

2025 Schedule of Benefits

Plan Name: Silver 500 \$10 Generic Drugs



Plan Information

| | |
|---------------------------|--------------|
| Primary Member | [John Doe] |
| Member ID | [104000000] |
| Date of Birth | [01/01/1965] |
| Effective Date | [01/01/2025] |
| Last Coverage Change Date | [01/01/2024] |

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

Highlights

| | |
|--|--|
| Annual Deductible* | Individual: \$500 Family: \$1,000 |
| Coinsurance | 30% |
| Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays) | Individual: \$3,000 Family: \$6,000 |



* Deductible: The individual Deductible applies to each covered family member. No one person can contribute more than the individual Deductible amount. Once two or more covered family members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Calendar Year.

** Out-of-Pocket Maximum: The individual Out-of-Pocket Limit applies to each covered family member. Once a member has reached their individual Out-of-Pocket Limit, the plan will pay 100% of their Covered Services. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year.

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 | \$20 copay | None |
| Specialist | \$40 copay | None |
| Urgent Care | \$30 copay | None |

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| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|--|---|--|
| Diagnostic Services | | |
| Lab | 30% coinsurance after deductible | None |
| X-Ray/Radiology | 30% coinsurance after deductible | None |
| Advanced Imaging (PET, MRI, MRA, CT, SPECT) | 30% coinsurance after deductible | None |
| Mammograms (Outpatient) | | |
| Preventive | No charge | Refer to your Evidence of Coverage |
| Diagnostic | 30% coinsurance after deductible | None |
| Inpatient Services | | |
| Facility Fee | 30% coinsurance after deductible | None |
| Physician/Surgeon Fees | 30% coinsurance after deductible | 1 visit per physician per day |
| Skilled Nursing Facility | 30% coinsurance after deductible | 90 Day limit per Benefit Year |
| Outpatient Services | | |
| Facility Fee | 30% coinsurance after deductible | None |
| Physician/Surgeon Fees | 30% coinsurance after deductible | None |
| Maternity Services | | |
| Prenatal Visit, Office Visits, and Postpartum Care | \$40 copay | None |
| Inpatient Services | 30% coinsurance after deductible | None |
| Outpatient Services | 30% coinsurance after deductible | None |
| Ambulance Services | 30% coinsurance after deductible for both in-network and out-of-network providers | None |
| Emergency Health Care Services | 30% 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 | \$20 copay | 20 visits per Benefit Year |
| Occupational Therapy | \$20 copay | 20 visits per Benefit Year |
| Speech Therapy | \$20 copay | 20 visits 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 Cognitive Rehabilitation Therapy Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation | \$20 copay \$20 copay \$20 copay 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible \$20 copay 30% coinsurance after deductible 30% coinsurance after deductible | 20 visits per Benefit Year If received from a Chiropractor, see Chiropractor Services for cost share 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 If received from a Chiropractor, see Chiropractor Services for cost share 30 visits per Benefit Year 20 visits per Benefit Year Refer to your Evidence of Coverage |
| Chiropractor Services | \$20 copay | Limits for Physical Therapy and Manipulation apply Cost share includes all Covered Services rendered during the visit |
| Autism Spectrum Disorder Services Occupational Therapy Speech Therapy Adaptive Behavior Treatment | \$20 copay \$20 copay \$20 copay | 20 visits per Benefit Year 20 visits per Benefit Year 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 | \$20 copay 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible | None |

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| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|--|---|
| 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 All Other Services | 30% coinsurance after deductible 30% 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. |
| Hospice Care | 30% 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 | 30% 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 \$10 copay Up to \$20 copay Up to \$60 copay after deductible Up to \$250 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. |
| 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. Refer to your Evidence of Coverage for additional eyewear options that may have an additional charge. |
| Other Dental Services Accidental Dental Dental Anesthesia | 30% coinsurance after deductible 30% coinsurance after deductible | \$3,000 per Member Per Injury All Services combined Refer to your Evidence of Coverage |

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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.

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Dependent Information

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|---------------------|--------------|
| Dependent Name | [John Doe] |
| Relationship to You | [104000000] |
| Date of Birth | [01/01/1965] |
| Effective Date | [01/01/2025] |

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