2025 Schedule of Benefits
Plan Name: Platinum Limited Zero $5 Generic Drugs

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: $0 Family: $0
Coinsurance	0%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $4,300 Family: $8,600

* 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 and Mental Health/Substance Abuse	$10 copay	None
Specialist	$20 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	$30 copay	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	$100 copay	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	$30 copay	None
Inpatient Services		
Facility Fee	$350 copay per stay	None
Physician/Surgeon Fees	No charge	1 visit per physician per day
Skilled Nursing Facility	$150 copay per stay	None
Outpatient Services		
Facility Fee	$150 copay	None
Physician/Surgeon Fees	$150 copay	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$20 copay	None
Inpatient Services	$350 copay	None
Outpatient Services	$150 copay	None
Ambulance Services	No charge after deductible	None
Emergency Health Care Services	$100 copay	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	$10 copay	30 visits per Benefit Year
Occupational Therapy	$10 copay	30 visits per Benefit Year
Speech Therapy	$10 copay	None
Manipulation Therapy	No charge after deductible	30 visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$10 copay	30 visits per Benefit Year
Occupational Therapy	$10 copay	30 visits per Benefit Year
Speech Therapy	$10 copay	None
Pulmonary Rehabilitation	No charge after deductible	30 visits per Benefit Year
Cardiac Rehabilitation Services	No charge after deductible	36 visits per Benefit Year
Manipulation Therapy	No charge after deductible	30 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	$10 copay	None
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	No charge after deductible	Refer to your Evidence of Coverage
Chiropractor Services	$20 copay	Limits for Physical Therapy and Manipulation apply
Chronic Pain Treatment		
Physical Therapy	$10 copay	20 combined visits per event, in addition to any Rehabilitative and Habilitative visits
Occupational Therapy	$10 copay	
Chronic Pain Management Program	$10 copay	
Chiropractic/Osteopathic Manipulation Services	$10 copay	
Autism Spectrum Disorder Services		
Physical Therapy	$10 copay	Combined limit with Habilitative Services
Occupational Therapy	$10 copay	Combined limit with Habilitative Services
Speech Therapy	$10 copay	Combined limit with Habilitative Services
Adaptive Behavior Treatment	$10 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	$10 copay	None
Outpatient Services		
Intensive Outpatient Program (IOP) Services	$150 copay	
Partial Hospitalization Program (PHP) Services	$150 copay	
Residential Services	$150 copay per stay	
Opioid Treatment Program	No charge after deductible	
Inpatient Services	$350 copay per stay	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
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
Home Health		
Private Duty Nursing	No charge after deductible	35 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	No charge after deductible	Included in all other services limits
All Other Services	No charge after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	No charge after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	No charge after deductible	Refer to your Evidence of Coverage
Durable Medical Equipment		
Medical Supplies		
Orthotic Device		
Prosthetics		
Prescription Drugs		
Tier 0 (Preventive)	No charge	Up to a 90-day supply when filled at: Retail or 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 $35 per 30-day supply in aggregate.
Tier 1 (Low Cost)	Up to $5 copay	
Tier 2 (Preferred)	Up to $10 copay	
Tier 3 (Non-Preferred)	Up to $50 copay	
Tier 4 (Specialty)	Up to $150 copay	
Vision (pediatric)		
Children's 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.
Children's Eyewear	No charge	Limited to one pair of glasses or 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.
Other Dental Services		
Accidental Dental	No charge after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	No charge after deductible	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 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.

The copays and coinsurance listed in the 'You Pay' column would only apply if the item or service is not furnished directly by a provider meeting the criteria outlined below, otherwise there would be no cost to you.

1) an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603);
2) a provider who was referred by one of the organizations listed in item 1.

You may view the Access Plan required by Health Benefit Plan Network Access and Adequacy Act online at [CareSource.com]. You may also contact us at 1-855-202-0622 to request a copy.

Dependent Information

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