Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	$30 copay	None
X-Ray/Radiology	30% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	30% coinsurance after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	30% coinsurance after deductible	None
Inpatient Services		
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
Outpatient Services		
Facility Fee	30% coinsurance after deductible	
Physician/Surgeon Fees	30% coinsurance after deductible	

Covered Service	You Pay	

Dependent Information

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

Learn more about CareSource and all our plan options at **www.caresource.com/marketplace.**