
Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	$10 copay	None
X-Ray/Radiology	$50 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	$100 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	$50 copay after deductible	None
Inpatient Services		
Facility Fee	$250 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	$150 copay after deductible per stay	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	15% coinsurance after deductible	None
Physician/Surgeon Fees	15% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$15 copay	None
Inpatient Services	$250 copay after deductible	None
Outpatient Services	15% coinsurance after deductible	None
Ambulance Services	15% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	$250 copay after deductible	If admitted to the hospital directly from the Emergency Department, these services will be covered the same as

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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	15% 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	45% coinsurance after deductible	Refer to your Evidence of Coverage

Prior Authorization:

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.**