

## 2024 Schedule of Benefits

Plan Name: CareSource Marketplace Bronze First Dental, Vision, & Fitness



### Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2024]
Last Coverage Change Date	[01/01/2023]

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

### Highlights

Annual Deductible*	Individual: \$7,500 Family: \$15,000
Coinsurance	50%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$9,400 Family: \$18,800



\* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$7,500 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 \$15,000 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 \$7,500 up to the family maximum of \$15,000. 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 \$9,400. 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>Preventive Services</b> As defined by federal & state law	No charge	Refer to your Evidence of Coverage
<b>Office Visits</b> Zero Cost Telemedicine Partner Primary Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics Specialist	No charge \$50 copay \$100 copay	Refer to your Evidence of Coverage None None
<b>Urgent Care</b>	\$75 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Diagnostic Services</b>		
Lab	50% coinsurance after deductible	None
X-Ray/Radiology	50% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	50% coinsurance after deductible	None
<b>Mammograms (Outpatient)</b>		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	50% coinsurance after deductible	None
<b>Inpatient Services</b>		
Facility Fee	50% coinsurance after deductible	None
Physician/Surgeon Fees	50% coinsurance after deductible	1 visit per physician per day
Skilled Nursing Facility	50% coinsurance after deductible	60 Day limit per Benefit Year
<b>Outpatient Services</b>		
Facility Fee	50% coinsurance after deductible	None
Physician/Surgeon Fees	50% coinsurance after deductible	None
<b>Maternity Services</b>		
Prenatal Visit, Office Visits, and Postpartum Care	\$100 copay	None
Inpatient Services	50% coinsurance after deductible	None
Outpatient Services	50% coinsurance after deductible	None
<b>Ambulance Services</b>	50% coinsurance after deductible	None
<b>Emergency Health Care Services</b>	50% coinsurance 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	\$50 copay	40 combined visits per Benefit Year
Occupational Therapy	\$50 copay	40 combined visits per Benefit Year
Speech Therapy	\$50 copay	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

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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 Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	\$50 copay \$50 copay \$50 copay 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible \$50 copay 50% coinsurance after deductible 50% coinsurance after deductible	40 combined visits per Benefit Year 40 combined visits per Benefit Year 40 combined visits per Benefit Year None None 40 combined visits per Benefit Year 40 combined visits per Benefit Year 40 combined visits per Benefit Year Refer to your Evidence of Coverage
<b>Autism Spectrum Disorder Services</b> Physical Therapy Occupational Therapy Speech Therapy Adaptive Behavior Treatment	\$50 copay \$50 copay \$50 copay \$50 copay	Combined limit with Habilitative Services Combined limit with Habilitative Services Combined limit with Habilitative Services 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	\$50 copay 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible	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> 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.
<b>Hospice Care</b>	50% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Diabetic Services</b> Education  Equipment  Supplies	50% coinsurance after deductible  50% coinsurance after deductible  50% 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> Appliances  Durable Medical Equipment  Medical Supplies  Orthotic Device  Prosthetics	50% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Prescription Drugs</b> Tier 0 (Preventive)  Tier 1 (Low Cost)  Tier 2 (Preferred)  Tier 3 (Non-Preferred)  Tier 4 (Specialty)	No charge  Up to \$25 copay  Up to \$50 copay after deductible  Up to \$100 copay after deductible  Up to \$500 copay after deductible	Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for drugs 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.
<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% coinsurance  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

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Other Dental Services</b>		
Accidental Dental	50% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	50% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Dental (pediatric)</b>		
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	40% 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	60% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Dental (adults)</b>		
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	
<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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### Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2024]

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