2024 Schedule of Benefits

Covered Service		You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services	X-RaNoneadiologya	a a	a
Lab			
X-Ray/Radiology			
Adva	a		

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Private Duty Nursing	25% coinsurance after deductible	35 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	25% coinsurance after deductible	Included in all other services limits
All Other Services	25% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	25% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetic Services		
Education	25% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	25% coinsurance after deductible	Refer to your Evidence of Coverage
Supplies	25% coinsurance after deductible	Diabetic device cost share not to exceed $100 per 30-day supply in aggregate.
Medical Supplies, Durable Medical Equipment, and Appliances Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	25% coinsurance after deductible	Refer to your Evidence of Coverage
Prescription Drugs Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred)		

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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Other Dental Services		
Accidental Dental	25% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	25% 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	40% coinsurance after deductible	Refer to your Evidence of Coverage
Dental (adults)		Refer to your Evidence of Coverage. Benefit is limited to $1,000 per Benefit Year.
Class I - Diagnostic/Preventive	No charge	
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-WV-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 Foonal detail o-c

Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	