

2021 Schedule of Benefits

Plan Name: CareSource Marketplace Bronze Zero Dental, Vision, & Fitness



Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2021]
Last Coverage Change Date	[01/01/2020]

Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2021]

Highlights

Annual Deductible*	Individual: \$0 Family: \$0
Coinsurance	0%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$0 Family: \$0



* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$0 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 \$0 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 toward the family Deductible is the individual Deductible amount, in this case \$0 up to the family maximum of \$0. The Annual Deductible applies to covered services identified as "after deductible" in the Covered Service table below.

** See Section 2: Evidence of Coverage for the Definition of Annual Out-of-Pocket Maximum. For family coverage, each individual covered member within your family is contributing toward the family Annual Out-of-Pocket Maximum. However, for each individual covered member within your family, the maximum amount each member would pay toward the family Annual Out-of-Pocket Maximum is the individual Out-of-Pocket Maximum, which is \$0. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Office Visits		
Primary Includes Primary Care Provider, Mental Health/Substance Abuse, Retail Clinics, and Telemedicine	No charge	None
Specialist	No charge	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Preventive Services As defined by federal & state law	No charge	Refer to your Evidence of Coverage
Diagnostic Services Lab	No charge	None
X-Ray/Radiology	No charge	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	No charge	None
Mammograms (outpatient) Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	No charge	None
Inpatient Services Facility/Physician	No charge	None
Skilled Nursing Facility	No charge	60 Day limit per benefit year
Outpatient Services Facility/Physician	No charge	None
Maternity Services Prenatal Visit, Office Visits, and Postpartum Care	No charge	None
Inpatient Services	No charge	None
Outpatient Services	No charge	None
Urgent Care	No charge	None
Ambulance Services	No charge	None
Emergency Health Care Services	No charge	If admitted to the hospital directly from the Emergency Department, these services will be covered the same as inpatient services and the applicable copayment and coinsurance will apply.

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Habilitative Services		
Physical Therapy	No charge	40 combined visits per benefit year
Occupational Therapy	No charge	40 combined visits per benefit year
Speech Therapy	No charge	40 combined visits per benefit year
Audiology	No charge	40 combined visits per benefit year
Manipulation Therapy	No charge	40 combined visits per benefit year
Rehabilitative Services		
Physical Therapy	No charge	40 combined visits per benefit year
Occupational Therapy	No charge	40 combined visits per benefit year
Speech Therapy	No charge	40 combined visits per benefit year
Pulmonary Rehabilitation	No charge	None
Manipulation Therapy	No charge	40 combined visits per benefit year
Cardiac Rehabilitation Services	No charge	None
Post-Cochlear Implant Aural Therapy	No charge	40 combined visits per benefit year
Cognitive Rehabilitation Therapy	No charge	40 combined visits per benefit year
Autism Spectrum Disorder Services		
Physical Therapy	No charge	Combined limit with Habilitative Services
Occupational Therapy	No charge	Combined limit with Habilitative Services
Speech Therapy	No charge	Combined limit with Habilitative Services
Behavioral Therapy	No charge	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services	Covered the same as office visits, inpatient services, and outpatient services	None
Transplant Services	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services, and outpatient services	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health Home Infusion Therapy All Other Services	No charge No charge	Included in all other services limits 120 combined visits per benefit year. A visit equals 2 hours or less.
Hospice Care	No charge	Refer to your Evidence of Coverage
Diabetic Services Education Equipment Supplies	No charge No charge No charge	Refer to your Evidence of Coverage Refer to your Evidence of Coverage Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances	No charge	Refer to your Evidence of Coverage
Prescription Drugs <i>Retail</i> Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty Preferred) Tier 5 (Specialty Non-Preferred)	No charge No charge No charge No charge No charge No charge	Up to a 30-day supply Up to a 30-day supply Up to a 30-day supply Up to a 30-day supply Up to a 30-day supply Up to a 30-day supply
<i>Mail Order</i> Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty Preferred) Tier 5 (Specialty Non-Preferred)	No charge No charge No charge No charge No charge No charge	Up to a 90-day supply Up to a 90-day supply Up to a 90-day supply Up to a 90-day supply Up to a 30-day supply Up to a 30-day supply
Vision (pediatric) Children's Eye Exam Low Vision Testing and Aids Children's Eyewear	No charge No charge No charge	1 routine eye exam per benefit year Limited to one evaluation and aid per benefit year. Limited to one pair of glasses or contact lenses per benefit year. If medically necessary, a replacement pair of glasses is allowed.
Vision (adults) Eye Exam Low Vision Testing and Aids Eyewear	No charge No charge No charge	1 routine eye exam per benefit year Limited to one evaluation and aid per benefit year. 1 pair of glasses/contacts per benefit year up to a \$250 allowance
Other Dental Services	No charge	Injury as a result of chewing or biting is not considered an accidental injury.

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Dental (pediatric)		
Class I – Diagnostic/Preventive	No charge	2 check-ups per benefit year. Refer to your Evidence of Coverage
Class II – Restorative/Basic	No charge	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	No charge	Refer to your Evidence of Coverage
Class IV - Orthodontics	No charge	Refer to your Evidence of Coverage
Dental (adults)		
Class I – Diagnostic/Preventive	No charge	Refer to your Evidence of Coverage. Benefit is limited to \$800 per benefit year.
Class II – Restorative/Basic	No charge	
Class III - Major/Comprehensive	No charge	
Class IV - Orthodontics	Not covered	

Prior Authorization: Some services and items require prior authorization, which is the process used by the Plan to determine if it meets medical necessity and coverage requirements prior to the service being provided. The provider, or the member when using an out-of-network provider, is responsible for obtaining prior authorization for the services and items described on the prior authorization list. Please refer to the prior authorization list attached to your Evidence of Coverage for additional detail or you can obtain the list at www.caresource.com/mp-GA-pa.

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.

For covered services listed in the Evidence of Coverage that are not specifically listed on this Schedule of Benefits, the cost sharing is equal to the coinsurance after the deductible.

The copays and coinsurance listed in the 'You Pay' column would only apply if the item or service is not furnished directly by a provider meeting the criteria outlined below, otherwise there would be no cost to you.

- 1) an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603);
- 2) a provider who was referred by one of the organizations listed in item 1.

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