2023 Schedule of Benefits
Plan Name: CareSource Marketplace Gold

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: $2,000 Family: $4,000
Coinsurance	25%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $8,700 Family: $17,400

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 $2,000 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 $4,000 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 $2,000 up to the family maximum of $4,000. 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. Once a member has reached their out-of-pocket maximum, the plan will pay 100% of their Covered Services. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

Cost sharing shown applies to services received in-person or via telehealth

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 Telehealth Partner	No charge	Refer to your Evidence of Coverage
Primary Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	$30 copay	None
Specialist	$60 copay	None
Urgent Care	$45 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	25% coinsurance after deductible	None
X-Ray/Radiology	25% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	25% coinsurance after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	25% coinsurance after deductible	None
Inpatient Services		
Facility Fee	25% coinsurance after deductible	None
Physician/Surgeon Fees	25% coinsurance after deductible	1 visit per physician per day
Skilled Nursing Facility	25% coinsurance after deductible	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	25% coinsurance after deductible	None
Physician/Surgeon Fees	25% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$60 copay	None
Inpatient Services	25% coinsurance after deductible	None
Outpatient Services	25% coinsurance after deductible	None
Ambulance Services	25% coinsurance after deductible for both in-network and out-of-network providers	None
Emergency Health Care Services	25% coinsurance after deductible for both in-network and 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	$30 copay	20 visits per Benefit Year
Occupational Therapy	$30 copay	20 visits per Benefit Year
Speech Therapy	$30 copay	20 visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$30 copay	20 visits per Benefit Year
Occupational Therapy	$30 copay	20 visits per Benefit Year
Speech Therapy	$30 copay	20 visits per Benefit Year
Pulmonary Rehabilitation	25% coinsurance after deductible	20 visits per Benefit Year
Cardiac Rehabilitation Services	25% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	25% coinsurance after deductible	12 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	$30 copay	30 visits per Benefit Year
Cognitive Rehabilitation Therapy	25% coinsurance after deductible	20 visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	25% coinsurance after deductible	Refer to your Evidence of Coverage
Autism Spectrum Disorder Services		
Occupational Therapy	$30 copay	20 visits per Benefit Year
Speech Therapy	$30 copay	20 visits per Benefit Year
Adaptive Behavior Treatment	$30 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	$30 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	25% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	25% coinsurance after deductible	None
Residential Services	25% coinsurance after deductible	
Opioid Treatment Program	25% coinsurance after deductible	
Inpatient Services	25% coinsurance 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	25% coinsurance after deductible	100 visits per Benefit Year, a visit equals 8 hours
All Other Services	25% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Hospice Care	25% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetic Services Education Equipment Supplies	25% 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	25% 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 $30 copay Up to $60 copay Up to $250 copay	 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 a 12-month supply of contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed.
Other Dental Services Accidental Dental Dental Anesthesia	 25% coinsurance after deductible 25% coinsurance after deductible	 $3,000 per Member Per Injury All Services combined Refer to your Evidence of Coverage
Dental (pediatric) Class I – Diagnostic/Preventive Class II – Minor Restorative Class III - Major/Comprehensive Class IV - Orthodontics	 No charge 15% coinsurance after deductible 40% coinsurance after deductible 40% 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

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-OH-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.

Ohio Revised Code Sections 3902.50 through 3902.54, Ohio Administrative Code Section 3901-8-17 and the Federal No Surprises Act establish patient protections including from out-of-network providers' surprise bills ("balance billing") for emergency care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain out-of-network providers.

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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