2021 Schedule of Benefits

Plan Name: CareSource Marketplace Low Deductible Silver 1 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: $4,950 Family: $9,900
Coinsurance	20%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $6,000 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. Once a member has reached their out-of-pocket maximum, the plan will pay 100% of their covered services. 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	$20 copay	None
Specialist	$40 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	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 for both in-network and out-of-network providers	None
Emergency Health Care Services	20% coinsurance after deductible for both in-network and out-of-network providers	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.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Habilitative Services		
Physical Therapy	$20 copay	20 visits per benefit year
Occupational Therapy	$20 copay	20 visits per benefit year
Speech Therapy	20% coinsurance after deductible	20 visits per benefit year
Rehabilitative Services		
Physical Therapy	$20 copay	20 visits per benefit year
Occupational Therapy	$20 copay	20 visits per benefit year
Speech Therapy	20% coinsurance after deductible	20 visits per benefit year
Pulmonary Rehabilitation	20% coinsurance after deductible	20 visits per benefit year
Cardiac Rehabilitation Services	20% coinsurance after deductible	36 visits per benefit year
Manipulation Therapy	20% coinsurance after deductible	12 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 Spectrum Disorder Services		
Occupational Therapy	$20 copay	20 visits per benefit year
Speech Therapy	20% coinsurance after deductible	20 visits per benefit year
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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Private Duty Nursing	20% coinsurance after deductible	100 visits per benefit year, a visit equals 8 hours
All Other Services	20% coinsurance after deductible	100 combined visits per benefit year. A visit equals at least 4 hours.
Hospice Care	20% coinsurance after deductible	Refer to your Evidence of Coverage
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
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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
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.
Vision (adults)		
Eye Exam	$65 copay	1 routine eye exam per benefit year
Low Vision Testing and Aids	No charge	Limited to one evaluation and aid per benefit year.
Eyewear	No charge	1 pair of glasses/contacts per benefit year up to a $250 allowance
Other Dental Services	20% coinsurance after deductible	$3,000 per Member Per Injury All Services combined
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
Dental (adults)		
Class I – Diagnostic/Preventive	$5 copay	Refer to your Evidence of Coverage. Benefit is limited to $800 per benefit year.
Class II – Restorative/Basic	20% coinsurance	
Class III - Major/Comprehensive	40% coinsurance	
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-OH-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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