Plan Name: CareSource Marketplace Standard Silver 2

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: $800 Family: $1,600
Coinsurance	30%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $3,000 Family: $6,000

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $800 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 $1,600 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 $800 up to the family maximum of $1,600. 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 $3,000. 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	$20 copay	None
Specialist	$40 copay	None
	$30 copay	None

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	(Network Providers Only)	(If Applicable)
Lab	30% coinsurance after deductible	None
X-Ray/Radiology	30% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	30% coinsurance after deductible	None
(Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	30% coinsurance after deductible	None
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	1 visit per physician per day
Skilled Nursing Facility	30% coinsurance after deductible	90 Day limit per Benefit Year
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	None
Prenatal Visit, Office Visits, and Postpartum Care	$40 copay	None
Inpatient Services	30% coinsurance after deductible	None
Outpatient Services	30% coinsurance after deductible	None
	30% coinsurance after deductible	Refer to your Evidence of Coverage
	30% coinsurance 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	$20 copay	20 visits per Benefit Year
Occupational Therapy	$20 copay	20 visits per Benefit Year
Speech Therapy	$20 copay	20 visits per Benefit Year

	(Network Providers Only)	(If Applicable)
Private Duty Nursing	30% coinsurance after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	30% coinsurance after deductible	None
All Other Services	30% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
	30% coinsurance after deductible	Refer to your Evidence of Coverage
Education Equipment Supplies		
Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	30% coinsurance after deductible	Refer to your Evidence of Coverage
(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.

(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	20% coinsurance after deductible	Refer to your Evidence of Coverage
Class III - Major/Comprehensive	40% coinsurance after deductible	Refer to your Evidence of Coverage
Class IV - Orthodontics	50% 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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