
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	
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Covered Service	You Pay (Network Providers Only)	Limit

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Vision (adults)		
Eye Exam	No charge	1 routine eye exam per Benefit Year
Low Vision Testing and Aids	No charge	Limited to one evaluation and aid per Benefit Year.
Eyewear	No charge	1 pair of glasses/contacts per Benefit Year up to a $250 allowance
Other Dental Services		
Accidental Dental	15% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	15% coinsurance after deductible	Refer to your Evidence of Coverage
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
Dental (adults)		
Class I - Diagnostic/Preventive	No charge	Refer to your Evidence of Coverage. Benefit is limited to $1,000 per Benefit Year.
Class II - Minor Restorative	15% coinsurance	
Class III - Major/Comprehensive	40% coinsurance	
Class IV - Orthodontics	Not covered	
Fitness Program	No charge	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-KY-pa**.

This Schedule of Benefits is a summary of your financial responsibility when you receive health care services from a physic(nancuaa)-1(jor/Cofobtain yyoua-1(hE,)1(o)-gz1(r)4)]T

The No Surprises Act is meant to ensure you’re kept out of the middle of provider plan billing disputes for those specific services by prohibiting facilities and providers from pursuing payment from you for more than the in-network cost-sharing

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.**