

2021 Schedule of Benefits

Plan Name: CareSource Marketplace Low Deductible Silver 2 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: \$900 Family: \$1,800 |
| Coinsurance | 10% |
| Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays) | Individual: \$2,500 Family: \$5,000 |



* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$900 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 \$1,800 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 \$900 up to the family maximum of \$1,800. 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 \$2,500. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|--|-------------------------------------|--------------------------|
| Office Visits | | |
| Primary Includes Primary Care Provider, Mental Health/Substance Abuse, Retail Clinics, and Telemedicine | \$10 copay | None |
| Specialist | \$30 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 | 10% coinsurance after deductible | None |
| X-Ray/Radiology | \$125 copay after deductible | None |
| Advanced Imaging (PET, MRI, MRA, CT, SPECT) | \$175 copay after deductible | None |
| Mammograms (outpatient) Preventive | No charge | Refer to your Evidence of Coverage |
| Diagnostic | \$125 copay after deductible | None |
| Inpatient Services Facility/Physician | \$200 copay after deductible | None |
| Skilled Nursing Facility | \$200 copay after deductible | None |
| Outpatient Services Facility/Physician | 10% coinsurance after deductible | None |
| Maternity Services Prenatal Visit, Office Visits, and Postpartum Care | \$30 copay | None |
| Inpatient Services | \$200 copay after deductible | None |
| Outpatient Services | 10% coinsurance after deductible | None |
| Urgent Care | \$75 copay | None |
| Ambulance Services | 10% coinsurance after deductible | None |
| Emergency Health Care Services | 10% 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) |
|--|--|---|
| Chronic Pain Treatment | \$10 copay | 20 combined visits per event |
| Habilitative Services | | |
| Physical Therapy | \$10 copay | 30 visits per benefit year* |
| Occupational Therapy | \$10 copay | 30 visits per benefit year* |
| Speech Therapy | 10% coinsurance after deductible | None |
| Manipulation Therapy | 10% coinsurance after deductible | 30 visits per benefit year* |
| Rehabilitative Services | | |
| Physical Therapy | \$10 copay | 30 visits per benefit year* |
| Occupational Therapy | \$10 copay | 30 visits per benefit year* |
| Speech Therapy | 10% coinsurance after deductible | None |
| Manipulation Therapy | 10% coinsurance after deductible | 30 visits per benefit year* |
| Pulmonary Rehabilitation | 10% coinsurance after deductible | 30 visits per benefit year |
| Cardiac Rehabilitation Services | 10% coinsurance after deductible | 36 visits per benefit year |
| Post-Cochlear Implant Aural Therapy | 10% coinsurance after deductible | None |
| Autism Spectrum Disorder Services | | |
| Physical Therapy | \$10 copay | Combined limit with Habilitative Services |
| Occupational Therapy | \$10 copay | Combined limit with Habilitative Services |
| Speech Therapy | 10% coinsurance after deductible | Combined limit with Habilitative Services |
| Behavioral Therapy | \$10 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 |

*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 | 10% coinsurance after deductible | 35 visits per benefit year. A visit equals 8 hours. |
| Home Infusion Therapy | 10% coinsurance after deductible | Included in all other services limits |
| All Other Services | 10% coinsurance after deductible | 100 combined visits per benefit year. A visit equals at least 4 hours. |
| Hospice Care | 10% coinsurance after deductible | Refer to your Evidence of Coverage |
| Diabetic Services | | |
| Education | 10% coinsurance after deductible | Refer to your Evidence of Coverage |
| Equipment | 10% coinsurance after deductible | Refer to your Evidence of Coverage |
| Supplies | 10% coinsurance after deductible | Refer to your Evidence of Coverage |
| Medical Supplies, Durable Medical Equipment, and Appliances | 10% 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) | \$10 copay | Up to a 30-day supply |
| Tier 2 (Preferred) | \$35 copay | Up to a 30-day supply |
| Tier 3 (Non-Preferred) | 10% 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) | \$25 copay | Up to a 90-day supply |
| Tier 2 (Preferred) | \$87.50 copay | Up to a 90-day supply |
| Tier 3 (Non-Preferred) | 10% 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 | No charge No charge | Limited to one evaluation and aid per benefit year. |
| Other Dental Services | 10% 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. Additional benefits available. 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-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.

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