CareSource North Carolina Co.
2024 Schedule of Benefits
Plan Name: CareSource Marketplace Diabetes Silver 2 Dental, Vision, & Fitness

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: $750 Family: $1,500
Coinsurance	20%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $3,000 Family: $6,000

This summary shows in-network benefits only.

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $750 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 $1,500 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 $750 up to the family maximum of $1,500. 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 $3,000. 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 Telemedicine Partner	No charge	Refer to your Evidence of Coverage
Primary		
Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	$5 copay	None
Specialist	$40 copay	None
Urgent Care	$20 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	$40 copay	None
X-Ray/Radiology	$150 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	$200 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	$150 copay after deductible	None
Inpatient Services		
Facility Fee	$250 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	20% coinsurance after deductible	60 Day limit per Benefit Year
Outpatient Services		
Facility Fee	20% coinsurance after deductible	None
Physician/Surgeon Fees	20% coinsurance after deductible	None
Surgical and Reconstructive Services		
Anesthesia	20% coinsurance after deductible	Refer to your Evidence of Coverage
Bariatric Surgery		
Congenital Anomaly, including Cleft Lip/Palate		
Reconstructive Surgery		
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$40 copay	None
Inpatient Services	$250 copay after deductible	None
Outpatient Services	20% coinsurance after deductible	None
Well Baby Visits and Care	No charge	None
Ambulance Services	20% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	$250 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	$5 copay	30 visits Combined per Benefit Year
Occupational Therapy	$5 copay	30 visits Combined per Benefit Year
Manipulation Therapy	20% coinsurance after deductible	30 visits Combined per Benefit Year

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$5 copay	30 visits Combined per Benefit Year
Occupational Therapy	$5 copay	30 visits Combined per Benefit Year
Speech Therapy	20% coinsurance after deductible	30 visits per Benefit Year
Pulmonary Rehabilitation	20% coinsurance after deductible	None
Cardiac Rehabilitation Services	20% coinsurance after deductible	None
Manipulation Therapy	20% coinsurance after deductible	30 visits Combined per Benefit Year
Post-Cochlear Implant Aural Therapy	20% coinsurance after deductible	Combined Limit with Speech Therapy
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	20% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Services	$40 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical Therapy	$5 copay	None
Occupational Therapy	$5 copay	None
Speech Therapy	20% coinsurance after deductible	None
Adaptive Behavior Treatment	$5 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	$5 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	20% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	20% coinsurance after deductible	None
Residential Services	20% coinsurance after deductible	
Opioid Treatment Program	20% coinsurance after deductible	
Inpatient Services	$250 copay after deductible per stay	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Transplant Services		
Transplants	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
Donor Location Costs	20% coinsurance after deductible	
Transportation and Lodging	20% coinsurance after deductible	
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services, and outpatient services	None
Home Health		
Private Duty Nursing	20% coinsurance after deductible	None
Home Infusion Therapy	20% coinsurance after deductible	None
All Other Services	20% coinsurance after deductible	None
Hospice Care	20% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetic Services		
Education	20% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	20% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetes Care Management	20% coinsurance after deductible	Refer to your Evidence of Coverage
Preferred Diabetic Drugs and Supplies	No charge	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	20% coinsurance after deductible	Refer to your Evidence of Coverage
Durable Medical Equipment		
Medical Supplies		
Orthotic Device for Positional Plagiocephaly		
Prosthetics		
Hearing Aids	20% coinsurance after deductible	1 hearing aid per hearing-impaired ear every 36 months
Reproductive Health		
Infertility Treatment	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
Sexual Dysfunction		
Sterilization		

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
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 are 3 times the copay.
Tier 1 (Low Cost)	Up to $2 copay	
Tier 2 (Preferred)	Up to $30 copay	
Tier 3 (Non-Preferred)	30% coinsurance after deductible	
Tier 4 (Specialty)	40% 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.
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	20% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	20% 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

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Other Covered Services 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**.

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	[01/01/2024]

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