay. There is an annual limit of $800 per plan year.*

Vision Benefits

Plan	Deductible	Annual Exam (Preventive Care) Copay	Glasses/Contacts Coinsurance	Eye Exam for Medical Conditions	Annual Limit (Exam + Glasses or Contacts)	Age Limit
CareSource Gold Dental & Vision	$0	$25	20%	$40	$150	19 +
CareSource Silver Dental & Vision	$0	$25	30%	$50	$150	19 +
CareSource Silver Dental & Vision (Silver 1 level)	$0	$25	30%	$50	$150	19 +
CareSource Silver Dental & Vision (Silver 2 level)	$0	$25	15%	$10	$150	19 +
CareSource Silver Dental & Vision (Silver 3 level)	$0	$25	5%	$0	$150	19 +
CareSource Bronze Dental & Vision	$0	$25	40%	$75	$150	19 +

CARESOURCE SIMPLE CHOICE PLANS

These are our Federal Standard plans. The benefit levels are the same for every health insurer, but the provider networks, monthly premiums, and medications covered vary.

Plan Type	Metal Level	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Urgent Care Copay	Emergency Copay
Individual	Gold	$1,250	$4,750	20%	$20	$20	$50	$65	$250 after deductible
Family	Gold	$2,500	$9,500	20%	$20	$20	$50	$65	$250 after deductible

Plan Type	Metal Level	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Urgent Care Copay	Emergency Copay
Individual	Silver	$3,500	$7,150	20%	$30	$30	$65	$75	$400 after deductible
Family	Silver	$7,000	$14,300	20%	$30	$30	$65	$75	$400 after deductible

Plan Type	Metal Level	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Urgent Care Copay	Emergency Copay
Individual	Silver 1	$3,000	$5,700	20%	$30	$30	$65	$75	$300 after deductible
Family	Silver 1	$6,000	$9,500	20%	$30	$30	$65	$75	$300 after deductible

Plan Type	Metal Level	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Urgent Care Copay	Emergency Copay
Individual	Silver 2	$700	$2,000	20%	$10	$10	$25	$40	$150 after deductible
Family	Silver 2	$1,400	$4,000	20%	$10	$10	$25	$40	$150 after deductible

Plan Type	Metal Level	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Urgent Care Copay	Emergency Copay
Individual	Silver 3	$250	$1,250	5%	$5	$5	$15	$25	$100 after deductible
Family	Silver 3	$500	$2,500	5%	$5	$5	$15	$25	$100 after deductible

Plan Type	Metal Level	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Urgent Care Copay	Emergency Copay
Individual	Bronze	$6,650	$7,150	50%	$45 (for the first three visits)	$45 (for the first three visits)	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance after deductible
Family	Bronze	$13,300	$14,300	50%	$45 (for the first three visits)	$45 (for the first three visits)	50% Coinsurance after deductible	50% Coinsurance	50% Coinsurance after deductible

Prescription Drug Coverage

Plan Type	Metal Level	Preventive	Generic	Preferred Brand	Non-preferred Brand	Preferred Specialty	Non-preferred Specialty
Individual/Family	Gold	$0	$10	$30	$75	30% Coinsurance	N/A
Individual/Family	Silver	$0	$15	$50	$100	40% Coinsurance	N/A
Individual/Family	Silver 1	$0	$10	$50	$100	40% Coinsurance	N/A
Individual/Family	Silver 2	$0	$5	$25	$50	30% Coinsurance	N/A
Individual/Family	Silver 3	$0	$3	$5	$10	25% Coinsurance	N/A
Individual/Family	Bronze	$0	$35	35% Coinsurance after deductible	40% Coinsurance after deductible	45% Coinsurance after deductible	N/A

CARESOURCE LOW PREMIUM PLANS

Eligibility for different levels of Silver plans is based on your reported income.

Cost sharing reductions are calculated by the Health Insurance Marketplace when you submit your household income information to healthcare.gov.

Plan Type	Metal Level	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Emergency Copay
Individual	Silver	$6,150	$7,000	15%	$30	$30	$50	15% Coinsurance after deductible
Family	Silver	$12,300	$14,000	15%	$30	$30	$50	15% Coinsurance after deductible

Plan Type	Metal Level	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Emergency Copay
Individual	Silver 1	$5,000	$6,000	15%	$25	$25	$45	15% Coinsurance after deductible
Family	Silver 1	$10,000	$12,000	15%	$25	$25	$45	15% Coinsurance after deductible

Plan Type	Metal Level	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Emergency Copay
Individual	Silver 2	$1,100	$2,100	10%	$15	$15	$30	10% Coinsurance after deductible
Family	Silver 2	$2,200	$4,200	10%	$15	$15	$30	10% Coinsurance after deductible

Plan Type	Metal Level	Annual Deductible	Out-of-Pocket Limit	Coinsurance	Primary Care Visit Copay	Retail Clinic Visit Copay	Specialist Visit Copay	Emergency Copay
Individual	Silver 3	$500	$900	5%	$5	$5	$10	5% Coinsurance after deductible
Family	Silver 3	$1,000	$1,800	5%	$5	$5	$10	5% Coinsurance after deductible

Prescription Drug Coverage

Plan Type	Metal Level	Preventive	Generic	Preferred Brand	Non-preferred Brand	Preferred Specialty	Non-preferred Specialty
Individual/Family	Silver	$0	$10	$50	15% after deductible	15% after deductible	15% after deductible
Individual/Family	Silver 1	$0	$0	$50	15% after deductible	15% after deductible	15% after deductible
Individual/Family	Silver 2	$0	$0	$45	15% after deductible	15% after deductible	15% after deductible
Individual/Family	Silver 3	$0	$0	$20	15% after deductible	15% after deductible	15% after deductible

There is a $100 copay for all Urgent Care Visits. An annual exam for pediatric vision is provided at no charge; copayments would apply only if additional visits are needed (see Specialist Visit Copay for costs) and no deductible must be met for this service.

If you, or someone you're helping, have questions about CareSource, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-479-9502 TTY: 711.

ARABIC
إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، اتصل على 1-800-479-9502 TTY: 711.

AMHARIC
እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ CareSource ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-800-479-9502 TTY: 711 ይደውሉ።

BURMESE
CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား စကားပြောဆိုရန် 1-800-479-9502 TTY: 711 ဤတွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

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，请致电 1-800-479-9502 TTY: 711。

CUSHITE – OROMO
Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-800-479-9502 TTY: 711 tiin bilbilaa.

DUTCH
Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk, bel dan naar 1-800-479-9502 TTY: 711.

FRENCH (CANADA)
Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète, veuillez téléphoner au 1-800-479-9502 TTY: 711.

GERMAN
Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, rufen Sie die Nummer 1-800-479-9502 TTY: 711 an.

GUJARATI જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તેમ ાંથી કોઈને CareSource વિશે પ્રશ્નો હોય તો તમને મદદ અને મ હ ાહતી મેળિ ાનો અવિક ર છે. ત ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર ાપ્ત કરી શક ર છે. ્ ભ વષરો ા ત કરિ મ ટે,આ 1-800-479-9502 TTY: 711 પર કોલ કરો.

HINDI
यदि आपके, या आप जिसकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल हैं तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, 1-800-479-9502 TTY: 711.

ITALIAN
Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete, chiami il 1-800-479-9502 TTY: 711.

JAPANESE
ご本人様、または身の回りの方で、CareSource に関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます（無償）。 通訳をご利用の場合は、1-800-479-9502 TTY: 711 にご連絡ください。

KOREAN
귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 주십시오: 1-800-479-9502 TTY: 711.

PENNSYLVANIA DUTCH
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-479-9502 TTY: 711 uffrufe.

RUSSIAN
Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком, позвоните по номеру 1-800-479-9502 TTY: 711.

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, llame al 1-800-479-9502 TTY: 711.

UKRAINIAN
Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, зателефонуйте за номером 1-800-479-9502 TTY: 711.

VIETNAMESE
Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi số 1-800-479-9502 TTY: 711.

Notice of Non-Discrimination

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, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-800-479-9502 TTY: 711.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building, Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Limitations and Exclusions

Some limitations and exclusions apply to CareSource plans.

CareSource does not cover acupuncture, bariatric surgery, cosmetic surgery, or hearing aids.

Any combination of network benefits for skilled nursing facility/inpatient rehabilitation facility services is limited to one hundred (100) days per calendar year.

Copayments or coinsurance apply to allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations covered under "preventative care services") received in a physician's office. When the only charge from a physician office visit is for allergy injections, allergy serum, diagnostic services or other therapy services, then any copayments are waived.

Home Health Care visits are limited to a combined one hundred (100) visits each benefit year. The one hundred (100) visit limit for Home Health Care Services does not apply to private duty nursing visits rendered in the home, which are subject to a separate one hundred (100) visit limit.

You must receive all covered health care services and prescription drug benefits from in-network CareSource providers, except in the case of an emergency and otherwise provided by applicable law and plan Evidence of Coverage.

Dental and vision services for adults are covered only if optional coverage is selected.

If different types of therapy services are performed during one physician office service or outpatient service, then each different type of therapy service will be considered a separate therapy visit. Each therapy visit will count against the applicable maximum visits listed below. For example, if both a physical therapy service and a spinal manipulation service are performed during a physician office service or outpatient service, they will count as both one physical therapy visit and one spinal manipulation visit.

Separate twenty (20) visit limit for physical therapy, occupational therapy, speech therapy, and pulmonary rehab. Thirty-six (36) visit limit for cardiac rehab. Twelve (12) visit limit for spinal manipulation.

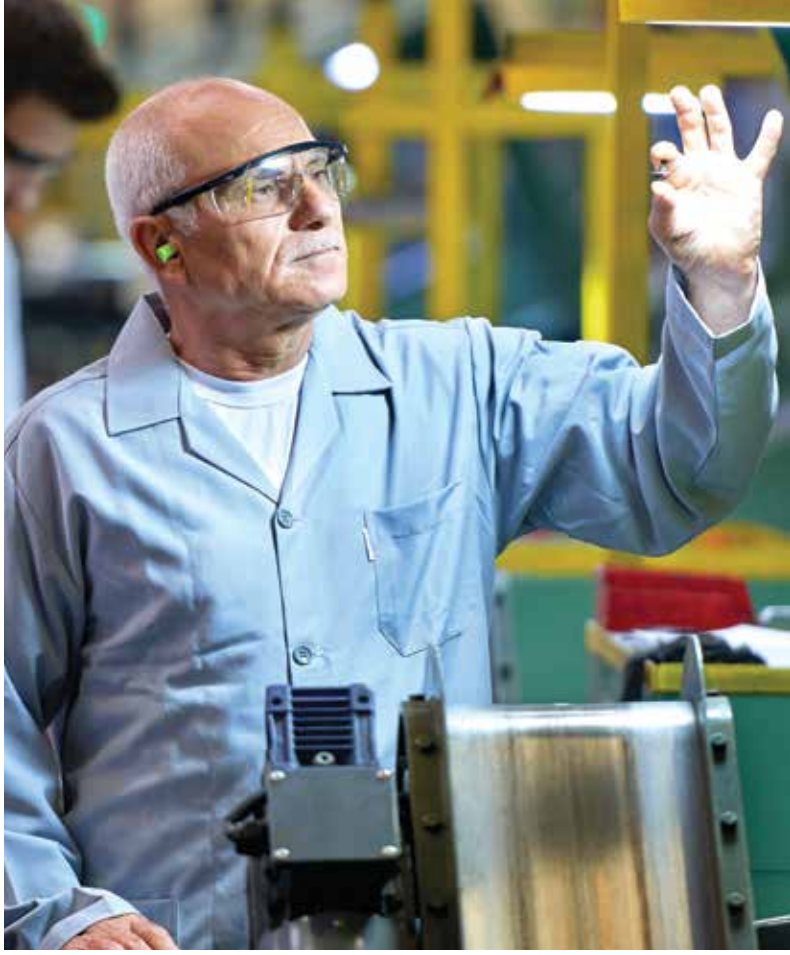
This is a partial list of exclusions. For a complete list, see the CareSource Evidence of Coverage document at **CareSource.com/marketplace/oh/plan-details**.

How to enroll, determine your cost, and qualify for subsidies

Our website is designed to help you find the plan that's right for you and your family. It will ask you questions and take you to the Marketplace to determine if you qualify for subsidies. Based on the answers you give, it will allow you to compare the CareSource plans you can choose from.

Just follow these steps:

- Go to **CareSource.com/marketplace**
- Click on "Enroll."
- Follow the prompts and you will be routed to the Marketplace to determine your eligibility for cost savings.
- Complete the eligibility form using the personal financial information you've collected. Allow 20–40 minutes to complete this process. The Marketplace will determine your eligibility and if you qualify for a subsidy. It will also let you know if you or your family members qualify for health care coverage through Medicaid, Medicare, or CHIP (Children's Health Insurance Program).
- Once complete, the Marketplace will automatically return you to CareSource to apply any subsidies, calculate your costs, and compare plans.
- You can then select your plan and choose your payment method to pay your first premium.



What You Will Need

Collect the following information for each family member you are enrolling before starting your eligibility form on the Health Insurance Marketplace:

- Social Security number or document number for legal immigrants
- Employer and income information; for example, wage and tax statements from pay stubs or W-2 forms
- If currently covered by health insurance, the policy number
- If eligible for employer health insurance coverage (even if the coverage is through another person, for example, a spouse or a parent), information about the employer's health insurance plan

Need help to enroll or choose a plan?

Our Member Services staff will be happy to help you! Just call toll-free **1-800-479-9502** (TTY 1-800-750-0750 or 711). Open enrollment begins on **November 1, 2016**.

2017 OH Plan

P.O. Box 8738
Dayton, OH 45401-8738

CareSource.com/marketplace

CareSource plans have exclusions, limitations, reductions, and terms under which the policy may be continued in force or discontinued. Premiums, deductibles, and copays may vary based on individual circumstances. Benefits and costs may vary based upon plan selection. For costs and complete details of coverage, please review the CareSource Evidence of Coverage and Schedule of Benefits documents at CareSource.com/marketplace.

Preventive care received in-network will be at no cost. Not all plans may have low premiums and low deductibles. Premiums and deductibles may vary.

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.

CareSource is a Qualified Health Plan issuer in the Health Insurance Marketplace.

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