2025 Schedule of Benefits
Plan Name: Core Silver 1000 $2 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: $1,000 Family: $2,000
Coinsurance	20%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $3,000 Family: $6,000

This summary shows in-network benefits only.

* 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	$10 copay	None
Specialist	$35 copay	None
Urgent Care	$25 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	$15 copay	None
X-Ray/Radiology	$150 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	$200 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	No charge	None
Inpatient Services		
Facility Fee	$325 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	$250 copay after deductible per stay	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	20% coinsurance after deductible	None
Physician/Surgeon Fees	20% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$35 copay	None
Inpatient Services	$325 copay after deductible	None
Outpatient Services	20% coinsurance after deductible	None
Ambulance Services	20% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	$325 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	$10 copay	25 visits per Benefit Year
Occupational Therapy	$10 copay	25 visits per Benefit Year
Speech Therapy	$10 copay	25 visits per Benefit Year
		Visit limits do not apply to Behavioral Health/Substance Use Disorder services

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$10 copay	25 visits per Benefit Year
Occupational Therapy	$10 copay	25 visits per Benefit Year
Speech Therapy	$10 copay	25 visits per Benefit Year
Pulmonary Rehabilitation	20% coinsurance after deductible	25 visits per Benefit Year
Cardiac Rehabilitation Services	20% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	20% coinsurance after deductible	20 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	$10 copay	30 visits per Benefit Year
Cognitive Rehabilitation Therapy	20% coinsurance after deductible	20 visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	20% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Services	$10 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical Therapy	$10 copay	None
Occupational Therapy	$10 copay	None
Speech Therapy	$10 copay	None
Adaptive Behavior Treatment	$10 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	$10 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	20% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	20% coinsurance after deductible	None
Residential Services	$250 copay after deductible per stay	
Opioid Treatment Program	20% coinsurance after deductible	
Inpatient Services	$325 copay after deductible per stay	
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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Private Duty Nursing	20% coinsurance after deductible	250 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	20% coinsurance after deductible	None
All Other Services	20% coinsurance after deductible	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	20% coinsurance after deductible	Refer to your Evidence of Coverage
Hearing Aids	20% coinsurance after deductible	1 hearing aid per hearing-impaired ear every 36 months
Prescription Drugs		
Tier 0 (Preventive)	No charge	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.
Tier 1 (Low Cost)	Up to $2 copay	
Tier 2 (Preferred)	Up to $40 copay	
Tier 3 (Non-Preferred)	40% coinsurance after deductible	
Tier 4 (Specialty)	45% coinsurance after deductible	
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 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.
Other Dental Services		
Accidental Dental	20% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	20% coinsurance 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-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.

Dependent Information

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