2023 Schedule of Benefits

Plan Name: CareSource Marketplace Standard Silver 3 Dental, Vision, & Fitness

Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2023]
Last Coverage Change Date	[01/01/2022]

[Dependent information can be found at the end of this document.]

Highlights

Annual Deductible*	Individual: $250 Family: $500
Coinsurance	15%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $900 Family: $1,800

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $250 of Covered Services each Benefit Year before CareSource begins to pay for any covered service where the Annual Deductible applies. For family coverage, you are responsible for paying the first $500 for Covered Services for your entire family each Benefit Year before CareSource begins to pay for any covered service where the Annual Deductible applies. However, for each individual covered member within your family, the maximum amount each member would pay toward the family Deductible is the individual Deductible amount, in this case $250 up to the family maximum of $500. The Annual Deductible applies to Covered Services identified as "after deductible" in the Covered Service table below.

** See Section 2: Evidence of Coverage for the Definition of Annual Out-of-Pocket Maximum. For family coverage, each individual covered member within your family is contributing toward the family Annual Out-of-Pocket Maximum. However, for each individual covered member within your family, the maximum amount each member would pay toward the family Annual Out-of-Pocket Maximum is the individual Out-of-Pocket Maximum, which is $900. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

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, Psychiatrist, Chiropractor (office visit only), and Retail Clinics	No charge	None
Specialist	$15 copay	None
Urgent Care	$20 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)
Rehabilitative Services		
Physical Therapy	No charge	25 visits per Benefit Year
Occupational Therapy	No charge	ctible
Speech Therapy	15% coinsurance after deductible	15% coi456.88s ance after dedu
Pulmonary Rehabilitation	15% coinsurance after deductible	CardAutens]TJOut /<eo426 669.6Progbilitan
Cardiac Rehabilitation Services	15% coinsurance after deductible	15% c4 348.544 ance after dedu
Manipulation Therapy	15% coinsurance after deductible	
Post-Cochlear Implant Aural Therapy	15% coinsurance after deductible	
Cognitive Rehabilitation Therapy	15% coinsurance after deductible	ctible
Other Rehabilitative Services	15% c4 319.044 ance after dedu	
Includes Chemotherapy, Dialysis, and Radiation	15% coinsurance after deductible	
	ctible 15% c4 260.044 ance after dedu	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Vision (adults)		
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.
Eyewear	No charge	1 pair of glasses/contacts per Benefit Year up to a $250 allowance
Other Dental Services		
Accidental Dental	15% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	15% 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	15% coinsurance after deductible	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	40% coinsurance after deductible	Refer to your Evidence of Coverage
Class IV - Orthodontics	45% 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	15% coinsurance	
Class III - Major/Comprehensive	40% 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-KY-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.

No Surprises Act: The No Surprises Act requires CareSource & Providers to hold patients harmless from surprise medical bills stemming from out-of-network emergency care, out of network air ambulance, and services provided by out-of-network

The No Surprises Act is meant to ensure you’re kept out of the middle of provider plan billing disputes for those specific services by prohibiting facilities and providers from pursuing payment from you for more than the in-network cost-sharing amount as based on the Recognized Amount in most situations. One situation where you may still be involved is regarding non-emergency services provided by a non-network provider while you are in a network facility. 86NaciEdet o Surpriss (Actg)]TJT
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