Plan Name: CareSource Marketplace Essential Silver

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2023]
Last Coverage Change Date	[01/01/2022]

Annual Deductible*	Individual: $6,150 Family: $12,300
Coinsurance	0%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $6,150 Family: $12,300

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $6,150 of Covered Services each Benefit Year before CareSource begins to pay for any covered service where the Annual Deductible applies. For family coverage, you are responsible for paying the first $12,300 for Covered Services for your entire family each Benefit Year before CareSource begins to pay for any covered service where the Annual Deductible applies. However, for each individual covered member within your family, the maximum amount each member would pay toward the family Deductible is the individual Deductible amount, in this case $6,150 up to the family maximum of $12,300. The Annual Deductible applies to Covered Services identified as “after deductible” in the Covered Service table below.

** See Section 2: Evidence of Coverage for the Definition of Annual Out-of-Pocket Maximum. For family coverage, each individual covered member within your family is contributing toward the family Annual Out-of-Pocket Maximum. However, for each individual covered member within your family, the maximum amount each member would pay toward the family Annual Out-of-Pocket Maximum is the individual Out-of-Pocket Maximum, which is $6,150. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

	(Network Providers Only)	(If Applicable)
As defined by federal & state law	No charge	Refer to your Evidence of Coverage
Zero Cost Telemedicine Partner	No charge	Refer to your Evidence of Coverage
Primary		
Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	$0 for first three visits then no charge after deductible	None
Specialist	No charge after deductible	None
	No charge after deductible	None

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	(Network Providers Only)	(If Applicable)
Lab	No charge after deductible	None
X-Ray/Radiology	No charge after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	No charge after deductible	None
(Outpatient) Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	No charge after deductible	None
Facility Fee	No charge after deductible	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	No charge after deductible	90 Day limit per Benefit Year
Facility Fee	No charge after deductible	None
Physician/Surgeon Fees	No charge after deductible	None
Prenatal Visit, Office Visits, and Postpartum Care	No charge after deductible	None
Inpatient Services	No charge after deductible	None
Outpatient Services	No charge after deductible	None
	No charge after deductible	Refer to your Evidence of Coverage
	No charge after deductible	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.
Physical Therapy	$0 for first three visits then no charge after deductible	20 visits per Benefit Year
Occupational Therapy	$0 for first three visits then no charge after deductible	20 visits per Benefit Year
Speech Therapy	No charge after deductible	20 visits per Benefit Year

Physical Therapy

Occupational Therapy

Speech Therapy

Pulmonary Rehabilitation

Cardiac Rehabilitation Services

Manipulation Therapy

Private Duty Nursing	No charge after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	No charge after deductible	None
All Other Services	No charge after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
	No charge after deductible	Refer to your Evidence of Coverage

Education

Equipment

Supplies

(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	25% coinsurance after deductible	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	45% coinsurance after deductible	Refer to your Evidence of Coverage
Class IV - Orthodontics	55% coinsurance after deductible	Refer to your Evidence of Coverage

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2023]

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