2025 Schedule of Benefits
Plan Name: Low Premium Silver 6000 $3 Generic Drugs

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	30%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $7,250 Family: $14,500

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 a member has reached their individual Out-of-Pocket Limit, the plan will pay 100% of their Covered Services. 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.

Cost sharing shown applies to services received in-person or via telehealth

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 Telehealth Partner	No charge	Refer to your Evidence of Coverage
Primary		
Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	$30 copay	None
Specialist	$70 copay	None
Urgent Care	$50 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	$200 copay after deductible	None
Inpatient Services		
Facility Fee	$450 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	$450 copay after deductible per stay	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$70 copay	None
Inpatient Services	$450 copay after deductible	None
Outpatient Services	30% coinsurance after deductible	None
Ambulance Services	30% coinsurance after deductible for both in-network and out-of-network providers	None
Emergency Health Care Services	$450 copay after deductible for both in-network and out-of-network providers	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	$30 copay	20 visits per Benefit Year
Occupational Therapy	$30 copay	20 visits per Benefit Year
Speech Therapy	$30 copay	20 visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$30 copay	20 visits per Benefit Year If received from a Chiropractor, see Chiropractor Services for cost share
Occupational Therapy	$30 copay	20 visits per Benefit Year
Speech Therapy	$30 copay	20 visits per Benefit Year
Pulmonary Rehabilitation	30% coinsurance after deductible	20 visits per Benefit Year
Cardiac Rehabilitation Services	30% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	30% coinsurance after deductible	12 visits per Benefit Year If received from a Chiropractor, see Chiropractor Services for cost share
Post-Cochlear Implant Aural Therapy	$30 copay	30 visits per Benefit Year
Cognitive Rehabilitation Therapy	30% coinsurance after deductible	20 visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	30% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Services	$30 copay	Limits for Physical Therapy and Manipulation apply Cost share includes all Covered Services rendered during the visit
Autism Spectrum Disorder Services		
Occupational Therapy	$30 copay	20 visits per Benefit Year
Speech Therapy	$30 copay	20 visits per Benefit Year
Adaptive Behavior Treatment	$30 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	$30 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	30% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	30% coinsurance after deductible	None
Residential Services	$450 copay after deductible per stay	
Opioid Treatment Program	30% coinsurance after deductible	
Inpatient Services	$450 copay after deductible per stay	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
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
Home Health		
Private Duty Nursing	30% coinsurance after deductible	100 visits per Benefit Year, a visit equals 8 hours
All Other Services	30% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	30% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	30% 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 a 12-month supply of 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.
Other Dental Services		
Accidental Dental	30% coinsurance after deductible	$3,000 per Member Per Injury All Services combined
Dental Anesthesia	30% coinsurance after deductible	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-OH-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.

Ohio Revised Code Sections 3902.50 through 3902.54, Ohio Administrative Code Section 3901-8-17 and the Federal No Surprises Act establish patient protections including from out-of-network providers' surprise bills ("balance billing") for emergency care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain out-of-network providers.

Dependent Information

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