2024 Schedule of Benefits

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 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	15% coinsurance after deductible	20 visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health Private Duty Nursing Home Infusi) Ho5e Infusi)		

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.**