

2023 Schedule of Benefits

Plan Name: CareSource Marketplace Low Premium Silver 1 Dental,
Vision, & L5 (CareSou)-e Marketplace Low,



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	\$60 copay	None
Inpatient Services	\$450 copay after deductible	None
Outpatient Services	30% coinsurance after deductible	None
Ambulance Services	30% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	\$450 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	\$25	191.75 0 1911d

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Home Health		
Private Duty Nursing	30% coinsurance after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	30% coinsurance after deductible	None
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
Diabetic Services		
Education		
Equipment	30% coinsurance after deductible	Refer to your Evidence of Coverage
Supplies		
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances		
Durable Medical Equipment		
Medical Supplies	30% coinsurance after deductible	Refer to your Evidence of Coverage
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 any drug in Tiers 0-3
Tier 1 (Low Cost)	Up to \$10 copay	
Tier 2 (Preferred)	Up to \$60 copay	All others limited to a 30-day supply
Tier 3 (Non-Preferred)	40% coinsurance after deductible	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 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 50.4 17.499 0.25 17.499 h W n E Benefit Yar 15 08415 (u)1 ()1 (Mai)r0.106

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
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
Dental (pediatric) Class I – Diagnostic/Preventive	No charge	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage
Class II – Minor Restorative	30% coinsurance after deductible	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	50% coinsurance after deductible	Refer to your Evidence of Coverage
Class IV - Orthodontics	55% coinsurance after deductible	Refer to your Evidence of Coverage
Dental (adults) Class I – Diagnostic/Preventive	No charge	Refer to your Evidence of Coverage. Benefit is limited to \$1,000 per Benefit Year.
Class II – Minor Restorative	30% coinsurance	
Class III - Major/Comprehensive	50% coinsurance	
Class IV - Orthodontics	Not covered	
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.

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Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2023]

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