

## 2025 Schedule of Benefits

Plan Name: HSA Eligible Bronze 6000



### 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: \$6,000 Family: \$12,000
Coinsurance	60%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$7,200 Family: \$14,400



\* 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)
<b>Preventive Services</b> As defined by federal & state law	No charge	Refer to your Evidence of Coverage
<b>Office Visits</b> Zero Cost Telemedicine Partner	No charge	Refer to your Evidence of Coverage
Primary Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	60% coinsurance after deductible	None
Specialist	60% coinsurance after deductible	None
<b>Urgent Care</b>	60% coinsurance after deductible	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Diagnostic Services</b>		
Lab	60% coinsurance after deductible	None
X-Ray/Radiology	60% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	60% coinsurance after deductible	None
<b>Mammograms (Outpatient)</b>		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	60% coinsurance after deductible	None
<b>Inpatient Services</b>		
Facility Fee	60% coinsurance after deductible	None
Physician/Surgeon Fees	60% coinsurance after deductible	1 visit per physician per day
Skilled Nursing Facility	60% coinsurance after deductible	90 Day limit per Benefit Year
<b>Outpatient Services</b>		
Facility Fee	60% coinsurance after deductible	None
Physician/Surgeon Fees	60% coinsurance after deductible	None
<b>Maternity Services</b>		
Prenatal Visit, Office Visits, and Postpartum Care	60% coinsurance after deductible	None
Inpatient Services	60% coinsurance after deductible	None
Outpatient Services	60% coinsurance after deductible	None
<b>Ambulance Services</b>	60% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Emergency Health Care Services</b>	60% 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.
<b>Habilitative Services</b>		
Physical Therapy	60% coinsurance after deductible	20 visits per Benefit Year
Occupational Therapy	60% coinsurance after deductible	20 visits per Benefit Year
Speech Therapy	60% 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  Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible  60% 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  Combined Limit with Speech Therapy  Refer to your Evidence of Coverage
<b>Chiropractor Services</b>	60% coinsurance after deductible	Limits for Physical Therapy and Manipulation apply
<b>Autism Spectrum Disorder Services</b> Physical Therapy  Occupational Therapy  Speech Therapy  Adaptive Behavior Treatment	60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible	Combined limit with Habilitative Services  Combined limit with Habilitative Services  Combined limit with Habilitative Services  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	60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<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
<b>Home Health</b> Private Duty Nursing  Home Infusion Therapy  All Other Services	60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible	100 visits per Benefit Year. A visit equals 8 hours.  None  100 combined visits per Benefit Year. A visit equals at least 4 hours.
<b>Hospice Care</b>	60% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Medical Supplies, Durable Medical Equipment, and Appliances</b> Appliances  Durable Medical Equipment  Medical Supplies  Orthotic Device  Prosthetics	60% 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  60% coinsurance after deductible  60% coinsurance after deductible  60% coinsurance after deductible  60% 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 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.

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Other Dental Services</b> Accidental Dental  Dental Anesthesia	60% coinsurance after deductible  60% coinsurance after deductible	\$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-IN-pa](http://www.caresource.com/mp-IN-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.

Your CareSource marketplace plan was designed to meet certain requirements set by the Internal Revenue Service and qualifies as a high deductible health plan (HDHP). As such, your CareSource marketplace plan is compatible for use with a Health Savings Account (HSA). However, please be aware that CareSource is not offering or administering an HSA in conjunction with your CareSource marketplace HDHP. In addition, your enrollment in a CareSource marketplace HDHP is only one of the eligibility requirements for establishing and maintaining an HSA. You are responsible for determining whether you are eligible to establish an HSA. You should consult your financial, tax, or legal advisor for more information regarding your obligations and eligibility for establishing and maintaining an HSA.

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### Dependent Information

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

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