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



- \* 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	<b>You Pay</b> (Network Providers Only)	<b>Limit</b> (If Applicable)
Preventive Services 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

Covered Service	<b>You Pay</b> (Network Providers Only)	<b>Limit</b> (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	None
Physician/Surgeon Fees	deductible 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	<u> </u>	
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	<b>You Pay</b> (Network Providers Only)	<b>Limit</b> (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

Network Providers Only   (If Applicable)	Covered Service	You Pay	Limit
Home Infusion Therapy  40% coinsurance after deductible  Refer to your Evidence of Coverage  Medical Supplies, Durable Medical Equipment Amazone after deductible  Medical Supplies  Appliances  Appliances  Appliances  Durable Medical Equipment  Medical Supplies  Orthotic Device  Prosthetics  Prescription Drugs  Tier 0 (Preventive)  Tier 1 (Low Cost)  Tier 2 (Preferred)  Tier 3 (Non-Preferred)  Tier 4 (Speciality)  Tier 3 (Non-Preferred)  Tier 4 (Speciality)  Vision (pediatric)  Children's Eye Exam  Low Vision Testing and Aids  Children's Eyewear  No charge  Limited to one evaluation and aid per Benefit Year  Limited to one pair of glasses or contact lenses per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Low Vision Testing and Aids  No charge  Vision (adults)  Eye Exam  Low Vision Testing and Aids  No charge  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and			(If Applicable)
deductible   visit equals 2 hours or less.	Home Health Home Infusion Therapy		Included in all other services limits
Medical Supplies, Durable Medical Equipment And Appliances   Appliances	All Other Services		
Equipment, and Appliances Appliances Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics  Prescription Drugs Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty) Tier 4 (Specialty) Tier 4 (Specialty) To be a special to a sol day supply supplies for Retail are a special to a sol day supply. 90-day supply supplies for Retail are a special to a sol day supply. 90-day supplies for Retail are a special to a sol day supply. 90-day supplies for Retail are a special to a sol day supply. 90-day supplies for Retail are a special to a sol day supply. 90-day supplies for Retail are a special to a sol day supplies of a special to a sol day supplies for Retail are a special to a sol day supplies. 90-day supplies for Retail are a special to a sol day supplies of a special to a sol day supplies and a supply. 90-day supplies for a special to a 30-day supply supplies for a special to a 30-day supply. 90-day supplies for a special to a 30-day supply supplies for a special to a 30-day supply. 90-day supplies for a special to a 30-day supply. And special to a 30-day supply special and a special to a 30-day supply. And special to a 30-day supply special to a 30-day supplies for a special to a 30-day supplies for a special to a 30-day supplies for a special to a 30-day supplies	Hospice Care		Refer to your Evidence of Coverage
Medical Supplies       40% coinsurance after deductible         Orthotic Device       Prosthetics         Prescription Drugs Tier 0 (Preventive)       No charge       Up to \$3 copay       Up to \$3 copay Mail Order for drugs in Tiers 0-3 Mail Order for	Equipment, and Appliances		
Orthotic Device Prosthetics  Prescription Drugs Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty) Tier 4 (Specialty) Toky 50 copay Vision (pediatric) Children's Eyewear  Children's Eyewear  Children's Eyewar  Low Vision Testing and Aids  Vision (adults) Eye Exam Low Vision Testing and Aids  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Timited to one evaluation and aid per Benefit Year. If medically necessary, a replacement pair of glasses is allowed. Refer to your Evidence of Coverage for a dditional eyewear options that may have an additional charge.  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Timited to one evaluation and aid 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 No charge Limited to one evaluation and aid per Benefit Year. Low Vision Testing and Aids No charge Limited to one evaluation and aid per Benefit Year. Limited to one evaluation and aid per Benefit Year. Limited to one evaluation and aid per Benefit Year.  I pair of glasses/contacts per Benefit Year.  I pair of glasses/contacts per Benefit Year up to a \$250 allowance  Other Dental Services Accidental Dental  40% coinsurance after deductible  Refer to your Evidence of Coverage	Durable Medical Equipment		
Orthotic Device Prosthetics  Prescription Drugs Tier 0 (Preventive)  No charge Up to \$3 copay Mail Order for drugs in Tiers 0-3 Mail Order for	Medical Supplies		Refer to your Evidence of Coverage
Prescription Drugs Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty)  Vision (pediatric) Children's Eyewear  Children's Eyewear  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Children's Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Vision Testing and Aids  Vision (adults) Eye Exam  Low Vision Testing and Aids  Visio	Orthotic Device	deductible	There is your Evidence of Coverage
Tier 0 (Preventive) Tier 1 (Low Cost) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 3 (Non-Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty) Tier 4 (Specialty)  Vision (pediatric) Children's Eye Exam Low Vision Testing and Aids Tochildren's Eyewear  Children's Eyewear  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge  Vision (adults) Eye Exam Low Vision Testing and Aids  No charge Limited to one pair of glasses or contact lenses per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Limited to one evaluation and aid per Benefit Year  Experiment Year  No charge  Injury as a result of chewing or biting is not considered an accidental injury.  Refer to your Evidence of Coverage	Prosthetics		
Tier 2 (Preferred)  Tier 2 (Preferred)  Up to \$75 copay  All others limited to a 30-day supply  Any copays shown are for 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.  Vision (pediatric) Children's Eye Exam Low Vision Testing and Aids Children's Eyewear  No charge  No charge  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 No charge  Vision (adults) Eye Exam Low Vision Testing and Aids No charge  Vision (adults) Eye Exam Low Vision Testing and Aids No charge  I 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 S40 copay 1 routine eye exam per Benefit Year Limited to one evaluation and aid per Benefit Year.  Limited to one evaluation and aid per Benefit Year.  Limited to one evaluation and aid per Benefit Year.  I pair of glasses/contacts per Benefit Year up to a \$250 allowance  Other Dental Services Accidental Dental  Accidental Dental  Any coinsurance after deductible Injury as a result of chewing or biting is not considered an accidental injury.  Refer to your Evidence of Coverage	Prescription Drugs Tier 0 (Preventive)	No charge	
Tier 2 (Preferred)  Tier 3 (Non-Preferred)  Tier 3 (Non-Preferred)  Tier 3 (Non-Preferred)  Tier 4 (Specialty)  Vision (pediatric) Children's Eye Exam  Low Vision Testing and Aids  Pier 4 (Specialty)  No charge  No charge  No charge  No charge  Timited to one evaluation and aid per Benefit Year.  Time 4 (Specialty)  No charge  Tire 4 (Specialty)  No charge  I routine eye exam per Benefit Year  Limited to one evaluation and aid 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  No charge  Vision (adults) Eye Exam  No charge  No charge  1 routine eye exam 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  No charge  Tiroutine eye exam per Benefit Year. If medically necessary, a replacement pair of glasses is allowed. Refer to your Evidence of Coverage Benefit Year.  No charge  Timited to one evaluation and aid per Benefit Year.  Tiroutine eye exam per Benefit Year.  To pair of glasses/contacts per Benefit Year.  To pair of glasses/contacts per Benefit Year up to a \$250 allowance  Other Dental Services  Accidental Dental  Accidental Dental  Accidental Dental  Accidental Anesthesia  All others limited to a 30-day supply supplication and supplication and supplication and supplication and supplication and aid per Benefit Year.  Accidental Anesthesia  All others limited to a 30-day supplication and supplication an	Tier 1 (Low Cost)	Up to \$3 copay	
Tier 3 (Non-Preferred)  Tier 4 (Specialty)  Tier 4 (Specialty)  Solve coinsurance after deductible  Tier 4 (Specialty)  Solve coinsurance after deductible  No charge  No charge  Limited to one evaluation and aid per Benefit Year.  Children's Eyewear  Children's Eyewear  Children's Eyewear  No charge  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  Low Vision Testing and Aids  No charge  Toutine eye exam 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  Substitute to one evaluation and aid per Benefit Year.  Limited to one evaluation and aid per Benefit Year.  Limited to one evaluation and aid per Benefit Year.  Limited to one evaluation and aid per Benefit Year.  Limited to one evaluation and aid per Benefit Year.  I pair of glasses/contacts per Benefit Year up to a \$250 allowance  Other Dental Services  Accidental Dental  Any copay 1 routine eye exam per Benefit Year  Limited to one evaluation and aid per Benefit Year.  I pair of glasses/contacts per Benefit Year up to a \$250 allowance  Injury as a result of chewing or biting is not considered an accidental injury.  Refer to your Evidence of Coverage	Tier 2 (Preferred)	Up to \$75 copay	
Tier 4 (Specialty)  50% coinsurance after deductible  Tier 4 (Specialty)  50% coinsurance after deductible  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. 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  No charge  Vision (adults)  Eye exam  No charge  1 routine eye exam 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  No charge  1 routine eye exam per Benefit Year  Limited to one evaluation and aid per Benefit Year.  No charge  1 pair of glasses/contacts per Benefit Year up to a \$250 allowance  Other Dental Services  Accidental Dental  40% coinsurance after deductible  40% coinsurance after deductible  Vision Refer to your Evidence of Coverage	Tier 3 (Non-Preferred)		Any copays shown are for a 30-day
Children's Eye Exam Low Vision Testing and Aids No charge 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 Low Vision Testing and Aids 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 No charge Limited to one evaluation and aid per Benefit Year Limited to one evaluation and aid per Benefit Year.  1 pair of glasses/contacts per Benefit Year.  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. Refer to your Evidence of Coverage	Tier 4 (Specialty)		times the copay and for Mail Order are
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  Low Vision Testing and Aids  No charge  Limited to one evaluation and aid per Benefit Year.  Eyewear  No charge  I pair of glasses/contacts per Benefit Year.  Pear up to a \$250 allowance  Other Dental Services  Accidental Dental  40% coinsurance after deductible  Dental Anesthesia  Accidented injury.  Refer to your Evidence of Coverage		No charge	1 routine eye exam per Benefit Year
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 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. Refer to your Evidence of Coverage deductible	Low Vision Testing and Aids	No charge	
Sye Exam  Low Vision Testing and Aids  No charge  Eyewear  No charge  No charge  I pair of glasses/contacts per Benefit Year year up to a \$250 allowance  Other Dental Services  Accidental Dental  Dental Anesthesia  Accidental Anesthesia  Sye Exam  No charge  No charge  No charge  1 pair of glasses/contacts per Benefit Year up to a \$250 allowance  Injury as a result of chewing or biting is not considered an accidental injury.  Refer to your Evidence of Coverage deductible	Children's Eyewear	No charge	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
Low Vision Testing and Aids  No charge  Eyewear  No charge  No charge  1 pair of glasses/contacts per Benefit Year up to a \$250 allowance  Other Dental Services  Accidental Dental  Dental Anesthesia  Accidental Anesthesia  No charge  No charge  I pair of glasses/contacts per Benefit Year up to a \$250 allowance  Injury as a result of chewing or biting is not considered an accidental injury.  Refer to your Evidence of Coverage deductible	Vision (adults) Eye Exam	\$40 copay	1 routine eye exam per Benefit Year
Other Dental Services Accidental Dental  Dental Anesthesia  Accidental Anesthesia  Accidental Dental  40% coinsurance after deductible  40% coinsurance after deductible  Accidental Dental  40% coinsurance after deductible  Accidental Dental  Accidental Dental Anesthesia  Accidental Dental  Acciden	•		Limited to one evaluation and aid per
Accidental Dental  40% coinsurance after deductible  Dental Anesthesia  40% coinsurance after deductible  40% coinsurance after not considered an accidental injury.  Refer to your Evidence of Coverage deductible	Eyewear	No charge	
Dental Anesthesia  Highly as a result of chewing of biting is not considered an accidental injury.  Refer to your Evidence of Coverage deductible			
Dental Anesthesia  40% coinsurance after deductible  Refer to your Evidence of Coverage	Accidental Dental		
	Dental Anesthesia	40% coinsurance after Refer to your Evidence	
	Fitness Program		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]