

2026 Schedule of Benefits

Plan Name: Diabetes Silver 4600 \$0 Chronic Care Drugs & Services + Adult Vision & Fitness



Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2026]
Last Coverage Change Date	[01/01/2025]

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

Highlights

Annual Deductible*	Individual: \$4,600 Family: \$9,200
Coinsurance	50%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$8,000 Family: \$16,000



- * Deductible: The individual Deductible applies to each covered family member. No one person can contribute more than the individual Deductible amount. Once two or more covered family members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Calendar Year.
- ** Out-of-Pocket Maximum: The individual Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year.

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 Visits² Teladoc	No charge	Refer to your Evidence of Coverage
Primary Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	\$30 copay	None
Specialist	\$50 copay	None
Urgent Care¹	\$70 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services¹ Lab X-Ray/Radiology Advanced Imaging (PET, MRI, MRA, CT, SPECT)	 \$75 copay \$300 copay after deductible \$300 copay after deductible	 None None If received from a Chiropractor, see Chiropractic Care Services for cost share. None
Mammograms (Outpatient) Preventive Diagnostic ¹	 No charge \$300 copay after deductible	 Refer to your Evidence of Coverage None
Inpatient Services Facility Fee Physician/Surgeon Fees Skilled Nursing Facility	 \$600 copay after deductible per stay No charge after deductible 50% coinsurance after deductible	 None 1 visit per physician per day 90 Day limit per Benefit Year
Outpatient Services Facility Fee Physician/Surgeon Fees	 50% coinsurance after deductible 50% coinsurance after deductible	 None None
Maternity Services¹ Prenatal Visit, Office Visits, and Postpartum Care Inpatient Services Outpatient Services	 \$50 copay \$600 copay after deductible 50% coinsurance after deductible	 None None None
Ambulance Services	50% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services¹	50% coinsurance 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/Occupational Therapy Speech Therapy	 \$30 copay \$30 copay	 20 visits per Benefit Year If received from a Chiropractor, see Chiropractic Care Services for cost share. 20 visits per Benefit Year

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical/Occupational Therapy	\$30 copay	20 visits per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Speech Therapy	\$30 copay	20 visits per Benefit Year
Pulmonary Rehabilitation	50% coinsurance after deductible	20 visits per Benefit Year
Cardiac Rehabilitation Services	50% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	50% coinsurance after deductible	12 visits per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Post-Cochlear Implant Aural Therapy	\$30 copay	Combined Limit with Speech Therapy
Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	50% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Care Services		
X-Ray/Radiology	\$50 copay	None
Rehabilitative Services		
Physical Therapy	\$50 copay	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	\$50 copay	Limits for Physical Therapy and Manipulation apply
Habilitation Services		
Physical Therapy	\$50 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical/Occupational Therapy	\$30 copay	Combined limit with Habilitative Services
Speech Therapy	\$30 copay	Combined limit with Habilitative Services
Adaptive Behavior Treatment	\$30 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits ²	\$30 copay	None
Outpatient Services ¹		
Intensive Outpatient Program (IOP) Services	50% coinsurance after deductible	None
Partial Hospitalization Program (PHP) Services	50% coinsurance after deductible	None
Residential Services	50% coinsurance after deductible	None
Opioid Treatment Program	50% coinsurance after deductible	None
Inpatient Services ¹	\$600 copay after deductible per stay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Transplant Services	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
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	50% coinsurance after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	50% coinsurance after deductible	None
All Other Services	50% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	50% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	50% coinsurance after deductible	Refer to your Evidence of Coverage
Durable Medical Equipment	50% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies	50% coinsurance after deductible	Refer to your Evidence of Coverage
Orthotic Device	50% coinsurance after deductible	Refer to your Evidence of Coverage
Prosthetics	50% coinsurance after deductible	Refer to your Evidence of Coverage
\$0 Chronic Care Services		
\$0 Chronic Care Medical Services	No charge	Refer to caresource.com/INMPElite2026 for \$0 Chronic Care Medical Services, Drugs, and Self-Management Supplies
\$0 Chronic Care Drugs and \$0 Chronic Care Self-Management Supplies	No charge	
Prescription Drugs		
Preventive Drugs	No charge	Up to a 30-day supply for brand name drugs filled at Retail and Specialty Drugs
Generic Drugs	Up to \$10 copay	Up to a 90-day supply for all other Retail and Mail Order.
Preferred Brand Drugs	Up to \$80 copay	
Non-Preferred Brand Drugs	40% coinsurance after deductible	Any copays shown are for a 30-day supply. 90-day supplies available at 3 times the copay for Retail and 2.5 times the copay for Mail Order.
Specialty Drugs	50% coinsurance after deductible	

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Vision (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. Refer to your Evidence of Coverage for additional eyewear options that may have an additional charge.
Vision (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
Other Dental Services Accidental Dental Dental Anesthesia	50% coinsurance after deductible 50% coinsurance after deductible	\$3,000 per Member Per Injury All Services combined Refer to your Evidence of Coverage
Fitness Program	No charge	Refer to your Evidence of Coverage
Other Covered Services³ Allergy Testing Allergy Injections Allergy Serum	Covered the same as office visits or diagnostic services 50% coinsurance after deductible 50% coinsurance after deductible	None None None

¹ When receiving covered services at an office, urgent care or hospital visit, member may be subject to cost share charges from both the facility and the physician/surgeon.

² Charge shown for the office visit. Additional services rendered during the office visit may be subject to their applicable additional copayment or deductible/coinsurance as specified in the Schedule of Benefits. Charges applied per provider, per date of service.

³ Member cost-sharing may vary based on the place of service where it is rendered. Additional services and evaluations rendered during the visit may be subject to their applicable additional copayment or deductible/coinsurance as specified in the Schedule of Benefits.

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-IN-pa.

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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.

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Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2026]

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