

2024 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	[01/01/2024]
Last Coverage Change Date	[01/01/2023]

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

Highlights

Annual Deductible*	Individual: \$300 Family: \$600
Coinsurance	10%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$800 Family: \$1,600



* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$300 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 \$600 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 \$300 up to the family maximum of \$600. 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 \$800. 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	No charge	Refer to your Evidence of Coverage
Primary Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	No charge	None
Specialist	\$15 copay	None
Urgent Care	\$25 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	\$10 copay	None
X-Ray/Radiology	\$50 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$100 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$50 copay after deductible	None
Inpatient Services		
Facility Fee	\$300 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	\$200 copay after deductible per stay	60 Day limit per Benefit Year
Outpatient Services		
Facility Fee	10% coinsurance after deductible	None
Physician/Surgeon Fees	10% coinsurance after deductible	None
Surgical and Reconstructive Services		
Anesthesia		
Bariatric Surgery		
Congenital Anomaly, including Cleft Lip/Palate	10% coinsurance after deductible	Refer to your Evidence of Coverage
Reconstructive Surgery		
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	\$15 copay	None
Inpatient Services	\$300 copay after deductible	None
Outpatient Services	10% coinsurance after deductible	None
Well Baby Visits and Care	No charge	None
Ambulance Services	10% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	\$300 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	No charge	30 visits Combined per Benefit Year
Occupational Therapy	No charge	30 visits Combined per Benefit Year
Manipulation Therapy	10% coinsurance after deductible	30 visits Combined per Benefit Year

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Manipulation Therapy Post-Cochlear Implant Aural Therapy Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	No charge No charge 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible	30 visits Combined per Benefit Year 30 visits Combined per Benefit Year 30 visits per Benefit Year None None 30 visits Combined per Benefit Year Combined Limit with Speech Therapy Refer to your Evidence of Coverage
Chiropractor Services	\$15 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services Physical Therapy Occupational Therapy Speech Therapy Adaptive Behavior Treatment	No charge No charge 10% coinsurance after deductible No charge	None None None Includes Applied Behavior Analysis (ABA)
Behavioral Health Services Office Visits Outpatient Services Intensive Outpatient Program (IOP) Services Partial Hospitalization Program (PHP) Services Residential Services Opioid Treatment Program Inpatient Services	No charge 10% coinsurance after deductible 10% coinsurance after deductible \$200 copay after deductible per stay 10% coinsurance after deductible \$300 copay after deductible per stay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Transplant Services Transplants Donor Location Costs Transportation and Lodging	Covered the same as office visits, inpatient services, and outpatient services 10% coinsurance after deductible 10% coinsurance after deductible	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 Home Infusion Therapy All Other Services	10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible	None None None
Hospice Care	10% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetic Services Education Equipment Diabetes Care Management Supplies	10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible	Refer to your Evidence of Coverage Refer to your Evidence of Coverage Refer to your Evidence of Coverage Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances Appliances Durable Medical Equipment Medical Supplies Orthotic Device for Positional Plagiocephaly Prosthetics	10% coinsurance after deductible	Refer to your Evidence of Coverage
Hearing Aids	10% coinsurance after deductible	1 hearing aid per hearing-impaired ear every 36 months.
Reproductive Health Infertility Treatment Sexual Dysfunction Sterilization	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Prescription Drugs Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty)	No charge No charge Up to \$25 copay 30% coinsurance after deductible 45% coinsurance 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 are 3 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.
Vision (adults) 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
Other Dental Services Accidental Dental Dental Anesthesia	10% coinsurance after deductible 10% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury. 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 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
Dental (adults) Class I - Diagnostic/Preventive Class II - Minor Restorative 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.
Fitness Program	No charge	Refer to your Evidence of Coverage

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Other Covered Services Allergy Testing Blood Services Clinical Trials Nutritional Counseling	Covered the same as office visits, inpatient services, and outpatient services	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-NC-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.

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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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