CareSource Marketplace Low Premium Silver 3 Dental, Vision, & Fitness

Coverage for: Individual and Family | Plan Type: HMO

-The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact www.caresource.com/marketplace or call 833-230-2099. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at www.caresource.com/marketplace or call 833-230-2099 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | \$300 individual/\$600 family per Benefit Year | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. Preventive care. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. |
| Are there other deductibles for specific services? | No | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket</u> limit for this plan? | | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations Evanations 9 Other |
|---|---|--|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Network Provider Information* |
| If you visit a health care provider's office or clinic | Zero Cost Telehealth Partner | No charge | Not covered | Refer to your Evidence of Coverage |
| | Primary care visit to treat an injury or illness. | No charge | Not covered | None |
| | <u>Specialist</u> visit | \$15 copay | Not covered | None |
| | Preventive care/screening/immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test† | <u>Diagnostic test</u> (x-ray, blood | X-ray: \$50 copay after deductible | Not covered | None |
| | work) | Lab: \$10 copay | | None |
| | Imaging (CT/PET scans, MRIs) | \$100 copay after deductible | Not covered | None |
| If | Preventive drugs | No charge | Not covered | 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 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. Insulin cost share not to exceed \$30 per 30-day supply |
| If you need drugs | Generic drugs | Up to \$5 copay | Not covered | |
| to treat your illness or conditiont | Preferred brand drugs | Up to \$25 copay | Not covered | |
| More information about prescription drug coverage is available at www.caresource.com/marketplace. | Non-preferred brand drugs | 30% coinsurance after deductible | Not covered | |
| | Specialty drugs | 45% coinsurance after deductible | Not covered | |
| If you have outpatient surgery† | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance after deductible | Not covered | None |
| | Physician/surgeon fees | 10% coinsurance after deductible | Not covered | None |
| If you need immediate medical attention | Emergency room care | \$300 copay after deductible | \$300 copay after deductible | Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department. |
| | Emergency medical transportation | 10% coinsurance after deductible | 10% coinsurance after deductible | Refer to your Evidence of Coverage |

^{*}For more information about limitations and exceptions, see the <u>plan</u> or policy document at www.caresource.com/marketplace or call 833-230-2099. †Prior authorization may be required, for more details see www.caresource.com/mp-KY-pa. ADV-SBC-KY002(2023)ELP-Silver 3

| | | What You Will Pay | | Limitations Exceptions & Other |
|--|------------------------------------|--|---|---|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Network Provider Information* |
| | <u>Urgent care</u> | \$25 copay | \$25 copay | If you receive services in addition to <u>urgent</u> <u>care</u> , additional <u>copayments</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply. |
| If you have a hospital stay† | Facility fee (e.g., hospital room) | \$300 copay after deductible per stay | Not covered | None |
| | Physician/surgeon fees | No charge after deductible | Not covered | 1 visit per physician per day |
| If you need mental health, behavioral | | | | |

abuse services†

^{*}For more information about limitations and exceptions, see the <u>plan</u> or policy document at www.caresource.com/marketplace or call 833-230-2099. †Prior authorization may be required, for more details see www.caresource.com/mp-KY-pa. ADV-SBC-KY002(2023)ELP-Silver 3

| | What You Will Pay | | | | |
|----------------------|-------------------------------|---|---|--|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Network Provider Information* | |
| | Habilitation services† | | | | |
| | Physical/Occupational therapy | No charge | Not covered | 25 visits per Benefit Year | |
| | Speech therapy | 10% coinsurance after deductible | Not covered | 25 visits per Benefit Year | |
| | Hearing Aids | 10% coinsurance after deductible | Not covered | 1 hearing aid per hearing-impaired ear every 36 months | |
| | Skilled nursing care† | \$200 copay after deductible per stay | Not covered | 90 Day limit per Benefit Year | |
| | Durable medical equipment† | 10% coinsurance after deductible | Not covered | Refer to your Evidence of Coverage | |
| | Hospice services | No charge for in- network and out-of- network by Medicare | | | |
| | | | | | |

^{*}For more information about limitations and exceptions, see the <u>plan</u> or policy document at www.caresource.com/marketplace or call 833-230-2099. †Prior authorization may be required, for more details see www.caresource.com/mp-KY-pa. ADV-SBC-KY002(2023)ELP-Silver 3

ADV-SBC-KY002(2023)ELP-Silver 3

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan