2022 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	[01/01/2022]
Last Coverage Change Date	[01/01/2021]

[Dependent information can be found at the end of this document.]

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

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 $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		
Zero Cost Telemedicine Partner	No charge	Refer to your Evidence of Coverage
Primary	$10 copay	None
Includes Primary Care Provider, Mental Health/Substance Abuse, Retail Clinics, and all other telemedicine		
Specialist	$30 copay	None
Preventive Services		
As defined by federal & state law	No charge	Refer to your Evidence of Coverage

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
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	1 visit per physician per day
Skilled Nursing Facility	$200 copay after deductible	60 Day limit per Benefit Year
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	$200 copay 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	$10 copay	40 combined visits per Benefit Year
Occupational Therapy	$10 copay	40 combined visits per Benefit Year
Speech Therapy	10% coinsurance after deductible	40 combined visits per Benefit Year
Audiology	10% coinsurance after deductible	40 combined visits per Benefit Year
Manipulation Therapy	10% coinsurance after deductible	40 combined visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$10 copay	40 combined visits per Benefit Year
Occupational Therapy	$10 copay	40 combined visits per Benefit Year
Speech Therapy	10% coinsurance after deductible	40 combined visits per Benefit Year
Pulmonary Rehabilitation	10% coinsurance after deductible	None
Cardiac Rehabilitation Services	10% coinsurance after deductible	None
Manipulation Therapy	10% coinsurance after deductible	40 combined visits per Benefit Year
Post-Cochlear Implant Aural Therapy	10% coinsurance after deductible	40 combined visits per Benefit Year
Cognitive Rehabilitation Therapy	10% coinsurance after deductible	40 combined visits per Benefit Year
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
Adaptive Behavior Treatment	$10 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits		
Behavioral Health Providers (other than Psychiatrist)	$10 copay	
Psychiatrist	$30 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	10% coinsurance after deductible	None
Partial Hospitalization Program (PHP) Services	10% coinsurance after deductible	
Residential Services	$200 copay after deductible	
Opioid Treatment Program	10% coinsurance after deductible	
Inpatient Services	$200 copay after deductible	
Transplant Services	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage

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		
Home Infusion Therapy	10% coinsurance after deductible	Included in all other services limits
All Other Services	10% coinsurance after deductible	120 combined visits per Benefit Year. A visit equals 2 hours or less.
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 (Retail)		
Tier 0 (Preventive)	No charge	Up to a 90 day supply for Tier 0 – Tier 3 Up to a 30 day supply for Tier 4 & 5 Costs shown are for a 30 day supply. Copays for a 90 day supply will be three times the shown amount.
Tier 1 (Low Cost)	Up to $10 copay	
Tier 2 (Preferred)	Up to $35 copay	
Tier 3 (Non-Preferred)	10% coinsurance after deductible	
Tier 4 (Specialty Preferred)	45% coinsurance after deductible	
Tier 5 (Specialty Non-Preferred)	50% coinsurance after deductible	
Prescription Drugs (Mail Order)		
Tier 0 (Preventive)	No charge	90 day supply for Tier 0 – Tier 3 Up to a 30 day supply for Tier 4 & 5 Copays shown are for a 90 day supply.
Tier 1 (Low Cost)	Up to $25 copay	
Tier 2 (Preferred)	Up to $87.50 copay	
Tier 3 (Non-Preferred)	10% coinsurance after deductible	
Tier 4 (Specialty Preferred)	45% coinsurance after deductible	
Tier 5 (Specialty Non-Preferred)	50% coinsurance after deductible	

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.
Vision (adults)		
Eye Exam	$25 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	10% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental (pediatric)		
Class I – Diagnostic/Preventive	No charge	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage
Class II – Restorative/Basic	15% 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	45% coinsurance after deductible	Refer to your Evidence of Coverage
Dental (adults)		
Class I – Diagnostic/Preventive	No charge	Refer to your Evidence of Coverage. Benefit is limited to $1,000 per Benefit Year.
Class II – Restorative/Basic	15% coinsurance	
Class III - Major/Comprehensive	40% coinsurance	
Class IV - Orthodontics	Not covered	
Fitness Program	No charge	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-GA-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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Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2022]

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