

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	25% coinsurance	None
X-Ray/Radiology	25% coinsurance	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	25% coinsurance	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	25% coinsurance	None
Inpatient Services		
Facility Fee	25% coinsurance	None
Physician/Surgeon Fees	25% coinsurance	1 visit per physician per day
Skilled Nursing Facility	25% coinsurance	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	25% coinsurance	None
Physician/Surgeon Fees	25% coinsurance	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$10 copay	None
Inpatient Services	25% coinsurance	None
Outpatient Services	25% coinsurance	None
Ambulance Services	25% coinsurance	Refer to your Evidence of Coverage
Emergency Health Care Services	25% coinsurance	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	No charge	20 visits per Benefit Year
Occupational Therapy	No charge	20 visits per Benefit Year
Speech Therapy	No charge	20 visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Manipulation Therapy		

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diabetic Services Education Equipment	25% coinsurance	Refer to your Evidence of Coverage

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]