

2021 Schedule of Benefits

Plan Name: CareSource Marketplace Standard Silver 3 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: \$400 Family: \$800
Coinsurance	5%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$750 Family: \$1,500



* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$400 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 \$800 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 \$400 up to the family maximum of \$800. 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 \$750. 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	\$5 copay	None
Specialist	\$15 copay	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	5% coinsurance after deductible	None
X-Ray/Radiology	\$50 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$100 copay after deductible	None
Mammograms (outpatient) Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$50 copay after deductible	None
Inpatient Services Facility/Physician	\$150 copay after deductible	None
Skilled Nursing Facility	\$150 copay after deductible	90 Day limit per benefit year
Outpatient Services Facility/Physician	5% coinsurance after deductible	None
Maternity Services Prenatal Visit, Office Visits, and Postpartum Care	\$15 copay	None
Inpatient Services	\$150 copay after deductible	None
Outpatient Services	5% coinsurance after deductible	None
Urgent Care	\$25 copay	None
Ambulance Services	5% coinsurance after deductible	None
Emergency Health Care Services	5% 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)
Habilitative Services		
Physical Therapy	\$5 copay	20 visits per benefit year
Occupational Therapy	\$5 copay	20 visits per benefit year
Speech Therapy	5% coinsurance after deductible	20 visits per benefit year
Rehabilitative Services		
Physical Therapy	\$5 copay	20 visits per benefit year
Occupational Therapy	\$5 copay	20 visits per benefit year
Speech Therapy	5% coinsurance after deductible	20 visits per benefit year
Pulmonary Rehabilitation	5% coinsurance after deductible	20 visits per benefit year
Cardiac Rehabilitation Services	5% coinsurance after deductible	36 visits per benefit year
Manipulation Therapy	5% coinsurance after deductible	12 visits per benefit year
Post-Cochlear Implant Aural Therapy	5% coinsurance after deductible	Combined Limit with Speech Therapy
Autism Spectrum Disorder Services		
Physical Therapy	\$5 copay	Combined limit with Habilitative Services
Occupational Therapy	\$5 copay	Combined limit with Habilitative Services
Speech Therapy	5% coinsurance after deductible	Combined limit with Habilitative Services
Behavioral Therapy	\$5 copay	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		
Private Duty Nursing	5% coinsurance after deductible	100 visits per benefit year, a visit equals 8 hours or less
Home Infusion Therapy	5% coinsurance after deductible	None
All Other Services	5% coinsurance after deductible	100 combined visits per benefit year. A visit equals at least 4 hours.
Hospice Care	5% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetic Services		
Education	5% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	5% coinsurance after deductible	Refer to your Evidence of Coverage
Supplies	5% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances	5% coinsurance after deductible	Refer to your Evidence of Coverage
Prescription Drugs		
<i>Retail</i>		
Tier 0 (Preventive)	No charge	Up to a 30-day supply
Tier 1 (Low Cost)	\$5 copay	Up to a 30-day supply
Tier 2 (Preferred)	\$15 copay	Up to a 30-day supply
Tier 3 (Non-Preferred)	5% coinsurance after deductible	Up to a 30-day supply
Tier 4 (Specialty Preferred)	45% coinsurance after deductible	Up to a 30-day supply
Tier 5 (Specialty Non-Preferred)	50% coinsurance after deductible	Up to a 30-day supply
<i>Mail Order</i>		
Tier 0 (Preventive)	No charge	Up to a 90-day supply
Tier 1 (Low Cost)	\$12.50 copay	Up to a 90-day supply
Tier 2 (Preferred)	\$37.50 copay	Up to a 90-day supply
Tier 3 (Non-Preferred)	5% coinsurance after deductible	Up to a 90-day supply
Tier 4 (Specialty Preferred)	45% coinsurance after deductible	Up to a 30-day supply
Tier 5 (Specialty Non-Preferred)	50% coinsurance after deductible	Up to a 30-day supply

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
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	\$0 copay 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	5% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental (pediatric) Class I – Diagnostic/Preventive Class II – Restorative/Basic Class III - Major/Comprehensive Class IV - Orthodontics	\$5 copay 15% coinsurance after deductible 40% coinsurance after deductible 45% 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
Dental (adults) Class I – Diagnostic/Preventive Class II – Restorative/Basic Class III - Major/Comprehensive Class IV - Orthodontics	\$5 copay 15% coinsurance 40% coinsurance Not covered	Refer to your Evidence of Coverage. Benefit is limited to \$800 per benefit year.

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.

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.

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