**2023 Schedule of Benefits**
Plan Name: CareSource Marketplace Bronze Limited Dental, Vision, & Fitness

## 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: $9,100<br>Family: $18,200 |
| Coinsurance | 0% |
| Annual Out-of-Pocket Maximum**<br>(includes deductible, coinsurance, and copays) | Individual: $9,100<br>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 $9,100 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 $18,200 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 $9,100 up to the family maximum of $18,200. 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<br>(Network Providers Only) | Limit<br>(If Applicable) |
|---|---|---|
| **Preventive Services**<br>As defined by federal & state law | No charge | Refer to your Evidence of Coverage |
| **Office Visits** | | |
| Zero Cost Telehealth Partner | No charge | Refer to your Evidence of Coverage |
| Primary | | |
| Includes Primary Care Provider, Mental Health/Substance Abuse, Psychiatrist, Chiropractor (office visit only), and Retail Clinics | No charge after deductible | None |
| Specialist | No charge after deductible | None |
| **Urgent Care** | No charge after deductible | None |

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| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Diagnostic Services** | | |
| Lab | No charge after deductible | None |
| X-Ray/Radiology | No charge after deductible | None |
| Advanced Imaging (PET, MRI, MRA, CT, SPECT) | No charge after deductible | None |
| **Mammograms** (Outpatient) | | |
| Preventive | No charge | Refer to your Evidence of Coverage |
| Diagnostic | No charge after deductible | None |
| **Inpatient Services** | | |
| Facility Fee | No charge after deductible | None |
| Physician/Surgeon Fees | No charge after deductible | 1 visit per physician per day |
| Skilled Nursing Facility | No charge after deductible | 90 Day limit per Benefit Year |
| **Outpatient Services** | | |
| Facility Fee | No charge after deductible | None |
| Physician/Surgeon Fees | No charge after deductible | None |
| **Maternity Services** | | |
| Prenatal Visit, Office Visits, and Postpartum Care | No charge after deductible | None |
| Inpatient Services | No charge after deductible | None |
| Outpatient Services | No charge after deductible | None |
| **Ambulance Services** | No charge after deductible | Refer to your Evidence of Coverage |
| **Emergency Health Care Services** | No charge after deductible<br>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. |
| **Habilitative Services** | | |
| Physical Therapy | No charge after deductible | 25 visits per Benefit Year |
| Occupational Therapy | No charge after deductible | 25 visits per Benefit Year |
| Speech Therapy | No charge after deductible | 25 visits per Benefit Year |

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Rehabilitative Services** | | |
| Physical Therapy | No charge after deductible | 25 visits per Benefit Year |
| Occupational Therapy | No charge after deductible | 25 visits per Benefit Year |
| Speech Therapy | No charge after deductible | 25 visits per Benefit Year |
| Pulmonary Rehabilitation | No charge after deductible | 25 visits per Benefit Year |
| Cardiac Rehabilitation Services | No charge after deductible | 36 visits per Benefit Year |
| Manipulation Therapy | No charge after deductible | 20 visits per Benefit Year |
| Post-Cochlear Implant Aural Therapy | No charge after deductible | 30 visits per Benefit Year |
| Cognitive Rehabilitation Therapy | No charge after deductible | 20 visits per Benefit Year |
| Other Rehabilitative Services<br>Includes Chemotherapy, Dialysis, and Radiation | No charge after deductible | Refer to your Evidence of Coverage |
| **Autism Spectrum Disorder Services** | | |
| Physical Therapy | No charge after deductible | None |
| Occupational Therapy | No charge after deductible | None |
| Speech Therapy | No charge after deductible | None |
| Adaptive Behavior Treatment | No charge after deductible | Includes Applied Behavior Analysis (ABA) |
| **Behavioral Health Services** | | |
| Office Visits | No charge after deductible | |
| Outpatient Services | | |
| Intensive Outpatient Program (IOP) Services | No charge after deductible | |
| Partial Hospitalization Program (PHP) Services | No charge after deductible | None |
| Residential Services | No charge after deductible | |
| Opioid Treatment Program | No charge after deductible | |
| Inpatient Services | No charge after deductible | |
| **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 |
| **Home Health** | | |
| Private Duty Nursing | No charge after deductible | 250 visits per Benefit Year. A visit equals 8 hours. |
| Home Infusion Therapy | No charge after deductible | None |
| All Other Services | No charge after deductible | 100 combined visits per Benefit Year. A visit equals at least 4 hours. |

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

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Hospice Care** | No charge for in-network and out-of-network by Medicare approved providers | Refer to your Evidence of Coverage |
| **Diabetic Services**<br>Education<br>Equipment<br>Supplies | No charge after deductible | Refer to your Evidence of Coverage |
| **Medical Supplies, Durable Medical Equipment, and Appliances**<br>Appliances<br>Durable Medical Equipment<br>Medical Supplies<br>Orthotic Device<br>Prosthetics | No charge after deductible | Refer to your Evidence of Coverage |
| **Hearing Aids** | No charge after deductible | 1 hearing aid per hearing-impaired ear every 36 months |
| **Prescription Drugs**<br>Tier 0 (Preventive)<br>Tier 1 (Low Cost)<br>Tier 2 (Preferred)<br>Tier 3 (Non-Preferred)<br>Tier 4 (Specialty) | No charge<br>No charge after deductible<br>No charge after deductible<br>No charge after deductible<br>No charge 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<br>All others limited to a 30-day supply<br>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.<br>Insulin cost share not to exceed $30 per 30-day supply |
| **Vision** (pediatric)<br>Children's Eye Exam<br>Low Vision Testing and Aids<br>Children's Eyewear | No charge<br>No charge<br>No charge | 1 routine eye exam per Benefit Year<br>Limited to one evaluation and aid per Benefit Year.<br>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. |
| **Vision** (adults)<br>Eye Exam<br>Low Vision Testing and Aids<br>Eyewear | 40% coinsurance<br>No charge<br>No charge | 1 routine eye exam per Benefit Year<br>Limited to one evaluation and aid per Benefit Year.<br>1 pair of glasses/contacts per Benefit Year up to a $250 allowance |
| **Other Dental Services**<br>Accidental Dental<br>Dental Anesthesia | No charge after deductible<br>No charge after deductible | Injury as a result of chewing or biting is not considered an accidental injury.<br>Refer to your Evidence of Coverage |

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Dental** (pediatric)<br>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 | No charge after deductible for all services | Refer to your Evidence of Coverage |
| Class III - Major/Comprehensive | No charge after deductible | Refer to your Evidence of Coverage |
| Class IV - Orthodontics | No charge after deductible for all services | Refer to your Evidence of Coverage |
| **Dental** (adults)<br>Class I – Diagnostic/Preventive | No charge | Refer to your Evidence of Coverage. Benefit is limited to $1,000 per Benefit Year. |
| Class II – Minor Restorative | 40% coinsurance | |
| Class III - Major/Comprehensive | 50% 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-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**.

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.

**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 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.

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.

## Dependent Information

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

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