

## 2021 Schedule of Benefits

Plan Name: CareSource Marketplace Low Deductible Silver



### 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: \$5,100 Family: \$10,200
Coinsurance	20%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$7,500 Family: \$15,000



\* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$5,100 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 \$10,200 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 \$5,100 up to the family maximum of \$10,200. 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 \$7,500. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Office Visits</b>		
Primary Includes Primary Care Provider, Mental Health/Substance Abuse, Retail Clinics, and Telemedicine	\$25 copay	None
Specialist	\$60 copay	None

Learn more about CareSource and all our plan options at [www.caresource.com/marketplace](http://www.caresource.com/marketplace).

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Preventive Services</b> As defined by federal & state law	No charge	Refer to your Evidence of Coverage
<b>Diagnostic Services</b> Lab  X-Ray/Radiology  Advanced Imaging (PET, MRI, MRA, CT, SPECT)	20% coinsurance after deductible  \$200 copay after deductible  \$250 copay after deductible	None  None  None
<b>Mammograms</b> (outpatient) Preventive  Diagnostic	No charge  \$200 copay after deductible	Refer to your Evidence of Coverage  None
<b>Inpatient Services</b> Facility/Physician  Skilled Nursing Facility	\$500 copay after deductible  \$500 copay after deductible	None  90 Day limit per benefit year
<b>Outpatient Services</b> Facility/Physician	20% coinsurance after deductible	None
<b>Maternity Services</b> Prenatal Visit, Office Visits, and Postpartum Care  Inpatient Services  Outpatient Services	\$60 copay  \$500 copay after deductible  20% coinsurance after deductible	None  None  None
<b>Urgent Care</b>	\$75 copay	None
<b>Ambulance Services</b>	20% coinsurance after deductible	None
<b>Emergency Health Care Services</b>	20% coinsurance after deductible	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)
<b>Habilitative Services</b> Physical Therapy  Occupational Therapy  Speech Therapy	\$25 copay  \$25 copay  20% coinsurance after deductible	20 visits per benefit year  20 visits per benefit year  20 visits per benefit year
<b>Rehabilitative Services</b> Physical Therapy  Occupational Therapy  Speech Therapy  Pulmonary Rehabilitation  Cardiac Rehabilitation Services  Manipulation Therapy  Post-Cochlear Implant Aural Therapy	\$25 copay  \$25 copay  20% coinsurance after deductible  20% coinsurance after deductible  20% coinsurance after deductible  20% coinsurance after deductible  20% coinsurance after deductible	20 visits per benefit year  20 visits per benefit year  20 visits per benefit year  20 visits per benefit year  36 visits per benefit year  12 visits per benefit year  Combined Limit with Speech Therapy
<b>Autism Spectrum Disorder Services</b> Physical Therapy  Occupational Therapy  Speech Therapy  Behavioral Therapy	\$25 copay  \$25 copay  20% coinsurance after deductible  \$25 copay	Combined limit with Habilitative Services  Combined limit with Habilitative Services  Combined limit with Habilitative Services  Includes Applied Behavior Analysis (ABA)
<b>Behavioral Health Services</b>	Covered the same as office visits, inpatient services, and outpatient services	None
<b>Transplant Services</b>	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
<b>Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder</b>	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)
<b>Home Health</b> Private Duty Nursing  Home Infusion Therapy  All Other Services	20% coinsurance after deductible  20% coinsurance after deductible  20% coinsurance after deductible	100 visits per benefit year, a visit equals 8 hours or less  None  100 combined visits per benefit year. A visit equals at least 4 hours.
<b>Hospice Care</b>	20% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Diabetic Services</b> Education  Equipment  Supplies	20% coinsurance after deductible  20% coinsurance after deductible  20% coinsurance after deductible	Refer to your Evidence of Coverage  Refer to your Evidence of Coverage  Refer to your Evidence of Coverage
<b>Medical Supplies, Durable Medical Equipment, and Appliances</b>	20% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Prescription Drugs</b> <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 \$20 copay \$50 copay 20% coinsurance after deductible 45% coinsurance after deductible 50% coinsurance after deductible	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 \$50 copay \$125 copay 20% coinsurance after deductible 45% coinsurance after deductible 50% coinsurance after deductible	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

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Vision</b> (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.
<b>Other Dental Services</b>	20% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
<b>Dental</b> (pediatric) Class I – Diagnostic/Preventive  Class II – Restorative/Basic  Class III - Major/Comprehensive  Class IV - Orthodontics	\$15 copay  20% coinsurance after deductible  40% coinsurance after deductible  50% coinsurance after deductible	2 check-ups per benefit year. Refer to your Evidence of Coverage  Refer to your Evidence of Coverage  Refer to your Evidence of Coverage  Refer to your Evidence of Coverage

**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-IN-pa](http://www.caresource.com/mp-IN-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](http://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.

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