

## 2025 Schedule of Benefits

Plan Name: Low Premium Bronze 9200 \$25 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: \$9,200 Family: \$18,400
Coinsurance	0%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$9,200 Family: \$18,400



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

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

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Medical Supplies, Durable Medical Equipment, and Appliances</b> Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	No charge 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 Up to \$25 copay No charge after deductible No charge after deductible No charge 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.
<b>Vision (adults)</b> Eye Exam Low Vision Testing and Aids Eyewear	40% coinsurance No charge No charge	1 routine eye exam per Benefit Year Limited to one evaluation and aid per Benefit Year. 1 pair of glasses/contacts per Benefit Year up to a \$250 allowance
<b>Other Dental Services</b> Accidental Dental Dental Anesthesia	No charge after deductible No charge after deductible	\$3,000 per Member Per Injury All Services combined Refer to your Evidence of Coverage
<b>Fitness Program</b>	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-IN-pa](http://www.caresource.com/mp-IN-pa).

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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.

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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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