2025 Schedule of Benefits
Plan Name: Preventive Silver 700 $0 Select 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: $700 Family: $1,400
Coinsurance	0%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $700 Family: $1,400

* 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)
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 after deductible	None
Specialist	No charge after deductible	None
Urgent Care	No charge after deductible	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
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
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	No charge	None
Inpatient Services		
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	60 Day limit per Benefit Year
Outpatient Services		
Facility Fee	No charge after deductible	None
Physician/Surgeon Fees	No charge after deductible	None
Maternity Services		
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
Ambulance Services	No charge after deductible	None
Emergency Health Care Services	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.
Habilitative Services		
Physical Therapy	No charge after deductible	40 combined visits per Benefit Year
Occupational Therapy	No charge after deductible	40 combined visits per Benefit Year
Speech Therapy	No charge after deductible	40 combined visits per Benefit Year
Audiology	No charge after deductible	40 combined visits per Benefit Year
Manipulation Therapy	No charge after deductible	40 combined visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	No charge after deductible	40 combined visits per Benefit Year
Occupational Therapy	No charge after deductible	40 combined visits per Benefit Year
Speech Therapy	No charge after deductible	40 combined visits per Benefit Year
Pulmonary Rehabilitation	No charge after deductible	None
Cardiac Rehabilitation Services	No charge after deductible	None
Manipulation Therapy	No charge after deductible	40 combined visits per Benefit Year
Post-Cochlear Implant Aural Therapy	No charge after deductible	Combined Limit with Speech Therapy
Cognitive Rehabilitation Therapy	No charge after deductible	40 combined visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	No charge after deductible	Refer to your Evidence of Coverage
Autism Spectrum Disorder Services		
Physical Therapy	No charge after deductible	None
Occupational Therapy	No charge after deductible	None
Speech Therapy	No charge after deductible	None
Adaptive Behavior Treatment	No charge after deductible	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	No charge after deductible	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	No charge after deductible	
Partial Hospitalization Program (PHP) Services	No charge after deductible	None
Residential Services	No charge after deductible	
Opioid Treatment Program	No charge after deductible	
Inpatient Services	No charge after deductible	
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		
Home Infusion Therapy	No charge after deductible	Included in all other services limits
All Other Services	No charge after deductible	120 combined visits per Benefit Year. A visit equals 2 hours or less.
Hospice Care	No charge after deductible	Refer to your Evidence of Coverage

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Medical Supplies, Durable Medical Equipment, and Appliances Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	No charge after deductible	Refer to your Evidence of Coverage
Preventive Plan Services Select Preventive Drugs Select Preventive Supplies Specialized Medical Services	No charge	Refer to caresource.com/GAMPElite2025 for Select Drugs, Supplies, and Specialized Medical Services
Prescription Drugs Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty)	No charge No charge after deductible 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.
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.
Other Dental Services Accidental Dental Dental Anesthesia	 No charge after deductible No charge after deductible	 Injury as a result of chewing or biting is not considered an accidental injury. 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.

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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]