

## 2024 Schedule of Benefits

Plan Name: CareSource Marketplace Low Premium Silver 2 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: \$1,000 Family: \$2,000
Coinsurance	20%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$2,700 Family: \$5,400



\* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$1,000 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 \$2,000 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 \$1,000 up to the family maximum of \$2,000. 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 \$2,700. 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)
<b>Preventive Services</b> As defined by federal & state law	No charge	Refer to your Evidence of Coverage
<b>Office Visits</b> Zero Cost Telehealth Partner	No charge	Refer to your Evidence of Coverage
Primary Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	\$5 copay	None
Specialist	\$40 copay	None
<b>Urgent Care</b>	\$25 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Diagnostic Services</b>		
Lab	\$15 copay	None
X-Ray/Radiology	\$150 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$200 copay after deductible	None
<b>Mammograms (Outpatient)</b>		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$150 copay after deductible	None
<b>Inpatient Services</b>		
Facility Fee	\$350 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	\$300 copay after deductible per stay	90 Day limit per Benefit Year
<b>Outpatient Services</b>		
Facility Fee	20% coinsurance after deductible	None
Physician/Surgeon Fees	20% coinsurance after deductible	None
<b>Maternity Services</b>		
Prenatal Visit, Office Visits, and Postpartum Care	\$40 copay	None
Inpatient Services	\$350 copay after deductible	None
Outpatient Services	20% coinsurance after deductible	None
<b>Ambulance Services</b>		
	20% coinsurance after deductible for both in-network and out-of-network providers	None
<b>Emergency Health Care Services</b>	\$350 copay 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.
<b>Habilitative Services</b>		
Physical Therapy	\$5 copay	20 visits per Benefit Year
Occupational Therapy	\$5 copay	20 visits per Benefit Year
Speech Therapy	20% coinsurance after deductible	20 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	\$5 copay \$5 copay 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible	20 visits per Benefit Year 20 visits per Benefit Year 20 visits per Benefit Year 20 visits per Benefit Year 36 visits per Benefit Year 12 visits per Benefit Year 30 visits per Benefit Year 20 visits per Benefit Year Refer to your Evidence of Coverage
<b>Chiropractor Services</b>	\$40 copay	Limits for Physical Therapy and Manipulation apply
<b>Autism Spectrum Disorder Services</b> Occupational Therapy Speech Therapy Adaptive Behavior Treatment	\$5 copay 20% coinsurance after deductible \$5 copay	20 visits per Benefit Year 20 visits per Benefit Year 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	\$5 copay 20% coinsurance after deductible 20% coinsurance after deductible \$300 copay after deductible per stay 20% coinsurance after deductible \$350 copay after deductible per stay	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> Private Duty Nursing  All Other Services	20% coinsurance after deductible  20% coinsurance after deductible	100 visits per Benefit Year, a visit equals 8 hours  100 combined visits per Benefit Year. A visit equals at least 4 hours.
<b>Hospice Care</b>	20% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Diabetic Services</b> Education  Equipment  Supplies	20% coinsurance after deductible  20% coinsurance after deductible  20% 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	20% 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 \$2 copay  Up to \$40 copay  40% 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 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 a 12-month supply of 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	\$30 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

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Other Dental Services</b>		
Accidental Dental	20% coinsurance after deductible	\$3,000 per Member Per Injury All Services combined
Dental Anesthesia	20% 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	25% coinsurance after deductible	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	45% coinsurance after deductible	Refer to your Evidence of Coverage
Class IV - Orthodontics	50% 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	25% coinsurance	
Class III - Major/Comprehensive	45% 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-OH-pa](http://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](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.

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.

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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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