



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: \$0 Family: \$0
Coinsurance	0%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$0 Family: \$0



\* 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)
<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	No charge	None
Specialist	No charge	None
<b>Urgent Care</b>	No charge	None

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Diagnostic Services</b>		
Lab	No charge	None
X-Ray/Radiology	No charge	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	No charge	None
<b>Mammograms (Outpatient)</b>		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	No charge	None
<b>Inpatient Services</b>		
Facility Fee	No charge	None
Physician/Surgeon Fees	No charge	1 visit per physician per day
Skilled Nursing Facility	No charge	90 Day limit per Benefit Year
<b>Outpatient Services</b>		
Facility Fee	No charge	None
Physician/Surgeon Fees	No charge	None
<b>Maternity Services</b>		
Prenatal Visit, Office Visits, and Postpartum Care	No charge	None
Inpatient Services	No charge	None
Outpatient Services	No charge	None
<b>Ambulance Services</b>	No charge for both in-network and out-of-network providers	None
<b>Emergency Health Care Services</b>	No charge 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	No charge	20 visits per Benefit Year
Occupational Therapy	No charge	20 visits per Benefit Year
Speech Therapy	No charge	20 visits per Benefit Year

Learn more about CareSource and all our plan options at [www.caresource.com/marketplace](http://www.caresource.com/marketplace).

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Rehabilitative Services</b>		
Physical Therapy	No charge	20 visits per Benefit Year If received from a Chiropractor, see Chiropractor Services for cost share
Occupational Therapy	No charge	20 visits per Benefit Year
Speech Therapy	No charge	20 visits per Benefit Year
Pulmonary Rehabilitation	No charge	20 visits per Benefit Year
Cardiac Rehabilitation Services	No charge	36 visits per Benefit Year
Manipulation Therapy	No charge	12 visits per Benefit Year If received from a Chiropractor, see Chiropractor Services for cost share
Post-Cochlear Implant Aural Therapy	No charge	30 visits per Benefit Year
Cognitive Rehabilitation Therapy	No charge	20 visits per Benefit Year
Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	No charge	Refer to your Evidence of Coverage
<b>Chiropractor Services</b>	No charge	Limits for Physical Therapy and Manipulation apply Cost share includes all Covered Services rendered during the visit
<b>Autism Spectrum Disorder Services</b>		
Occupational Therapy	No charge	20 visits per Benefit Year
Speech Therapy	No charge	20 visits per Benefit Year
Adaptive Behavior Treatment	No charge	Includes Applied Behavior Analysis (ABA)
<b>Behavioral Health Services</b>		
Office Visits	No charge	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	No charge	
Partial Hospitalization Program (PHP) Services	No charge	None
Residential Services	No charge	
Opioid Treatment Program	No charge	
Inpatient Services	No charge	
<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

Learn more about CareSource and all our plan options at [www.caresource.com/marketplace](http://www.caresource.com/marketplace).

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Home Health</b> Private Duty Nursing  All Other Services	No charge  No charge	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>	No charge	Refer to your Evidence of Coverage
<b>Medical Supplies, Durable Medical Equipment, and Appliances</b> Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	No charge	Refer to your Evidence of Coverage
<b>Healthy Heart Plan Services</b> Select Healthy Heart Drugs Select Healthy Heart Supplies Specialized Medical Services	No charge	Refer to <a href="https://www.caresource.com/OHMPElite2025">caresource.com/OHMPElite2025</a> for Select Drugs, Supplies, and Specialized Medical Services
<b>Prescription Drugs</b> Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty)	No charge No charge No charge No charge No charge	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</b> (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.
<b>Other Dental Services</b> Accidental Dental  Dental Anesthesia	No charge  No charge	\$3,000 per Member Per Injury All Services combined 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](https://www.caresource.com/mp-OH-pa).

Learn more about CareSource and all our plan options at [www.caresource.com/marketplace](https://www.caresource.com/marketplace).

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.

Learn more about CareSource and all our plan options at **[www.caresource.com/marketplace](http://www.caresource.com/marketplace)**.

Dependent Information

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

Learn more about CareSource and all our plan options at [www.caresource.com/marketplace](http://www.caresource.com/marketplace).