

2025 Schedule of Benefits

Plan Name: Low Premium Silver 500 \$0 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: \$500 Family: \$1,000
Coinsurance	15%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$1,000 Family: \$2,000



* 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	You Pay (Network Providers Only)	Limit (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	No charge	None
Specialist	\$15 copay	None
Urgent Care	\$25 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 X-Ray/Radiology Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$10 copay \$50 copay after deductible \$100 copay after deductible	None None None
Mammograms (Outpatient) Preventive Diagnostic	No charge \$50 copay after deductible	Refer to your Evidence of Coverage None
Inpatient Services Facility Fee Physician/Surgeon Fees Skilled Nursing Facility	\$300 copay after deductible per stay No charge after deductible \$200 copay after deductible per stay	None 1 visit per physician per day 90 Day limit per Benefit Year
Outpatient Services Facility Fee Physician/Surgeon Fees	15% coinsurance after deductible 15% coinsurance after deductible	None None
Maternity Services Prenatal Visit, Office Visits, and Postpartum Care Inpatient Services Outpatient Services	\$15 copay \$300 copay after deductible 15% coinsurance after deductible	None None None
Ambulance Services	15% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	\$300 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 Occupational Therapy Speech Therapy	No charge No charge No charge	20 visits per Benefit Year 20 visits per Benefit Year 20 visits per Benefit Year

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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services 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 No charge No charge 15% coinsurance after deductible 15% coinsurance after deductible 15% coinsurance after deductible No charge 15% 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
Chiropractor Services	\$15 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services Physical Therapy Occupational Therapy Speech Therapy Adaptive Behavior Treatment	No charge No charge No charge No charge	Combined limit with Habilitative Services Combined limit with Habilitative Services Combined limit with Habilitative Services Includes Applied Behavior Analysis (ABA)
Behavioral Health Services Office Visits Outpatient Services Intensive Outpatient Program (IOP) Services Partial Hospitalization Program (PHP) Services Residential Services Opioid Treatment Program Inpatient Services	No charge 15% coinsurance after deductible 15% coinsurance after deductible \$200 copay after deductible per stay 15% coinsurance after deductible \$300 copay after deductible per stay	None
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

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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health Private Duty Nursing	15% coinsurance after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	15% coinsurance after deductible	None
All Other Services	15% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	15% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	15% coinsurance after deductible	Refer to your Evidence of Coverage
Prescription Drugs Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty)	No charge No charge Up to \$25 copay 30% coinsurance after deductible 45% 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.
Vision (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 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 Eyewear	\$25 copay 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
Other Dental Services Accidental Dental Dental Anesthesia	15% coinsurance after deductible 15% coinsurance after deductible	\$3,000 per Member Per Injury All Services combined Refer to your Evidence of Coverage

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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
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-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.

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.

Learn more about CareSource and all our plan options at 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.