**2025 Schedule of Benefits**
Plan Name: Low Premium Silver 6000 $3 Generic Drugs Adult Vision & Fitness

## 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<br>Family: $12,000 |
| Coinsurance | 40% |
| Annual Out-of-Pocket Maximum**<br>(includes deductible, coinsurance, and copays) | Individual: $9,000<br>Family: $18,000 |

This summary shows in-network benefits only.

* 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<br>(Network Providers Only) | Limit<br>(If Applicable) |
|---|---|---|
| **Preventive Services**<br>As defined by federal & state law | No charge | Refer to your Evidence of Coverage |
| **Office Visits** | | |
| Zero Cost Telemedicine Partner | No charge | Refer to your Evidence of Coverage |
| Primary | | |
| Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics | $35 copay | None |
| Specialist | $75 copay | None |
| **Urgent Care** | $70 copay | None |

Learn more about CareSource and all our plan options at **www.caresource.com/marketplace.**

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Diagnostic Services** | | |
| Lab | $40 copay | None |
| X-Ray/Radiology | $200 copay after deductible | None |
| Advanced Imaging (PET, MRI, MRA, CT, SPECT) | $250 copay after deductible | None |
| **Mammograms** (Outpatient) | | |
| Preventive | No charge | Refer to your Evidence of Coverage |
| Diagnostic | No charge | None |
| **Inpatient Services** | | |
| Facility Fee | $500 copay after deductible per stay | None |
| Physician/Surgeon Fees | No charge after deductible | 1 visit per physician per day |
| Skilled Nursing Facility | $500 copay after deductible per stay | 60 Day limit per Benefit Year |
| **Outpatient Services** | | |
| Facility Fee | 40% coinsurance after deductible | None |
| Physician/Surgeon Fees | 40% coinsurance after deductible | None |
| **Maternity Services** | | |
| Prenatal Visit, Office Visits, and Postpartum Care | $75 copay | None |
| Inpatient Services | $500 copay after deductible | None |
| Outpatient Services | 40% coinsurance after deductible | None |
| **Ambulance Services** | 40% coinsurance after deductible | None |
| **Emergency Health Care Services** | $500 copay 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 Therapy | $35 copay | 40 combined visits per Benefit Year |
| Occupational Therapy | $35 copay | 40 combined visits per Benefit Year |
| Speech Therapy | $35 copay | 40 combined visits per Benefit Year |
| Audiology | 40% coinsurance after deductible | 40 combined visits per Benefit Year |
| Manipulation Therapy | 40% coinsurance after deductible | 40 combined visits per Benefit Year |

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Rehabilitative Services** | | |
| Physical Therapy | $35 copay | 40 combined visits per Benefit Year |
| Occupational Therapy | $35 copay | 40 combined visits per Benefit Year |
| Speech Therapy | $35 copay | 40 combined visits per Benefit Year |
| Pulmonary Rehabilitation | 40% coinsurance after deductible | None |
| Cardiac Rehabilitation Services | 40% coinsurance after deductible | None |
| Manipulation Therapy | 40% coinsurance after deductible | 40 combined visits per Benefit Year |
| Post-Cochlear Implant Aural Therapy | $35 copay | Combined Limit with Speech Therapy |
| Cognitive Rehabilitation Therapy | 40% coinsurance after deductible | 40 combined visits per Benefit Year |
| Other Rehabilitative Services | | |
| Includes Chemotherapy, Dialysis, and Radiation | 40% coinsurance after deductible | Refer to your Evidence of Coverage |
| **Autism Spectrum Disorder Services** | | |
| Physical Therapy | $35 copay | None |
| Occupational Therapy | $35 copay | None |
| Speech Therapy | $35 copay | None |
| Adaptive Behavior Treatment | $35 copay | Includes Applied Behavior Analysis (ABA) |
| **Behavioral Health Services** | | |
| Office Visits | $35 copay | |
| Outpatient Services | | |
| Intensive Outpatient Program (IOP) Services | 40% coinsurance after deductible | |
| Partial Hospitalization Program (PHP) Services | 40% coinsurance after deductible | None |
| Residential Services | $500 copay after deductible per stay | |
| Opioid Treatment Program | 40% coinsurance after deductible | |
| Inpatient Services | $500 copay after deductible per stay | |
| **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 |

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **Home Health** | | |
| Home Infusion Therapy | 40% coinsurance after deductible | Included in all other services limits |
| All Other Services | 40% coinsurance after deductible | 120 combined visits per Benefit Year. A visit equals 2 hours or less. |
| **Hospice Care** | 40% coinsurance after deductible | Refer to your Evidence of Coverage |
| **Medical Supplies, Durable Medical Equipment, and Appliances** | | |
| Appliances | 40% coinsurance after deductible | Refer to your Evidence of Coverage |
| Durable Medical Equipment | | |
| Medical Supplies | | |
| Orthotic Device | | |
| Prosthetics | | |
| **Prescription Drugs** | | |
| Tier 0 (Preventive) | 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. |
| Tier 1 (Low Cost) | Up to $3 copay | |
| Tier 2 (Preferred) | Up to $75 copay | |
| Tier 3 (Non-Preferred) | 40% coinsurance after deductible | |
| Tier 4 (Specialty) | 50% coinsurance after deductible | |
| **Vision** (pediatric) | | |
| Children's Eye Exam | No charge | 1 routine eye exam per Benefit Year |
| Low Vision Testing and Aids | No charge | Limited to one evaluation and aid per Benefit Year. |
| Children's Eyewear | No charge | 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 | $40 copay | 1 routine eye exam per Benefit Year |
| Low Vision Testing and Aids | No charge | Limited to one evaluation and aid per Benefit Year. |
| Eyewear | No charge | 1 pair of glasses/contacts per Benefit Year up to a $250 allowance |
| **Other Dental Services** | | |
| Accidental Dental | 40% coinsurance after deductible | Injury as a result of chewing or biting is not considered an accidental injury. |
| Dental Anesthesia | 40% coinsurance after deductible | Refer to your Evidence of Coverage |
| **Fitness Program** | No charge | 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-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.

## Dependent Information

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