2021 Schedule of Benefits

Plan Name: CareSource Marketplace HSA Eligible Bronze

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: $5,400 Family: $10,800
Coinsurance	50%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $7,000 Family: $14,000

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $5,400 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 $10,800 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 $5,400 up to the family maximum of $10,800. 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 $7,000. 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 Includes Primary Care Provider, Mental Health/Substance Abuse, Retail Clinics, and Telemedicine	50% coinsurance after deductible	None
Specialist	50% coinsurance after deductible	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	50% coinsurance after deductible	None
X-Ray/Radiology	50% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	50% coinsurance after deductible	None
Mammograms (outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	50% coinsurance after deductible	None
Inpatient Services		
Facility/Physician	50% coinsurance after deductible	None
Skilled Nursing Facility	50% coinsurance after deductible	None
Outpatient Services Facility/Physician	50% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	50% coinsurance after deductible	None
Inpatient Services	50% coinsurance after deductible	None
Outpatient Services	50% coinsurance after deductible	None
Urgent Care	50% coinsurance after deductible	None
Ambulance Services	50% coinsurance after deductible	None
Emergency Health Care Services	50% 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.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Chronic Pain Treatment	50% coinsurance after deductible	20 combined visits per event
Habilitative Services		
Physical Therapy	50% coinsurance after deductible	30 visits per benefit year*
Occupational Therapy	50% coinsurance after deductible	30 visits per benefit year*
Speech Therapy	50% coinsurance after deductible	None
Manipulation Therapy	50% coinsurance after deductible	30 visits per benefit year*
Rehabilitative Services		
Physical Therapy	50% coinsurance after deductible	30 visits per benefit year*
Occupational Therapy	50% coinsurance after deductible	30 visits per benefit year*
Speech Therapy	50% coinsurance after deductible	None
Manipulation Therapy	50% coinsurance after deductible	30 visits per benefit year*
Pulmonary Rehabilitation	50% coinsurance after deductible	30 visits per benefit year
Cardiac Rehabilitation Services	50% coinsurance after deductible	36 visits per benefit year
Post-Cochlear Implant Aural Therapy	50% coinsurance after deductible	None
Autism Spectrum Disorder Services		
Physical Therapy	50% coinsurance after deductible	Combined limit with Habilitative Services
Occupational Therapy	50% coinsurance after deductible	Combined limit with Habilitative Services
Speech Therapy	50% coinsurance after deductible	Combined limit with Habilitative Services
Behavioral Therapy	50% coinsurance after deductible	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

***In addition to any visits covered under Chronic Pain Treatment benefit.

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
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	50% coinsurance after deductible	35 visits per benefit year. A visit equals 8 hours.
Home Infusion Therapy	50% coinsurance after deductible	Included in all other services limits
All Other Services	50% coinsurance after deductible	100 combined visits per benefit year. A visit equals at least 4 hours.
Hospice Care	50% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetic Services		
Education	50% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	50% coinsurance after deductible	Refer to your Evidence of Coverage
Supplies	50% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances	50% 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)	50% coinsurance after deductible	Up to a 30-day supply
Tier 2 (Preferred)	50% coinsurance after deductible	Up to a 30-day supply
Tier 3 (Non-Preferred)	50% coinsurance after deductible	Up to a 30-day supply
Tier 4 (Specialty Preferred)	50% 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% coinsurance after deductible	Up to a 90-day supply
Tier 2 (Preferred)	50% coinsurance after deductible	Up to a 90-day supply
Tier 3 (Non-Preferred)	50% coinsurance after deductible	Up to a 90-day supply
Tier 4 (Specialty Preferred)	50% 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 contact lenses per benefit year. If medically necessary, a replacement pair of glasses is allowed.
Other Dental Services	50% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental (pediatric)		
Class I – Diagnostic/Preventive	50% coinsurance after deductible	2 check-ups per benefit year. Additional benefits available. Refer to your Evidence of Coverage
Class II – Restorative/Basic	50% coinsurance after deductible	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	50% 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-WV-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.

Your CareSource marketplace plan was designed to meet certain requirements set by the Internal Revenue Service and qualifies as a high deductible health plan (HDHP). As such, your CareSource marketplace plan is compatible for use with a Health Savings Account (HSA). However, please be aware that CareSource is not offering or administering an HSA in conjunction with your CareSource marketplace HDHP. In addition, your enrollment in a CareSource marketplace HDHP is only one of the eligibility requirements for establishing and maintaining an HSA. You are responsible for determining whether you are eligible to establish an HSA. You should consult your financial, tax, or legal advisor for more information regarding your obligations and eligibility for establishing and maintaining an HSA.