



Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2024]
Last Coverage Change Date	[01/01/2023]

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

Highlights

Annual Deductible*	Individual: \$1,000 Family: \$2,000
Coinsurance	30%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$7,500 Family: \$15,000



\* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$1,000 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 \$2,000 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 \$1,000 up to the family maximum of \$2,000. 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 \$7,500. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Preventive Services</b> As defined by federal & state law	No charge	Refer to your Evidence of Coverage
<b>Office Visits</b> Zero Cost Telemedicine Partner	No charge	Refer to your Evidence of Coverage
Primary Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	\$15 copay	None
Specialist	\$50 copay	None
<b>Urgent Care</b>	\$30 copay	None

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Diagnostic Services</b>		
Lab	\$30 copay	None
X-Ray/Radiology	30% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	30% coinsurance after deductible	None
<b>Mammograms (Outpatient)</b>		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	30% coinsurance after deductible	None
<b>Inpatient Services</b>		
Facility Fee	\$500 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	30% coinsurance after deductible	60 Day limit per Benefit Year
<b>Outpatient Services</b>		
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	None
<b>Surgical and Reconstructive Services</b>		
Anesthesia		
Bariatric Surgery		
Congenital Anomaly, including Cleft Lip/Palate	30% coinsurance after deductible	Refer to your Evidence of Coverage
Reconstructive Surgery		
<b>Maternity Services</b>		
Prenatal Visit, Office Visits, and Postpartum Care	\$50 copay	None
Inpatient Services	\$500 copay after deductible	None
Outpatient Services	30% coinsurance after deductible	None
Well Baby Visits and Care	No charge	None
<b>Ambulance Services</b>	30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Emergency Health Care Services</b>	\$500 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.
<b>Habilitative Services</b>		
Physical Therapy	\$15 copay	30 visits Combined per Benefit Year
Occupational Therapy	\$15 copay	30 visits Combined per Benefit Year
Manipulation Therapy	30% coinsurance after deductible	30 visits Combined per Benefit Year

Learn more about CareSource and all our plan options at [www.caresource.com/marketplace](http://www.caresource.com/marketplace).

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Rehabilitative Services</b>		
Physical Therapy	\$15 copay	30 visits Combined per Benefit Year
Occupational Therapy	\$15 copay	30 visits Combined per Benefit Year
Speech Therapy	30% coinsurance after deductible	30 visits per Benefit Year
Pulmonary Rehabilitation	30% coinsurance after deductible	None
Cardiac Rehabilitation Services	30% coinsurance after deductible	None
Manipulation Therapy	30% coinsurance after deductible	30 visits Combined per Benefit Year
Post-Cochlear Implant Aural Therapy	30% coinsurance after deductible	Combined Limit with Speech Therapy
Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Chiropractor Services</b>	\$50 copay	Limits for Physical Therapy and Manipulation apply
<b>Autism Spectrum Disorder Services</b>		
Physical Therapy	\$15 copay	None
Occupational Therapy	\$15 copay	None
Speech Therapy	30% coinsurance after deductible	None
Adaptive Behavior Treatment	\$15 copay	Includes Applied Behavior Analysis (ABA)
<b>Behavioral Health Services</b>		
Office Visits	\$15 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	30% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	30% coinsurance after deductible	None
Residential Services	30% coinsurance after deductible	
Opioid Treatment Program	30% coinsurance after deductible	
Inpatient Services	\$500 copay after deductible per stay	

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Transplant Services</b> Transplants  Donor Location Costs  Transportation and Lodging	Covered the same as office visits, inpatient services, and outpatient services 30% coinsurance after deductible 30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder</b>	Covered the same as office visits, inpatient services, and outpatient services	None
<b>Home Health</b> Private Duty Nursing  Home Infusion Therapy  All Other Services	30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible	None None None
<b>Hospice Care</b>	30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Diabetic Services</b> Education  Equipment  Diabetes Care Management  Preferred Diabetic Drugs and Supplies	30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible No charge	Refer to your Evidence of Coverage Refer to your Evidence of Coverage Refer to your Evidence of Coverage Refer to your Evidence of Coverage
<b>Medical Supplies, Durable Medical Equipment, and Appliances</b> Appliances Durable Medical Equipment Medical Supplies Orthotic Device for Positional Plagiocephaly Prosthetics	30% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Hearing Aids</b>	30% coinsurance after deductible	1 hearing aid per hearing-impaired ear every 36 months
<b>Reproductive Health</b> Infertility Treatment Sexual Dysfunction Sterilization	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Prescription Drugs</b> Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty)	No charge Up to \$2 copay Up to \$60 copay 30% coinsurance after deductible 40% coinsurance 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 are 3 times the copay.
<b>Vision</b> (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.
<b>Vision</b> (adults) Eye Exam Low Vision Testing and Aids  Eyewear	No charge No charge  No charge	1 routine eye exam per Benefit Year Limited to one evaluation and aid per Benefit Year.  1 pair of glasses/contacts per Benefit Year up to a \$250 allowance
<b>Other Dental Services</b> Accidental Dental  Dental Anesthesia	30% coinsurance after deductible 30% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury. Refer to your Evidence of Coverage
<b>Dental</b> (pediatric) Class I - Diagnostic/Preventive  Class II - Minor Restorative  Class III - Major/Comprehensive  Class IV - Orthodontics	No charge  15% coinsurance after deductible  40% coinsurance after deductible  40% coinsurance after deductible	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage  Refer to your Evidence of Coverage  Refer to your Evidence of Coverage  Refer to your Evidence of Coverage
<b>Dental</b> (adults) Class I - Diagnostic/Preventive Class II - Minor Restorative Class III - Major/Comprehensive Class IV - Orthodontics	No charge 15% coinsurance 40% coinsurance Not covered	Refer to your Evidence of Coverage. Benefit is limited to \$1,000 per Benefit Year.
<b>Fitness Program</b>	No charge	Refer to your Evidence of Coverage

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Other Covered Services</b> Allergy Testing Blood Services Clinical Trials Nutritional Counseling	Covered the same as office visits, inpatient services, and outpatient services	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-NC-pa](http://www.caresource.com/mp-NC-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](http://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.

The copays and coinsurance listed in the 'You Pay' column would only apply if the item or service is not furnished directly by a provider meeting the criteria outlined below, otherwise there would be no cost to you.

- 1) an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603);
- 2) a provider who was referred by one of the organizations listed in item 1.

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Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2024]

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