



Plan Information

| | |
|---------------------------|--------------|
| Primary Member | [John Doe] |
| Member ID | [104000000] |
| Date of Birth | [01/01/1965] |
| Effective Date | [01/01/2023] |
| Last Coverage Change Date | [01/01/2022] |

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

Highlights

| | |
|--|---|
| Annual Deductible* | Individual: \$6,500 Family: \$13,000 |
| Coinsurance | 50% |
| Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays) | Individual: \$9,100 Family: \$18,200 |



* 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 \$9,100. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

| 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 |
| Office Visits Zero Cost Telemedicine Partner Primary Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics Specialist | No charge \$30 copay \$70 copay | Refer to your Evidence of Coverage None None |
| Urgent Care | \$50 copay | None |

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|--|---------------------------------------|--|
| Diagnostic Services | | |
| Lab | \$40 copay | None |
| X-Ray/Radiology | \$200 copay after deductible | None |
| Advanced Imaging (PET, MRI, MRA, CT, SPECT) | \$250 copay after deductible | None |
| Mammograms (Outpatient) | | |
| Preventive | No charge | Refer to your Evidence of Coverage |
| Diagnostic | \$200 copay after deductible | None |
| Inpatient Services | | |
| Facility Fee | \$500 copay after deductible per stay | None |
| Physician/Surgeon Fees | No charge after deductible | 1 visit per physician per day |
| Skilled Nursing Facility | \$500 copay after deductible per stay | 60 Day limit per Benefit Year |
| Outpatient Services | | |
| Facility Fee | 50% coinsurance after deductible | None |
| Physician/Surgeon Fees | 50% coinsurance after deductible | None |
| Maternity Services | | |
| Prenatal Visit, Office Visits, and Postpartum Care | \$70 copay | None |
| Inpatient Services | \$500 copay after deductible | None |
| Outpatient Services | 50% coinsurance after deductible | None |
| Ambulance Services | 50% coinsurance after deductible | None |
| Emergency Health Care Services | \$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. |
| Habilitative Services | | |
| Physical Therapy | \$30 copay | 40 combined visits per Benefit Year |
| Occupational Therapy | \$30 copay | 40 combined visits per Benefit Year |
| Speech Therapy | 50% coinsurance after deductible | 40 combined visits per Benefit Year |
| Audiology | 50% coinsurance after deductible | 40 combined visits per Benefit Year |
| Manipulation Therapy | 50% coinsurance after deductible | 40 combined visits per Benefit Year |

Learn more about CareSource and all our plan options at www.caresource.com/marketplace.

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|--|--|---|
| Rehabilitative Services | | |
| Physical Therapy | \$30 copay | 40 combined visits per Benefit Year |
| Occupational Therapy | \$30 copay | 40 combined visits per Benefit Year |
| Speech Therapy | 50% coinsurance after deductible | 40 combined visits per Benefit Year |
| Pulmonary Rehabilitation | 50% coinsurance after deductible | None |
| Cardiac Rehabilitation Services | 50% coinsurance after deductible | None |
| Manipulation Therapy | 50% coinsurance after deductible | 40 combined visits per Benefit Year |
| Post-Cochlear Implant Aural Therapy | 50% coinsurance after deductible | 40 combined visits per Benefit Year |
| Cognitive Rehabilitation Therapy | 50% coinsurance after deductible | 40 combined visits per Benefit Year |
| Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation | 50% coinsurance after deductible | Refer to your Evidence of Coverage |
| Autism Spectrum Disorder Services | | |
| Physical Therapy | \$30 copay | Combined limit with Habilitative Services |
| Occupational Therapy | \$30 copay | Combined limit with Habilitative Services |
| Speech Therapy | 50% coinsurance after deductible | Combined limit with Habilitative Services |
| Adaptive Behavior Treatment | \$30 copay | Includes Applied Behavior Analysis (ABA) |
| Behavioral Health Services | | |
| Office Visits | \$30 copay | |
| Outpatient Services | | |
| Intensive Outpatient Program (IOP) Services | 50% coinsurance after deductible | |
| Partial Hospitalization Program (PHP) Services | 50% coinsurance after deductible | None |
| Residential Services | \$500 copay after deductible per stay | |
| Opioid Treatment Program | 50% coinsurance after deductible | |
| Inpatient Services | \$500 copay after deductible per stay | |
| Transplant Services | Covered the same as office visits, inpatient services, and outpatient services | Refer to your Evidence of Coverage |
| Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder | Covered the same as office visits, inpatient services, and outpatient services | 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) |
|---|---|---|
| Home Health Home Infusion Therapy All Other Services | 50% coinsurance after deductible 50% coinsurance after deductible | Included in all other services limits 120 combined visits per Benefit Year. A visit equals 2 hours or less. |
| Hospice Care | 50% coinsurance after deductible | Refer to your Evidence of Coverage |
| Diabetic Services Education Equipment Supplies | 50% coinsurance after deductible | Refer to your Evidence of Coverage |
| Medical Supplies, Durable Medical Equipment, and Appliances Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics | 50% coinsurance after deductible | Refer to your Evidence of Coverage |
| Prescription Drugs Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty) | No charge Up to \$15 copay Up to \$75 copay 40% coinsurance after deductible 50% coinsurance after deductible | Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for any drug in Tiers 0-3 All others limited to a 30-day supply Any copays shown are for a 30-day supply. 90-day supplies for Retail are 3 times the copay and for Mail Order are 2.5 times the copay. |
| 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. |
| Other Dental Services Accidental Dental Dental Anesthesia | 50% coinsurance after deductible 50% coinsurance after deductible | Injury as a result of chewing or biting is not considered an accidental injury. Refer to your Evidence of Coverage |

Learn more about CareSource and all our plan options at www.caresource.com/marketplace.

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---------------------------------|-------------------------------------|---|
| 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 – Minor Restorative | 30% coinsurance after deductible | Refer to your Evidence of Coverage |
| Class III - Major/Comprehensive | 50% coinsurance after deductible | Refer to your Evidence of Coverage |
| Class IV - Orthodontics | 55% coinsurance after deductible | 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.

Learn more about CareSource and all our plan options at www.caresource.com/marketplace.

Dependent Information

| | |
|---------------------|--------------|
| Dependent Name | [John Doe] |
| Relationship to You | [104000000] |
| Date of Birth | [01/01/1965] |
| Effective Date | [01/01/2023] |

Learn more about CareSource and all our plan options at www.caresource.com/marketplace.