

## 2021 Schedule of Benefits

Plan Name: CareSource Marketplace Low Premium Silver 2



### 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: \$1,300 Family: \$2,600
Coinsurance	10%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$2,800 Family: \$5,600



\* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$1,300 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 \$2,600 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 \$1,300 up to the family maximum of \$2,600. 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 \$2,800. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Office Visits</b>		
Primary Includes Primary Care Provider, Mental Health/Substance Abuse, Retail Clinics, and Telemedicine	\$15 copay	None
Specialist	\$40 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Preventive Services</b> As defined by federal & state law	No charge	Refer to your Evidence of Coverage
<b>Diagnostic Services</b> Lab	10% coinsurance after deductible	None
X-Ray/Radiology	\$150 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$200 copay after deductible	None
<b>Mammograms</b> (outpatient) Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$150 copay after deductible	None
<b>Inpatient Services</b> Facility/Physician	\$300 copay after deductible	None
Skilled Nursing Facility	\$300 copay after deductible	None
<b>Outpatient Services</b> Facility/Physician	10% coinsurance after deductible	None
<b>Maternity Services</b> Prenatal Visit, Office Visits, and Postpartum Care	\$40 copay	None
Inpatient Services	\$300 copay after deductible	None
Outpatient Services	10% coinsurance after deductible	None
<b>Urgent Care</b>	\$75 copay	None
<b>Ambulance Services</b>	10% coinsurance after deductible	None
<b>Emergency Health Care Services</b>	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)
<b>Chronic Pain Treatment</b>	\$15 copay	20 combined visits per event
<b>Habilitative Services</b>		
Physical Therapy	\$15 copay	30 visits per benefit year*
Occupational Therapy	\$15 copay	30 visits per benefit year*
Speech Therapy	10% coinsurance after deductible	None
Manipulation Therapy	10% coinsurance after deductible	30 visits per benefit year*
<b>Rehabilitative Services</b>		
Physical Therapy	\$15 copay	30 visits per benefit year*
Occupational Therapy	\$15 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
<b>Autism Spectrum Disorder Services</b>		
Physical Therapy	\$15 copay	Combined limit with Habilitative Services
Occupational Therapy	\$15 copay	Combined limit with Habilitative Services
Speech Therapy	10% coinsurance after deductible	Combined limit with Habilitative Services
Behavioral Therapy	\$15 copay	Includes Applied Behavior Analysis (ABA)
<b>Behavioral Health Services</b>	Covered the same as office visits, inpatient services, and outpatient services	None
<b>Transplant Services</b>	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)
<b>Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder</b>	Covered the same as office visits, inpatient services, and outpatient services	None
<b>Home Health</b>		
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.
<b>Hospice Care</b>	10% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Diabetic Services</b>		
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
<b>Medical Supplies, Durable Medical Equipment, and Appliances</b>	10% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Prescription Drugs</b>		
<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)	\$40 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)	\$100 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)
<b>Vision</b> (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.
<b>Other Dental Services</b>	10% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
<b>Dental</b> (pediatric) Class I – Diagnostic/Preventive   Class II – Restorative/Basic  Class III - Major/Comprehensive  Class IV - Orthodontics	\$20 copay   25% coinsurance after deductible  45% coinsurance after deductible  50% 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

**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](http://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](http://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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