

2026 Schedule of Benefits

Plan Name: Diabetes Silver HMO 1000 \$5 \$0 Chronic Care Services and Adult Vision and Fitness



Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2026]
Last Coverage Change Date	[01/01/2025]

[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: \$3,350 Family: \$6,700



- * 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 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.

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 Visits² Teladoc Primary Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics Specialist	No charge \$5 copay \$20 copay	Refer to your Evidence of Coverage None None
Urgent Care¹	\$20 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services¹		
Lab	\$40 copay	None
X-Ray/Radiology	\$250 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$200 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic ¹	No charge	None
Inpatient Services		
Facility Fee	\$250 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	20% coinsurance after deductible	60 Day limit per Benefit Year
Outpatient Services		
Facility Fee	20% coinsurance after deductible	None
Physician/Surgeon Fees	20% coinsurance after deductible	None
Maternity Services¹		
Prenatal Visit, Office Visits, and Postpartum Care	\$20 copay	None
Inpatient Services	\$250 copay after deductible	None
Outpatient Services	20% coinsurance after deductible	None
Ambulance Services	20% coinsurance after deductible	None
Emergency Health Care Services¹	15% 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.
Habilitative Services		
Physical/Occupational Therapy	\$5 copay	40 combined visits per Benefit Year If received from a Chiropractor, see Chiropractic Care Services for cost share.
Speech Therapy	\$5 copay	40 combined visits per Benefit Year
Audiology	20% coinsurance after deductible	40 combined visits per Benefit Year
Manipulation Therapy	20% coinsurance after deductible	40 combined visits per Benefit Year If received from a Chiropractor, see Chiropractor Services for cost share

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical/Occupational Therapy	\$5 copay	40 combined visits per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Speech Therapy	\$5 copay	40 combined visits per Benefit Year
Pulmonary Rehabilitation	20% coinsurance after deductible	None
Cardiac Rehabilitation Services	20% coinsurance after deductible	None
Manipulation Therapy	20% coinsurance after deductible	40 combined visits per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Post-Cochlear Implant Aural Therapy	\$5 copay	Combined Limit with Speech Therapy
Cognitive Rehabilitation Therapy	20% coinsurance after deductible	40 combined visits per Benefit Year
Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	20% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Care Services		
X-Ray/Radiology	\$250 copay after deductible	None
Rehabilitative Services		
Physical Therapy	\$20 copay	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	\$20 copay	Limits for Physical Therapy and Manipulation apply
Habilitation Services		
Physical Therapy	\$20 copay	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	\$20 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical/Occupational Therapy	\$5 copay	None
Speech Therapy	\$5 copay	None
Adaptive Behavior Treatment	\$5 copay	Includes Applied Behavior Analysis (ABA)

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Behavioral Health Services		
Office Visits ²	\$5 copay	None
Outpatient Services ¹		
Intensive Outpatient Program (IOP) Services	20% coinsurance after deductible	None
Partial Hospitalization Program (PHP) Services	20% coinsurance after deductible	None
Residential Services	20% coinsurance after deductible	None
Opioid Treatment Program	20% coinsurance after deductible	None
Inpatient Services ¹	\$250 copay after deductible per stay	None
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		
Home Infusion Therapy	20% coinsurance after deductible	Included in all other services limits
All Other Services	20% coinsurance after deductible	120 combined visits per Benefit Year. A visit equals 2 hours or less.
Hospice Care	20% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	20% coinsurance after deductible	Refer to your Evidence of Coverage
Durable Medical Equipment	20% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies	20% coinsurance after deductible	Refer to your Evidence of Coverage
Orthotic Device	20% coinsurance after deductible	Refer to your Evidence of Coverage
Prosthetics	20% coinsurance after deductible	Refer to your Evidence of Coverage

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
\$0 Chronic Care Services \$0 Chronic Care Medical Services \$0 Chronic Care Drugs and \$0 Chronic Care Self-Management Supplies	No charge No charge	Refer to caresource.com/GAMPElite2026 for \$0 Chronic Care Medical Services, Drugs, and Self-Management Supplies
Prescription Drugs Preventive Drugs Generic Drugs Preferred Brand Drugs Non-Preferred Brand Drugs Specialty Drugs	No charge Up to \$5 copay Up to \$50 copay 30% coinsurance after deductible 40% coinsurance after deductible	Up to a 30-day supply for brand name drugs filled at Retail and Specialty Drugs Up to a 90-day supply for all other Retail and Mail Order. Any copays shown are for a 30-day supply. 90-day supplies available at 3 times the copay for Retail and 2.5 times the copay for Mail Order.
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. Refer to your Evidence of Coverage for additional eyewear options that may have an additional charge.
Vision (adults) Eye Exam Low Vision Testing and Aids Eyewear	No charge 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	20% coinsurance after deductible 20% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury. Refer to your Evidence of Coverage
Fitness Program	No charge	Refer to your Evidence of Coverage
Other Covered Services³ Allergy Testing Allergy Injections Allergy Serum	Covered the same as office visits or diagnostic services 20% coinsurance after deductible 20% coinsurance after deductible	None None None

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- ¹ When receiving covered services at an office, urgent care or hospital visit, member may be subject to cost share charges from both the facility and the physician/surgeon.
- ² Charge shown for the office visit. Additional services rendered during the office visit may be subject to their applicable additional copayment or deductible/coinsurance as specified in the Schedule of Benefits. Charges applied per provider, per date of service.
- ³ Member cost-sharing may vary based on the place of service where it is rendered. Additional services and evaluations rendered during the visit may be subject to their applicable additional copayment or deductible/coinsurance as specified in the Schedule of Benefits.

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.

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	[01/01/2026]

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