

## 2022 Schedule of Benefits

Plan Name: CareSource Marketplace Low Premium Silver Limited  
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: \$6,500 Family: \$13,000
Coinsurance	30%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$8,700 Family: \$17,400



\* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$6,500 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 \$13,000 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 \$6,500 up to the family maximum of \$13,000. 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 \$8,700. 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>		
Zero Cost Telemedicine Partner	No charge	Refer to your Evidence of Coverage
Primary	\$30 copay	None
Includes Primary Care Provider, Mental Health/Substance Abuse, Retail Clinics, and all other telemedicine		
Specialist	\$70 copay	None
<b>Preventive Services</b>		
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)
<b>Diagnostic Services</b>		
Lab	30% coinsurance after deductible	None
X-Ray/Radiology	\$200 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$250 copay after deductible	None
<b>Mammograms (Outpatient)</b>		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$200 copay after deductible	None
<b>Inpatient Services</b>		
Facility/Physician	\$500 copay after deductible	1 visit per physician per day
Skilled Nursing Facility	\$500 copay after deductible	60 Day limit per Benefit Year
<b>Outpatient Services</b>		
Facility/Physician	30% coinsurance after deductible	None
<b>Maternity Services</b>		
Prenatal Visit, Office Visits, and Postpartum Care	\$70 copay	None
Inpatient Services	\$500 copay after deductible	None
Outpatient Services	30% coinsurance after deductible	None
<b>Urgent Care</b>	\$75 copay	None
<b>Ambulance Services</b>	30% coinsurance after deductible	None
<b>Emergency Health Care Services</b>	\$500 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.
<b>Habilitative Services</b>		
Physical Therapy	\$30 copay	40 combined visits per Benefit Year
Occupational Therapy	\$30 copay	40 combined visits per Benefit Year
Speech Therapy	30% coinsurance after deductible	40 combined visits per Benefit Year
Audiology	30% coinsurance after deductible	40 combined visits per Benefit Year
Manipulation Therapy	30% coinsurance after deductible	40 combined visits per Benefit Year

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Rehabilitative Services</b>		
Physical Therapy	\$30 copay	40 combined visits per Benefit Year
Occupational Therapy	\$30 copay	40 combined visits per Benefit Year
Speech Therapy	30% coinsurance after deductible	40 combined visits per Benefit Year
Pulmonary Rehabilitation	30% coinsurance after deductible	None
Cardiac Rehabilitation Services	30% coinsurance after deductible	None
Manipulation Therapy	30% coinsurance after deductible	40 combined visits per Benefit Year
Post-Cochlear Implant Aural Therapy	30% coinsurance after deductible	40 combined visits per Benefit Year
Cognitive Rehabilitation Therapy	30% coinsurance after deductible	40 combined visits per Benefit Year
<b>Autism Spectrum Disorder Services</b>		
Physical Therapy	\$30 copay	Combined limit with Habilitative Services
Occupational Therapy	\$30 copay	Combined limit with Habilitative Services
Speech Therapy	30% coinsurance after deductible	Combined limit with Habilitative Services
Adaptive Behavior Treatment	\$30 copay	Includes Applied Behavior Analysis (ABA)
<b>Behavioral Health Services</b>		
Office Visits		
Behavioral Health Providers (other than Psychiatrist)	\$30 copay	
Psychiatrist	\$70 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	30% coinsurance after deductible	None
Partial Hospitalization Program (PHP) Services	30% coinsurance after deductible	
Residential Services	\$500 copay after deductible	
Opioid Treatment Program	30% coinsurance after deductible	
Inpatient Services	\$500 copay after deductible	
<b>Transplant Services</b>	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage

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<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> Home Infusion Therapy	30% coinsurance after deductible	Included in all other services limits
All Other Services	30% coinsurance after deductible	120 combined visits per Benefit Year. A visit equals 2 hours or less.
<b>Hospice Care</b>	30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Diabetic Services</b> Education	30% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	30% coinsurance after deductible	Refer to your Evidence of Coverage
Supplies	30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Medical Supplies, Durable Medical Equipment, and Appliances</b>	30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Prescription Drugs (Retail)</b> 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 \$20 copay	
Tier 2 (Preferred)	Up to \$50 copay	
Tier 3 (Non-Preferred)	35% coinsurance after deductible	
Tier 4 (Specialty Preferred)	45% coinsurance after deductible	
Tier 5 (Specialty Non-Preferred)	50% coinsurance after deductible	
<b>Prescription Drugs (Mail Order)</b> 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 \$50 copay	
Tier 2 (Preferred)	Up to \$125 copay	
Tier 3 (Non-Preferred)	35% coinsurance after deductible	
Tier 4 (Specialty Preferred)	45% coinsurance after deductible	
Tier 5 (Specialty Non-Preferred)	50% coinsurance after deductible	

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Vision (pediatric)</b> 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>Vision (adults)</b> Eye Exam Low Vision Testing and Aids  Eyewear	\$40 copay No charge  No charge	1 routine eye exam per Benefit Year Limited to one evaluation and aid per Benefit Year.  1 pair of glasses/contacts per Benefit Year up to a \$250 allowance
<b>Other Dental Services</b>	30% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
<b>Dental (pediatric)</b> Class I – Diagnostic/Preventive  Class II – Restorative/Basic  Class III - Major/Comprehensive  Class IV - Orthodontics	No charge  30% coinsurance after deductible  50% coinsurance after deductible  55% 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
<b>Dental (adults)</b> Class I – Diagnostic/Preventive Class II – Restorative/Basic Class III - Major/Comprehensive Class IV - Orthodontics	No charge 30% coinsurance 50% coinsurance Not covered	Refer to your Evidence of Coverage. Benefit is limited to \$1,000 per Benefit Year.
<b>Fitness Program</b>	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](http://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](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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The copays and coinsurance listed in the 'You Pay' column would only apply if the item or service is not furnished directly by a provider meeting the criteria outlined below, otherwise there would be no cost to you.

- 1) an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603);
- 2) a provider who was referred by one of the organizations listed in item 1.

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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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