2023 Schedule of Benefits
Plan Name: CareSource Marketplace Standard Silver 1 Dental, Vision, & Fitness

Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	

Specialist	$80 copay	
Clinics		
Health/Substance Abuse, and Rehab		
Includes Primary Care Provider, Mental	$30 copay	
Primary		
Zero Cost Telemedicine Partner	No charge	
Office Visits		
As defined by federal & state law	No charge	Refer to your Evidence of Coverage
Preventive Services		

Coverage explains which benefits accrue to your 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 $7,500. Your Evidence of
individual covered member within your family is contributing toward the family Annual Out-of-Pocket Maximum.
** See Section 5: Evidence of Coverage for the Definition of Annual Out-of-Pocket Maximum. For family coverage, each

"after deductible" in the Covered Service table below.
case $2,700 up to the family maximum of $11,400. The Annual Deductible applies to Covered Services identified as
maximum amount each member would pay toward the family Deductible is the individual Deductible amount, in this
service where the Annual Deductible applies. However, for each individual covered member within your family, the
$11,400 for Covered Services for your entire family each Benefit Year before CareSource begins to pay for any covered
any covered service where the Annual Deductible applies. For family coverage, you are responsible for paying the first
are responsible for paying the first $2,700 of Covered Services each Benefit Year before CareSource begins to pay for
* See Section 5: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you

Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $7,500 Family: $14,400

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	40% coinsurance after deductible	
X-Ray/Radiology	40% coinsurance after deductible	
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	40% coinsurance after deductible	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health Private Duty Nursing Home Infusion Therapy All Other Services		

Dependent Information

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

Learn more about CareSource and all our plan options at www.caresource.com/marketplace .