2025 Schedule of Benefits
Plan Name: Core Gold 1500 $10 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: $1,500 Family: $3,000
Coinsurance	25%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $7,000 Family: $14,000

* 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	$20 copay	None
Specialist	$60 copay	None
Urgent Care	$40 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	$30 copay	None
X-Ray/Radiology	25% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	25% coinsurance after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	No charge	None
Inpatient Services		
Facility Fee	25% coinsurance after deductible	None
Physician/Surgeon Fees	25% coinsurance after deductible	1 visit per physician per day
Skilled Nursing Facility	25% coinsurance after deductible	60 Day limit per Benefit Year
Outpatient Services		
Facility Fee	25% coinsurance after deductible	None
Physician/Surgeon Fees	25% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$60 copay	None
Inpatient Services	25% coinsurance after deductible	None
Outpatient Services	25% coinsurance after deductible	None
Ambulance Services	25% coinsurance after deductible	None
Emergency Health Care Services	$400 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	$20 copay	40 combined visits per Benefit Year
Occupational Therapy	$20 copay	40 combined visits per Benefit Year
Speech Therapy	$20 copay	40 combined visits per Benefit Year
Audiology	25% coinsurance after deductible	40 combined visits per Benefit Year
Manipulation Therapy	25% coinsurance after deductible	40 combined visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$20 copay	40 combined visits per Benefit Year
Occupational Therapy	$20 copay	40 combined visits per Benefit Year
Speech Therapy	$20 copay	40 combined visits per Benefit Year
Pulmonary Rehabilitation	25% coinsurance after deductible	None
Cardiac Rehabilitation Services	25% coinsurance after deductible	None
Manipulation Therapy	25% coinsurance after deductible	40 combined visits per Benefit Year
Post-Cochlear Implant Aural Therapy	$20 copay	Combined Limit with Speech Therapy
Cognitive Rehabilitation Therapy	25% coinsurance after deductible	40 combined visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	25% coinsurance after deductible	Refer to your Evidence of Coverage
Autism Spectrum Disorder Services		
Physical Therapy	$20 copay	None
Occupational Therapy	$20 copay	None
Speech Therapy	$20 copay	None
Adaptive Behavior Treatment	$20 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	$20 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	25% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	25% coinsurance after deductible	None
Residential Services	25% coinsurance after deductible	
Opioid Treatment Program	25% coinsurance after deductible	
Inpatient Services	25% coinsurance 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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Home Infusion Therapy	25% coinsurance after deductible	Included in all other services limits
All Other Services	25% coinsurance after deductible	120 combined visits per Benefit Year. A visit equals 2 hours or less.
Hospice Care	25% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	25% 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 $10 copay	
Tier 2 (Preferred)	Up to $50 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 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	$50 copay	1 routine eye exam per Benefit Year
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	25% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	25% coinsurance after deductible	Refer to your Evidence of Coverage
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-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]