rvices		
As defined by federal & state law	No charge	Refer to your Evidence of Coverage
Office Visits		
Zero Cost Telemedicine Partner	No charge	Refer to your Evidence of Coverage
Primary		
Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	No charge	None
Specialist	$15 copay	None
Urgent Care	$25 copay	None

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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	No charge	20 visits per Benefit Year
Occupational Therapy	No charge	20 visits per Benefit Year
Speech Therapy	10% coinsurance after deductible	20 visits per Benefit Year
Pulmonary Rehabilitation	10% coinsurance after deductible	20 visits per Benefit Year
Cardiac Rehabilitation Services	10% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	10% coinsurance after deductible	12 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	10% coinsurance after deductible	Combined Limit with Speech Therapy
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	10% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Services	$15 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical Therapy	No charge	Combined limit with Habilitative Services
Occupational Therapy	No charge	Combined limit with Habilitative Services
Speech Therapy	10% coinsurance after deductible	Combined limit with Habilitative Services
Adaptive Behavior Treatment	No charge	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	No charge	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	10% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	10% coinsurance after deductible	None
Residential Services	$200 copay after deductible per stay	
Opioid Treatment Program	10% coinsurance after deductible	
Inpatient Services	$300 copay after deductible per stay	
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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Private Duty Nursing	10% coinsurance after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	10% coinsurance after deductible	None
All Other Services	10% coinsurance after deductible	100 combined visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Dental (pediatric)		
Class I - Diagnostic/Preventive	No charge	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage
Class II - Minor Restorative	20% coinsurance after deductible	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	40% coinsurance after deductible	Refer to your Evidence of Coverage
Class IV - Orthodontics	50% coinsurance after deductible	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-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**.

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]

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