



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: \$700<br>Family: \$1,400 |
| Coinsurance                                                                      | 0%                                   |
| Annual Out-of-Pocket Maximum**<br>(includes deductible, coinsurance, and copays) | Individual: \$700<br>Family: \$1,400 |



- \* 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<br>(Network Providers Only)                                           | Limit<br>(If Applicable)                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------|
| <b>Preventive Services</b><br>As defined by federal & state law                                                                                           | No charge                                                                     | Refer to your Evidence of Coverage                         |
| <b>Office Visits<sup>2</sup></b><br>Teladoc<br>Primary<br>Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics<br>Specialist | No charge<br><br>No charge after deductible<br><br>No charge after deductible | Refer to your Evidence of Coverage<br><br>None<br><br>None |
| <b>Urgent Care<sup>1</sup></b>                                                                                                                            | No charge after deductible                                                    | None                                                       |

| Covered Service                                       | You Pay<br>(Network Providers Only) | Limit<br>(If Applicable)                                                                                                                                                                               |
|-------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Diagnostic Services<sup>1</sup></b>                |                                     |                                                                                                                                                                                                        |
| Lab                                                   | No charge after deductible          | None                                                                                                                                                                                                   |
| X-Ray/Radiology                                       | No charge after deductible          | None<br>If received from a Chiropractor, see<br>Chiropractic Care Services for cost<br>share.                                                                                                          |
| Advanced Imaging (PET, MRI, MRA, CT,<br>SPECT)        | No charge after deductible          | None                                                                                                                                                                                                   |
| <b>Mammograms (Outpatient)</b>                        |                                     |                                                                                                                                                                                                        |
| Preventive                                            | No charge                           | Refer to your Evidence of Coverage                                                                                                                                                                     |
| Diagnostic <sup>1</sup>                               | No charge after deductible          | None                                                                                                                                                                                                   |
| <b>Inpatient Services</b>                             |                                     |                                                                                                                                                                                                        |
| Facility Fee                                          | No charge after deductible          | None                                                                                                                                                                                                   |
| Physician/Surgeon Fees                                | No charge after deductible          | 1 visit per physician per day                                                                                                                                                                          |
| Skilled Nursing Facility                              | No charge after deductible          | 90 Day limit per Benefit Year                                                                                                                                                                          |
| <b>Outpatient Services</b>                            |                                     |                                                                                                                                                                                                        |
| Facility Fee                                          | No charge after deductible          | None                                                                                                                                                                                                   |
| Physician/Surgeon Fees                                | No charge after deductible          | None                                                                                                                                                                                                   |
| <b>Maternity Services<sup>1</sup></b>                 |                                     |                                                                                                                                                                                                        |
| Prenatal Visit, Office Visits, and Postpartum<br>Care | No charge after deductible          | None                                                                                                                                                                                                   |
| Inpatient Services                                    | No charge after deductible          | None                                                                                                                                                                                                   |
| Outpatient Services                                   | No charge after deductible          | None                                                                                                                                                                                                   |
| <b>Ambulance Services</b>                             | No charge after deductible          | Refer to your Evidence of Coverage                                                                                                                                                                     |
| <b>Emergency Health Care Services<sup>1</sup></b>     | No charge after deductible          | If admitted to the hospital directly from<br>the Emergency Department, these<br>services will be covered the same as<br>inpatient services and the applicable<br>copayment and coinsurance will apply. |
| <b>Habilitative Services</b>                          |                                     |                                                                                                                                                                                                        |
| Physical/Occupational Therapy                         | No charge after deductible          | 20 visits per Benefit Year<br>If received from a Chiropractor, see<br>Chiropractic Care Services for cost<br>share.                                                                                    |
| Speech Therapy                                        | No charge after deductible          | 20 visits 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<br>(Network Providers Only) | Limit<br>(If Applicable)                                                                                      |
|---------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <b>Rehabilitative Services</b>                                                  |                                     |                                                                                                               |
| Physical/Occupational Therapy                                                   | No charge after deductible          | 20 visits per Benefit Year<br>If received from a Chiropractor, see Chiropractor Care Services for cost share. |
| Speech Therapy                                                                  | No charge after deductible          | 20 visits per Benefit Year                                                                                    |
| Pulmonary Rehabilitation                                                        | No charge after deductible          | 20 visits per Benefit Year                                                                                    |
| Cardiac Rehabilitation Services                                                 | No charge after deductible          | 36 visits per Benefit Year                                                                                    |
| Manipulation Therapy                                                            | No charge after deductible          | 12 visits per Benefit Year<br>If received from a Chiropractor, see Chiropractor Care Services for cost share. |
| Post-Cochlear Implant Aural Therapy                                             | No charge after deductible          | Combined Limit with Speech Therapy                                                                            |
| Other Rehabilitative Services<br>Includes Chemotherapy, Dialysis, and Radiation | No charge after deductible          | Refer to your Evidence of Coverage                                                                            |
| <b>Chiropractor Care Services</b>                                               |                                     |                                                                                                               |
| X-Ray/Radiology                                                                 | No charge after deductible          | None                                                                                                          |
| Rehabilitative Services                                                         |                                     |                                                                                                               |
| Physical Therapy                                                                | No charge after deductible          | Limits for Physical Therapy and Manipulation apply                                                            |
| Manipulation Therapy                                                            | No charge after deductible          | Limits for Physical Therapy and Manipulation apply                                                            |
| Habilitation Services                                                           |                                     |                                                                                                               |
| Physical Therapy                                                                | No charge after deductible          | Limits for Physical Therapy and Manipulation apply                                                            |
| <b>Autism Spectrum Disorder Services</b>                                        |                                     |                                                                                                               |
| Physical/Occupational Therapy                                                   | No charge after deductible          | Combined limit with Habilitative Services                                                                     |
| Speech Therapy                                                                  | No charge after deductible          | Combined limit with Habilitative Services                                                                     |
| Adaptive Behavior Treatment                                                     | No charge after deductible          | Includes Applied Behavior Analysis (ABA)                                                                      |
| <b>Behavioral Health Services</b>                                               |                                     |                                                                                                               |
| Office Visits <sup>2</sup>                                                      | No charge after deductible          | None                                                                                                          |
| Outpatient Services <sup>1</sup>                                                |                                     |                                                                                                               |
| Intensive Outpatient Program (IOP) Services                                     | No charge after deductible          | None                                                                                                          |
| Partial Hospitalization Program (PHP) Services                                  | No charge after deductible          | None                                                                                                          |
| Residential Services                                                            | No charge after deductible          | None                                                                                                          |
| Opioid Treatment Program                                                        | No charge after deductible          | None                                                                                                          |
| Inpatient Services <sup>1</sup>                                                 | No charge after deductible          | None                                                                                                          |

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| Covered Service                                                                            | You Pay<br>(Network Providers Only)                                            | Limit<br>(If Applicable)                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Transplant Services</b>                                                                 | Covered the same as office visits, inpatient services, and outpatient services | 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><br>Private Duty Nursing                                                 | No charge after deductible                                                     | 100 visits per Benefit Year. A visit equals 8 hours.                                                                                                                                                                                                                                                 |
| Home Infusion Therapy                                                                      | No charge after deductible                                                     | None                                                                                                                                                                                                                                                                                                 |
| All Other Services                                                                         | No charge after deductible                                                     | 100 combined visits per Benefit Year. A visit equals at least 4 hours.                                                                                                                                                                                                                               |
| <b>Hospice Care</b>                                                                        | No charge after deductible                                                     | Refer to your Evidence of Coverage                                                                                                                                                                                                                                                                   |
| <b>Medical Supplies, Durable Medical Equipment, and Appliances</b><br>Appliances           | No charge after deductible                                                     | Refer to your Evidence of Coverage                                                                                                                                                                                                                                                                   |
| Durable Medical Equipment                                                                  | No charge after deductible                                                     | Refer to your Evidence of Coverage                                                                                                                                                                                                                                                                   |
| Medical Supplies                                                                           | No charge after deductible                                                     | Refer to your Evidence of Coverage                                                                                                                                                                                                                                                                   |
| Orthotic Device                                                                            | No charge after deductible                                                     | Refer to your Evidence of Coverage                                                                                                                                                                                                                                                                   |
| Prosthetics                                                                                | No charge after deductible                                                     | Refer to your Evidence of Coverage                                                                                                                                                                                                                                                                   |
| <b>\$0 Chronic Care Services</b><br>\$0 Chronic Care Medical Services                      | No charge                                                                      | Refer to <a href="https://www.caresource.com/INMPElite2026">caresource.com/INMPElite2026</a> for \$0 Chronic Care Medical Services, Drugs, and Self-Management Supplies                                                                                                                              |
| \$0 Chronic Care Drugs and \$0 Chronic Care Self-Management Supplies                       | No charge                                                                      |                                                                                                                                                                                                                                                                                                      |
| <b>Prescription Drugs</b><br>Preventive Drugs                                              | No charge                                                                      | Up to a 30-day supply for brand name drugs filled at Retail and Specialty Drugs<br><br>Up to a 90-day supply for all other Retail and Mail Order.<br><br>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. |
| Generic Drugs                                                                              | No charge after deductible                                                     |                                                                                                                                                                                                                                                                                                      |
| Preferred Brand Drugs                                                                      | No charge after deductible                                                     |                                                                                                                                                                                                                                                                                                      |
| Non-Preferred Brand Drugs                                                                  | No charge after deductible                                                     |                                                                                                                                                                                                                                                                                                      |
| Specialty Drugs                                                                            | No charge after deductible                                                     |                                                                                                                                                                                                                                                                                                      |
| <b>Vision</b> (pediatric)<br>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. Refer to your Evidence of Coverage for additional eyewear options that may have an additional charge.                                                           |

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| Covered Service                           | You Pay<br>(Network Providers Only)                      | Limit<br>(If Applicable)                            |
|-------------------------------------------|----------------------------------------------------------|-----------------------------------------------------|
| <b>Other Dental Services</b>              |                                                          |                                                     |
| Accidental Dental                         | No charge after deductible                               | \$3,000 per Member Per Injury All Services combined |
| Dental Anesthesia                         | No charge after deductible                               | Refer to your Evidence of Coverage                  |
| <b>Other Covered Services<sup>3</sup></b> |                                                          |                                                     |
| Allergy Testing                           | Covered the same as office visits or diagnostic services | None                                                |
| Allergy Injections                        | No charge after deductible                               | None                                                |
| Allergy Serum                             | No charge after deductible                               | None                                                |

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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](http://www.caresource.com/mp-IN-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.

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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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