Plan Name: CareSource Marketplace Low Premium 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: $6,500 Family: $13,000
Coinsurance	50%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $9,100 Family: $18,200

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $6,500 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 $13,000 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 $6,500 up to the family maximum of $13,000. 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 $9,100. 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	$30 copay	None
Specialist	$70 copay	None
	$50 copay	None

Learn more about CareSource and all our plan options at

	(Network Providers Only)	(If Applicable)
Private Duty Nursing	50% coinsurance after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	50% coinsurance after deductible	None
All Other Services	50% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
	50% coinsurance after dedur	

	(Network Providers Only)	(If Applicable)
(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	30% coinsurance after deductible	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	50% coinsurance after deductible	Refer to your Evidence of Coverage
Class IV - Orthodontics	55% coinsurance after deductible	Refer to your Evidence of Coverage

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 .

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