

## 2027 Schedule of Benefits

Plan Name: Silver HMO 6000 \$30 \$0 Healthy heart care  
60224GA001001501



### Plan Information

|                           |              |
|---------------------------|--------------|
| Primary Member            | [John Doe]   |
| Member ID                 | [104000000]  |
| Date of Birth             | [01/01/1965] |
| Effective Date            | [01/01/2027] |
| Last Coverage Change Date | [01/01/2026] |

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

### Highlights

|                                                                                  |                                          |
|----------------------------------------------------------------------------------|------------------------------------------|
| Annual Deductible*                                                               | Individual: \$6,000<br>Family: \$12,000  |
| Coinsurance                                                                      | 50%                                      |
| Annual Out-of-Pocket Maximum**<br>(includes deductible, coinsurance, and copays) | Individual: \$10,800<br>Family: \$21,600 |



\* 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<br>(Network Providers Only) | Limit<br>(If Applicable)           |
|-----------------------------------------------------------------|-------------------------------------|------------------------------------|
| <b>Preventive Services</b><br>As defined by federal & state law | \$0 Copay                           | Refer to your Evidence of Coverage |

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| Covered Service                                                   | You Pay<br>(Network Providers Only)                                                                                                    | Limit<br>(If Applicable)                                                                                                                                                                   |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Physician Services – Office Visits<sup>2</sup></b>             |                                                                                                                                        |                                                                                                                                                                                            |
| Teladoc Health <sup>®</sup>                                       | \$0 Copay                                                                                                                              | Refer to your Evidence of Coverage                                                                                                                                                         |
| Retail Clinics                                                    | \$30 Copay                                                                                                                             | None                                                                                                                                                                                       |
| Primary Care Provider                                             | \$30 Copay                                                                                                                             | None                                                                                                                                                                                       |
| Specialist                                                        | \$50 Copay                                                                                                                             | None                                                                                                                                                                                       |
| Allergy Testing <sup>3</sup>                                      | See Primary Care Provider, Specialist, or Diagnostic Services since cost share is dependent on services rendered and place of service. | None                                                                                                                                                                                       |
| Allergy Treatment <sup>3</sup>                                    |                                                                                                                                        |                                                                                                                                                                                            |
| Allergy Injections                                                | 50% Coinsurance after deductible                                                                                                       | None                                                                                                                                                                                       |
| Allergy Serum                                                     | 50% Coinsurance after deductible                                                                                                       | None                                                                                                                                                                                       |
| <b>Behavioral Health Care and Substance Use Disorder Services</b> |                                                                                                                                        |                                                                                                                                                                                            |
| Office Visits <sup>2</sup>                                        | \$30 Copay                                                                                                                             | None                                                                                                                                                                                       |
| Outpatient Services <sup>1</sup>                                  |                                                                                                                                        |                                                                                                                                                                                            |
| Intensive Outpatient Program (IOP) Services                       | 50% Coinsurance after deductible                                                                                                       | None                                                                                                                                                                                       |
| Partial Hospitalization Program (PHP) Services                    | 50% Coinsurance after deductible                                                                                                       | None                                                                                                                                                                                       |
| Residential Treatment Services                                    | 50% Coinsurance after deductible                                                                                                       | None                                                                                                                                                                                       |
| Opioid Treatment Program                                          | 50% Coinsurance after deductible                                                                                                       | None                                                                                                                                                                                       |
| Inpatient Services <sup>1</sup>                                   | 50% Coinsurance after deductible                                                                                                       | None                                                                                                                                                                                       |
| <b>Diagnostic Services<sup>1</sup></b>                            |                                                                                                                                        |                                                                                                                                                                                            |
| Laboratory Tests                                                  | \$75 Copay Per Test                                                                                                                    | None                                                                                                                                                                                       |
| X-Ray/Radiology <sup>4</sup>                                      | \$400 Copay Per Service after deductible                                                                                               | None                                                                                                                                                                                       |
| Advanced Imaging (PET, MRI, MRA, CT, SPECT) <sup>5</sup>          | \$300 Copay Per Service after deductible                                                                                               | None                                                                                                                                                                                       |
| <b>Emergency Health Care Services</b>                             |                                                                                                                                        |                                                                                                                                                                                            |
| Emergency Room Facility                                           | 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. |
| Emergency Room Physician                                          | 50% Coinsurance after deductible                                                                                                       |                                                                                                                                                                                            |

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| Covered Service                               | You Pay<br>(Network Providers Only)      | Limit<br>(If Applicable)                                                                                    |
|-----------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| <b>Inpatient Services</b>                     |                                          |                                                                                                             |
| Facility Fee                                  | 50% Coinsurance after deductible         | None                                                                                                        |
| Physician/Surgeon Fees                        | 50% Coinsurance after deductible         | 1 Visit Per Day Per Physician                                                                               |
| Inpatient Rehabilitation Facility             | 50% Coinsurance after deductible         | 60 Days Per Year                                                                                            |
| Skilled Nursing Facility                      | 50% Coinsurance after deductible         | 60 Days Per Year                                                                                            |
| <b>Outpatient Services</b>                    |                                          |                                                                                                             |
| Facility Fee                                  | 50% Coinsurance after deductible         | None                                                                                                        |
| Physician/Surgeon Fees                        | 50% Coinsurance after deductible         | None                                                                                                        |
| <b>Urgent Care Services<sup>1</sup></b>       | \$70 Copay                               | None                                                                                                        |
| <b>\$0 Healthy heart care<sup>6</sup></b>     |                                          |                                                                                                             |
| Medical Services, Medical Supplies, and Drugs | \$0 Copay                                | Refer to <a href="https://www.caresource.com/GAMPElite2027">caresource.com/GAMPElite2027</a> for full list. |
| <b>Ambulance Services</b>                     | 50% Coinsurance after deductible         | Refer to your Evidence of Coverage                                                                          |
| <b>Autism Spectrum Disorder Services</b>      |                                          |                                                                                                             |
| Physical/Occupational Therapy                 | 50% Coinsurance after deductible         | None                                                                                                        |
| Speech Therapy                                | 50% Coinsurance after deductible         | None                                                                                                        |
| Adaptive Behavior Treatment                   | \$30 Copay                               | Includes Applied Behavior Analysis (ABA)                                                                    |
| <b>Chiropractic Care Services</b>             |                                          |                                                                                                             |
| Habilitative Services                         |                                          |                                                                                                             |
| Manipulation Therapy                          | \$50 Copay Per Therapy Type Per Day      | See <b>Habilitative Services – Outpatient Therapy</b> Manipulation Therapy                                  |
| Physical Therapy                              | \$50 Copay Per Therapy Type Per Day      | See <b>Habilitative Services – Outpatient Therapy</b> Physical Therapy                                      |
| Rehabilitative Services                       |                                          |                                                                                                             |
| Manipulation Therapy                          | \$50 Copay Per Therapy Type Per Day      | See <b>Rehabilitative Services – Outpatient Therapy</b> Manipulation Therapy                                |
| Physical Therapy                              | \$50 Copay Per Therapy Type Per Day      | See <b>Rehabilitative Services – Outpatient Therapy</b> Physical Therapy                                    |
| X-Ray/Radiology                               | \$400 Copay Per Service after deductible | None                                                                                                        |

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| Covered Service                                                                            | You Pay<br>(Network Providers Only)                                                                                                                                                                                       | Limit<br>(If Applicable)                                                                                 |
|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <b>Dental Services<sup>1</sup></b>                                                         |                                                                                                                                                                                                                           |                                                                                                          |
| Accidental Dental Services                                                                 | See Categories “Diagnostic Services”, “Durable Medical Equipment, Medical and Surgical Supply, Orthotics and Prosthetics”, “Inpatient Services”, or “Outpatient Services” as cost share is dependent on place of service. | Refer to your Evidence of Coverage                                                                       |
| Dental Anesthesia                                                                          | 50% Coinsurance after deductible                                                                                                                                                                                          | Refer to your Evidence of Coverage                                                                       |
| <b>Durable Medical Equipment, Medical and Surgical Supplies, Orthotics and Prosthetics</b> | 50% Coinsurance after deductible                                                                                                                                                                                          | Refer to your Evidence of Coverage                                                                       |
| <b>Habilitative Services – Outpatient Therapy</b>                                          |                                                                                                                                                                                                                           |                                                                                                          |
| Physical (PT)/Occupational Therapy (OT)                                                    | 50% Coinsurance after deductible<br><br>If received from a Chiropractor, see Chiropractic Care Services for cost share.                                                                                                   | 40 Combined Audiology/MT/OT/PT Visits Per Year                                                           |
| Speech Therapy (ST)                                                                        | 50% Coinsurance after deductible                                                                                                                                                                                          | 40 Combined Audiology/MT/OT/PT Visits Per Year                                                           |
| Audiology                                                                                  | 50% Coinsurance after deductible                                                                                                                                                                                          | 40 Combined Audiology/MT/OT/PT Visits Per Year                                                           |
| Manipulation Therapy (MT)                                                                  | 50% Coinsurance after deductible<br><br>If received from a Chiropractor, see Chiropractic Care Services for cost share.                                                                                                   | 40 Combined Audiology/MT/OT/PT Visits Per Year                                                           |
| <b>Home Health Care Services</b>                                                           |                                                                                                                                                                                                                           |                                                                                                          |
| Home Infusion Therapy                                                                      | 50% Coinsurance after deductible                                                                                                                                                                                          | 120 Combined Home Infusion Therapy and Covered Services Visits Per Year. A visit equals 2 hours or less. |
| Covered Services                                                                           | 50% Coinsurance after deductible                                                                                                                                                                                          | 120 Combined Home Infusion Therapy and Covered Services Visits Per Year. A visit equals 2 hours or less. |
| <b>Hospice Services</b>                                                                    | 50% Coinsurance after deductible                                                                                                                                                                                          | Refer to your Evidence of Coverage                                                                       |
| <b>Maternity Services<sup>1</sup></b>                                                      |                                                                                                                                                                                                                           |                                                                                                          |
| Prenatal Visit, Office Visits, and Postpartum Care                                         | \$50 Copay                                                                                                                                                                                                                | None                                                                                                     |
| Inpatient Services                                                                         | 50% Coinsurance after deductible                                                                                                                                                                                          | None                                                                                                     |
| Outpatient Services                                                                        | 50% Coinsurance after deductible                                                                                                                                                                                          | None                                                                                                     |

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| Covered Service                                                                            | You Pay<br>(Network Providers Only)                                                                                                                         | Limit<br>(If Applicable)                                                                                               |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <b>Rehabilitative Services – Outpatient Therapy</b>                                        |                                                                                                                                                             |                                                                                                                        |
| Physical (PT)/Occupational Therapy (OT)                                                    | 50% Coinsurance after deductible<br><br>If received from a Chiropractor, see Chiropractic Care Services for cost share.                                     | 40 Combined Cognitive Rehabilitative Therapy/MT/OT/PT/ST Visits Per Year                                               |
| Speech Therapy (ST)                                                                        | 50% Coinsurance after deductible                                                                                                                            | 40 Combined Cognitive Rehabilitative Therapy/MT/OT/PT/ST Visits Per Year                                               |
| Cardiac Rehabilitation Services                                                            | 50% Coinsurance after deductible                                                                                                                            | None                                                                                                                   |
| Cognitive Rehabilitation Therapy                                                           | 50% Coinsurance after deductible                                                                                                                            | 40 Combined Cognitive Rehabilitative Therapy/MT/OT/PT/ST Visits Per Year                                               |
| Manipulation Therapy (MT)                                                                  | 50% Coinsurance after deductible<br><br>If received from a Chiropractor, see Chiropractic Care Services for cost share.                                     | 40 Combined Cognitive Rehabilitative Therapy/MT/OT/PT/ST Visits Per Year                                               |
| Post-Cochlear Implant Aural Therapy                                                        | 50% Coinsurance after deductible                                                                                                                            | See Rehabilitative Speech Therapy                                                                                      |
| Pulmonary Rehabilitation                                                                   | 50% Coinsurance after deductible                                                                                                                            | None                                                                                                                   |
| Other Rehabilitative Services                                                              |                                                                                                                                                             |                                                                                                                        |
| Includes Chemotherapy, Dialysis, and Radiation                                             | 50% Coinsurance after deductible                                                                                                                            | Refer to your Evidence of Coverage                                                                                     |
| <b>Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder</b> | See Physician Services - Office Visits, Outpatient Services, or Inpatient Services since cost share is dependent on services rendered and place of service. | None                                                                                                                   |
| <b>Transplant Services</b>                                                                 | See Physician Services - Office Visits, Outpatient Services, or Inpatient Services since cost share is dependent on services rendered and place of service. | Refer to your Evidence of Coverage                                                                                     |
| <b>Vision Services</b>                                                                     |                                                                                                                                                             |                                                                                                                        |
| Children's Eye Exam                                                                        | \$0 Copay                                                                                                                                                   | 1 Routine Eye Exam Per Year                                                                                            |
| All Other Vision Services                                                                  | For cost share, refer to your Evidence of Coverage since cost share is dependent on services rendered.                                                      | Refer to your Evidence of Coverage                                                                                     |
| Children's Eyewear                                                                         | \$0 Copay                                                                                                                                                   | 1 Pair of Glasses Per Year or 1 Choice of Contact Supply Per Year. Refer to your Evidence of Coverage for more detail. |

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| Covered Service                       | You Pay<br>(Network Providers Only) | Limit<br>(If Applicable)                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prescription Drugs</b>             |                                     |                                                                                                                                                                                                                                                                                                                                           |
| Preventive                            | \$0 Copay                           | Generic, Preferred Brand and Non-Preferred Brand Drugs: Up to 30-day supply per fill at Retail; up to 90-day supply for Mail Order<br><br>Specialty Drugs: Up to 30-day supply per fill at Retail and Mail Order<br><br>Displayed cost share is for a 30-day supply. 90-day supply is available at 2.5 times the cost of a 30-day supply. |
| Preferred Generic Drugs               | Up to \$15 Copay                    |                                                                                                                                                                                                                                                                                                                                           |
| Preferred Brand Drugs                 | Up to \$100 Copay                   |                                                                                                                                                                                                                                                                                                                                           |
| Non-Preferred Generic and Brand Drugs | 50% Coinsurance after deductible    |                                                                                                                                                                                                                                                                                                                                           |
| Preferred Specialty Drugs             | 55% Coinsurance after deductible    |                                                                                                                                                                                                                                                                                                                                           |
| Non-Preferred Specialty Drugs         | 60% Coinsurance after deductible    |                                                                                                                                                                                                                                                                                                                                           |

- <sup>1</sup> 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.
- <sup>2</sup> 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.
- <sup>3</sup> 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.
- <sup>4</sup> Coverage for mammogram and breast ultrasound is covered at \$0 to the Member. If the Member is enrolled in a high deductible health plan, the Member may need to satisfy the minimum deductible of the plan prior to the service being covered at no cost share.
- <sup>5</sup> Coverage for breast MRI is covered at \$0 to the Member. If the Member is enrolled in a high deductible health plan, the Member may need to satisfy the minimum deductible of the plan prior to the service being covered at no cost share.
- <sup>6</sup> Medical services include EKGs, lipid panels, metabolic panels, and prothrombin tests. Medical supplies include gradient compression stockings and one blood pressure cuff (additional medical supplies subject to Durable Medical Equipment, Medical and Surgical Supplies, Orthotics and Prosthetics). For a complete list of \$0 Drugs and Supplies, please see the formulary.

**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 a non-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 healthcare 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      | [01/01/2027] |

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