**2021 Schedule of Benefits**
Plan Name: CareSource Marketplace Low Deductible Silver 1

## 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: $4,950<br>Family: $9,900 |
| Coinsurance | 20% |
| Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays) | Individual: $6,000<br>Family: $12,000 |

This summary shows in-network benefits only.

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $4,950 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 $9,900 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 $4,950 up to the family maximum of $9,900. 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 $6,000. 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<br>Includes Primary Care Provider, Mental Health/Substance Abuse, Chiropractor (office visit only), Optometrist (pediatric only), Retail Clinics, and Telemedicine | $20 copay | None |
| Specialist | $40 copay | None |

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

| 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 | 20% coinsurance after deductible | None |
| X-Ray/Radiology | $150 copay after deductible | None |
| Advanced Imaging (PET, MRI, MRA, CT, SPECT) | $225 copay after deductible | None |
| **Mammograms** (outpatient) | | |
| Preventive | No charge | Refer to your Evidence of Coverage |
| Diagnostic | $150 copay after deductible | None |
| **Inpatient Services** | | |
| Facility/Physician | $375 copay after deductible | None |
| Skilled Nursing Facility | $375 copay after deductible | 90 Day limit per benefit year |
| **Outpatient Services** Facility/Physician | 20% coinsurance after deductible | None |
| **Maternity Services** | | |
| Prenatal Visit, Office Visits, and Postpartum Care | $40 copay | None |
| Inpatient Services | $375 copay after deductible | None |
| Outpatient Services | 20% coinsurance after deductible | None |
| **Urgent Care** | $75 copay | None |
| **Ambulance Services** | 20% coinsurance after deductible | None |
| **Emergency Health Care Services** | 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. |
| **Habilitative Services** | | |
| Physical Therapy | $20 copay | 25 visits per benefit year |
| Occupational Therapy | $20 copay | 25 visits per benefit year |
| Speech Therapy | 20% coinsurance after deductible | 25 visits per benefit year |

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Rehabilitative Services** | | |
| Physical Therapy | $20 copay | 25 visits per benefit year |
| Occupational Therapy | $20 copay | 25 visits per benefit year |
| Speech Therapy | 20% coinsurance after deductible | 25 visits per benefit year |
| Pulmonary Rehabilitation | 20% coinsurance after deductible | 25 visits per benefit year |
| Cardiac Rehabilitation Services | 20% coinsurance after deductible | 36 visits per benefit year |
| Manipulation Therapy | 20% coinsurance after deductible | 20 visits per benefit year |
| Post-Cochlear Implant Aural Therapy | 20% coinsurance after deductible | 30 visits per benefit year |
| Cognitive Rehabilitation Therapy | 20% coinsurance after deductible | 20 visits per benefit year |
| **Autism Services Disorder Services** | | |
| Physical Therapy | $20 copay | Combined limit with Habilitative Services |
| Occupational Therapy | $20 copay | Combined limit with Habilitative Services |
| Speech Therapy | 20% coinsurance after deductible | Combined limit with Habilitative Services |
| Behavioral Therapy | $20 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 |
| **Home Health** | | |
| Private Duty Nursing | 20% coinsurance after deductible | 250 visits per benefit year. A visit equals 8 hours. |
| Home Infusion Therapy | 20% coinsurance after deductible | None |
| All Other Services | 20% coinsurance after deductible | 100 combined visits per benefit year. A visit equals at least 4 hours. |
| **Hospice Care** | No charge for in-network and out-of-network by Medicare approved providers | Refer to your Evidence of Coverage |

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Diabetic Services** | | |
| Education | 20% coinsurance after deductible | Refer to your Evidence of Coverage |
| Equipment | 20% coinsurance after deductible | Refer to your Evidence of Coverage |
| Supplies | 20% coinsurance after deductible | Refer to your Evidence of Coverage |
| **Medical Supplies, Durable Medical Equipment, and Appliances** | 20% coinsurance after deductible | Refer to your Evidence of Coverage |
| **Hearing Aids** | 30% coinsurance after deductible | 1 hearing aid per hearing-impaired ear every 36 months |
| **Prescription Drugs** | | |
| *Retail* | | |
| Tier 0 (Preventive) | No charge | Up to a 30-day supply |
| Tier 1 (Low Cost) | $20 copay | Up to a 30-day supply |
| Tier 2 (Preferred) | $40 copay | Up to a 30-day supply |
| Tier 3 (Non-Preferred) | 20% 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 |
| *Mail Order* | | |
| Tier 0 (Preventive) | No charge | Up to a 90-day supply |
| Tier 1 (Low Cost) | $50 copay | Up to a 90-day supply |
| Tier 2 (Preferred) | $100 copay | Up to a 90-day supply |
| Tier 3 (Non-Preferred) | 20% 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 |
| **Vision** (pediatric) | | |
| Children's Eye Exam | No charge | 1 routine eye exam per benefit year |
| Low Vision Testing and Aids | No charge | Limited to one evaluation and aid per benefit year. |
| Children's Eyewear | No charge | Limited to one pair of glasses or a 12-month supply of contact lenses per benefit year. If medically necessary, a replacement pair of glasses is allowed. |
| **Other Dental Services** | 20% coinsurance after deductible | Injury as a result of chewing or biting is not considered an accidental injury. |

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Dental** (pediatric) | | |
| Class I – Diagnostic/Preventive | $5 copay | 2 check-ups per benefit year. Refer to your Evidence of Coverage |
| Class II – Restorative/Basic | 20% coinsurance after deductible | Refer to your Evidence of Coverage |
| Class III - Major/Comprehensive | 40% coinsurance after deductible | Refer to your Evidence of Coverage |
| Class IV - Orthodontics | 50% coinsurance after deductible | 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-KY-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.