

2025 Schedule of Benefits

Plan Name: Diabetes Silver 250 \$0 Select Drugs & Specialized Services
Adult Vision & Fitness



Plan Information

| | |
|---------------------------|--------------|
| Primary Member | [John Doe] |
| Member ID | [104000000] |
| Date of Birth | [01/01/1965] |
| Effective Date | [01/01/2025] |
| Last Coverage Change Date | [01/01/2024] |

[Dependent information can be found at the end of this document.]

Highlights

| | |
|--|--------------------------------------|
| Annual Deductible* | Individual: \$250 Family: \$500 |
| Coinsurance | 15% |
| Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays) | Individual: \$800 Family: \$1,600 |



* Deductible: The individual Deductible applies to each covered family member. No one person can contribute more than the individual Deductible amount. Once two or more covered family members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Calendar Year.

** Out-of-Pocket Maximum: The individual Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year.

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|-------------------------------------|------------------------------------|
| Preventive Services As defined by federal & state law | No charge | Refer to your Evidence of Coverage |
| Office Visits Zero Cost Telehealth Partner | No charge | Refer to your Evidence of Coverage |
| Primary Includes Primary Care Provider, Behavioral Health/Substance Use Disorder, Psychiatrist, and Retail Clinics | No charge | None |
| Specialist | \$10 copay | None |
| Urgent Care | \$15 copay | None |

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| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|--|---|--|
| Diagnostic Services | | |
| Lab | \$30 copay | None |
| X-Ray/Radiology | \$125 copay after deductible | None |
| Advanced Imaging (PET, MRI, MRA, CT, SPECT) | \$175 copay after deductible | None |
| Mammograms (Outpatient) | | |
| Preventive | No charge | Refer to your Evidence of Coverage |
| Diagnostic | No charge | None |
| Inpatient Services | | |
| Facility Fee | \$150 copay after deductible per stay | None |
| Physician/Surgeon Fees | No charge after deductible | 1 visit per physician per day |
| Skilled Nursing Facility | 15% coinsurance after deductible | 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 | \$10 copay | None |
| Inpatient Services | \$150 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 | \$150 copay after deductible which also applies to out-of-network providers | 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 | 25 visits per Benefit Year |
| Occupational Therapy | No charge | 25 visits per Benefit Year |
| Speech Therapy | No charge | 25 visits per Benefit Year |
| | | Visit limits do not apply to Behavioral Health/Substance Use Disorder services |

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| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|--|--|
| Rehabilitative Services Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Manipulation Therapy Post-Cochlear Implant Aural Therapy Cognitive Rehabilitation Therapy Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation | No charge No charge No charge 15% coinsurance after deductible 15% coinsurance after deductible 15% coinsurance after deductible No charge 15% coinsurance after deductible 15% coinsurance after deductible | 25 visits per Benefit Year 25 visits per Benefit Year 25 visits per Benefit Year 25 visits per Benefit Year 36 visits per Benefit Year 20 visits per Benefit Year 30 visits per Benefit Year 20 visits per Benefit Year Refer to your Evidence of Coverage |
| Chiropractor Services | No charge | Limits for Physical Therapy and Manipulation apply |
| Autism Spectrum Disorder Services Physical Therapy Occupational Therapy Speech Therapy Adaptive Behavior Treatment | No charge No charge No charge No charge | None None None Includes Applied Behavior Analysis (ABA) |
| Behavioral Health Services Office Visits Outpatient Services Intensive Outpatient Program (IOP) Services Partial Hospitalization Program (PHP) Services Residential Services Opioid Treatment Program Inpatient Services | No charge 15% coinsurance after deductible 15% coinsurance after deductible 15% coinsurance after deductible 15% coinsurance after deductible \$150 copay after deductible per stay | None |
| 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 |

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| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|--|---|
| Home Health Private Duty Nursing Home Infusion Therapy All Other Services | 15% coinsurance after deductible 15% coinsurance after deductible 15% coinsurance after deductible | 250 visits per Benefit Year. A visit equals 8 hours. None 100 combined visits per Benefit Year. A visit equals at least 4 hours. |
| Hospice Care | No charge for in-network and out-of-network by Medicare approved providers | Refer to your Evidence of Coverage |
| Medical Supplies, Durable Medical Equipment, and Appliances Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics | 15% coinsurance after deductible | Refer to your Evidence of Coverage |
| Diabetes Plan Services Select Diabetic Drugs Select Diabetic Supplies Specialized Medical Services | No charge | Refer to caresource.com/KYMPElite2025 for Select Drugs, Supplies, and Specialized Medical Services |
| Hearing Aids | 15% coinsurance after deductible | 1 hearing aid per hearing-impaired ear every 36 months |
| Prescription Drugs Tier 0 (Preventive) Tier 1 (Low Cost) Tier 2 (Preferred) Tier 3 (Non-Preferred) Tier 4 (Specialty) | No charge No charge Up to \$25 copay 30% coinsurance after deductible 40% coinsurance after deductible | Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for drugs in Tiers 0-3 All others limited to a 30-day supply Any copays shown are for a 30-day supply. 90-day supplies are 3 times the copay. Insulin cost share not to exceed \$30 per 30-day supply in aggregate. |
| Vision (pediatric) Children's Eye Exam Low Vision Testing and Aids Children's Eyewear | No charge No charge No charge | 1 routine eye exam per Benefit Year Limited to one evaluation and aid per Benefit Year. Limited to one pair of glasses or a 12-month supply of contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed. Refer to your Evidence of Coverage for additional eyewear options that may have an additional charge. |

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| 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 |
| 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 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.

No Surprises Act: The No Surprises Act requires CareSource & Providers to hold patients harmless from surprise medical bills stemming from out-of-network emergency care, out of network air ambulance, and services provided by out-of-network providers at in-network facilities without the patient's informed consent or for certain ancillary services. Services subject to the No Surprises Act will have the same cost share requirements as Network Services, as listed in the above "You Pay" column, applied to the amount we initially determine to pay (also known as the Recognized Amount). These amounts will count towards your deductible and out of pocket maximum in similar fashion if they had been delivered by Network Providers.

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 amount as based on the Recognized Amount in most situations. One situation where you may still be involved is regarding non-emergency services provided by a non-network provider while you are in a network facility. The No Surprises Act prohibits these providers from balance billing you unless the provider gives you notice of their network status and an estimate of charges 72 hours prior to receiving the services, or same day as the appointment if scheduled less than 72 hours in advance. If you receive this notice and then consent to continue to receive the out-of-network care, the provider will be allowed to pursue payment from you for any amounts that we do not cover, otherwise known as balance billing.

See your Evidence of Coverage for further details.

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Dependent Information

| | |
|---------------------|--------------|
| Dependent Name | [John Doe] |
| Relationship to You | [104000000] |
| Date of Birth | [01/01/1965] |
| Effective Date | [01/01/2025] |

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