



### 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	20%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$2,700 Family: \$5,400



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 \$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 \$2,700. 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	\$5 copay	None
Specialist	\$40 copay	None
<b>Urgent Care</b>	\$25 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
<b>Diagnostic Services</b>		
Lab	\$15 copay	None
X-Ray/Radiology	\$150 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$200 copay after deductible	None
<b>Mammograms (Outpatient)</b>		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$150 copay after deductible	None
<b>Inpatient Services</b>		
Facility Fee	\$350 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	\$300 copay after deductible per stay	60 Day limit per Benefit Year
<b>Outpatient Services</b>		
Facility Fee	20% coinsurance after deductible	None
Physician/Surgeon Fees	20% coinsurance after deductible	None
<b>Surgical and Reconstructive Services</b>		
Anesthesia		
Bariatric Surgery		
Congenital Anomaly, including Cleft Lip/Palate	20% coinsurance after deductible	Refer to your Evidence of Coverage
Reconstructive Surgery		
<b>Maternity Services</b>		
Prenatal Visit, Office Visits, and Postpartum Care	\$40 copay	None
Inpatient Services	\$350 copay after deductible	None
Outpatient Services	20% coinsurance after deductible	None
Well Baby Visits and Care	No charge	None
<b>Ambulance Services</b>	20% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Emergency Health Care Services</b>	\$350 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	\$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)
<b>Rehabilitative Services</b> Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Manipulation Therapy Post-Cochlear Implant Aural Therapy Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	\$5 copay \$5 copay 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible	30 visits Combined per Benefit Year 30 visits Combined per Benefit Year 30 visits per Benefit Year None None 30 visits Combined per Benefit Year Combined Limit with Speech Therapy Refer to your Evidence of Coverage
<b>Chiropractor Services</b>	\$40 copay	Limits for Physical Therapy and Manipulation apply
<b>Autism Spectrum Disorder Services</b> Physical Therapy Occupational Therapy Speech Therapy Adaptive Behavior Treatment	\$5 copay \$5 copay 20% coinsurance after deductible \$5 copay	None None None Includes Applied Behavior Analysis (ABA)
<b>Behavioral Health Services</b> Office Visits Outpatient Services Intensive Outpatient Program (IOP) Services Partial Hospitalization Program (PHP) Services Residential Services Opioid Treatment Program Inpatient Services	\$5 copay 20% coinsurance after deductible 20% coinsurance after deductible \$300 copay after deductible per stay 20% coinsurance after deductible \$350 copay after deductible per stay	None

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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  20% coinsurance after deductible  20% 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	20% coinsurance after deductible  20% coinsurance after deductible  20% coinsurance after deductible	None  None  None
<b>Hospice Care</b>	20% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Diabetic Services</b> Education  Equipment  Diabetes Care Management  Supplies	20% coinsurance after deductible  20% coinsurance after deductible  20% coinsurance after deductible  20% coinsurance after deductible	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	20% coinsurance after deductible	Refer to your Evidence of Coverage
<b>Hearing Aids</b>	20% 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 \$40 copay 40% coinsurance after deductible 45% 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>Other Dental Services</b> Accidental Dental Dental Anesthesia	20% coinsurance after deductible 20% 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 25% coinsurance after deductible 45% coinsurance after deductible 50% 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>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).

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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	[01/01/2024]

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