

## 2022 Schedule of Benefits

Plan Name: CareSource Marketplace Low Premium Silver 3 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: \$450 Family: \$900
Coinsurance	5%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$900 Family: \$1,800



\* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$450 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 \$900 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 \$450 up to the family maximum of \$900. 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 \$900. 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 Telehealth Partner	No charge	Refer to your Evidence of Coverage
Primary	\$5 copay	None
Includes Primary Care Provider, Mental Health/Substance Abuse, Psychiatrist, Chiropractor (office visit only), Retail Clinics, and all other telehealth		
Specialist	\$15 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	5% coinsurance after deductible	None
X-Ray/Radiology	\$50 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$100 copay after deductible	None
<b>Mammograms (Outpatient)</b>		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$50 copay after deductible	None
<b>Inpatient Services</b>		
Facility/Physician	\$200 copay after deductible	1 visit per physician per day
Skilled Nursing Facility	\$200 copay after deductible	90 Day limit per Benefit Year
<b>Outpatient Services</b>		
Facility/Physician	5% coinsurance after deductible	None
<b>Maternity Services</b>		
Prenatal Visit, Office Visits, and Postpartum Care	\$15 copay	None
Inpatient Services	\$200 copay after deductible	None
Outpatient Services	5% coinsurance after deductible	None
<b>Urgent Care</b>	\$75 copay	None
<b>Ambulance Services</b>	5% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Emergency Health Care Services</b>	\$200 Copay after deductible which also applies to out-of-network providers	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	\$5 copay	25 visits per Benefit Year
Occupational Therapy	\$5 copay	25 visits per Benefit Year
Speech Therapy	5% coinsurance after deductible	25 visits per Benefit Year

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Rehabilitative Services</b> Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Manipulation Therapy Post-Cochlear Implant Aural Therapy Cognitive Rehabilitation Therapy	\$5 copay \$5 copay 5% coinsurance after deductible 5% coinsurance after deductible 5% coinsurance after deductible 5% coinsurance after deductible 5% coinsurance after deductible 5% coinsurance after deductible	25 visits per Benefit Year 25 visits per Benefit Year 25 visits per Benefit Year 25 visits per Benefit Year 36 visits per Benefit Year 20 visits per Benefit Year 30 visits per Benefit Year 20 visits per Benefit Year
<b>Autism Spectrum Disorder Services</b> Physical Therapy Occupational Therapy Speech Therapy Adaptive Behavior Treatment	\$5 copay \$5 copay 5% coinsurance after deductible \$5 copay	None None None Includes Applied Behavior Analysis (ABA)
<b>Behavioral Health Services</b> Office Visits Outpatient Services Intensive Outpatient Program (IOP) Services Partial Hospitalization Program (PHP) Services Residential Services Opioid Treatment Program Inpatient Services	\$5 copay 5% coinsurance after deductible 5% coinsurance after deductible \$200 copay after deductible 5% coinsurance after deductible \$200 copay after deductible	None None
<b>Transplant Services</b>	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
<b>Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder</b>	Covered the same as office visits, inpatient services, and outpatient services	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Home Health</b> Private Duty Nursing  Home Infusion Therapy  All Other Services	5% coinsurance after deductible  5% coinsurance after deductible  5% coinsurance after deductible	250 visits per Benefit Year. A visit equals 8 hours.  None  100 combined visits per Benefit Year. A visit equals at least 4 hours.
<b>Hospice Care</b>	No charge for in-network and out-of-network by Medicare approved providers	Refer to your Evidence of Coverage
<b>Diabetic Services</b> Education  Equipment  Supplies	5% coinsurance after deductible  5% coinsurance after deductible  5% coinsurance after deductible	Refer to your Evidence of Coverage  Refer to your Evidence of Coverage  Refer to your Evidence of Coverage
<b>Medical Supplies, Durable Medical Equipment, and Appliances</b>	5% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Hearing Aids</b>	5% coinsurance after deductible	1 hearing aid per hearing-impaired ear every 36 months
<b>Prescription Drugs (Retail)</b> Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty Preferred) Tier 5 (Specialty Non-Preferred)	No charge Up to \$5 copay Up to \$15 copay 5% coinsurance after deductible 45% coinsurance after deductible 50% coinsurance after deductible	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. Insulin cost share not to exceed \$30 per 30 day supply
<b>Prescription Drugs (Mail Order)</b> Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty Preferred) Tier 5 (Specialty Non-Preferred)	No charge Up to \$12.50 copay Up to \$37.50 copay 5% coinsurance after deductible 45% coinsurance after deductible 50% coinsurance after deductible	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. Insulin cost share not to exceed \$30 per 30 day supply

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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 a 12-month supply of 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	\$25 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>	5% 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 20% coinsurance after deductible 40% 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
<b>Dental (adults)</b> Class I – Diagnostic/Preventive Class II – Restorative/Basic Class III - Major/Comprehensive Class IV - Orthodontics	No charge 20% coinsurance 40% 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-KY-pa](http://www.caresource.com/mp-KY-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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**No Surprises Act:** The No Surprises Act requires CareSource & Providers to hold patients harmless from surprise medical bills stemming from out-of-network emergency care, out of network air ambulance, and services provided by out-of-network providers at in-network facilities without the patient's informed consent or for certain ancillary services. Services subject to the No Surprises Act will be have the same cost share requirements as Network Services, as listed in the above "You Pay" column, applied to the amount we initially determine to pay (also known as the Recognized Amount). These amounts will count towards your deductible and out of pocket maximum in similar fashion if they had been delivered by Network Providers.

The No Surprises Act is meant to ensure you're kept out of the middle of provider plan billing disputes for those specific services by prohibiting facilities and providers from pursuing payment from you for more than the in-network cost-sharing amount as based on the Recognized Amount in most situations. One situation where you may still be involved is regarding non-emergency services provided by a non-network provider while you are in a network facility. The No Surprises Act prohibits these providers from balance billing you unless the provider gives you notice of their network status and an estimate of charges 72 hours prior to receiving the services, or same day as the appointment if scheduled less than 72 hours in advance. If you receive this notice and then consent to continue to receive the out-of-network care, the provider will be allowed to pursue payment from you for any amounts that we do not cover, otherwise known as balance billing.

See your Evidence of Coverage for further details.

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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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