Plan Name: CareSource Marketplace Standard 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: $5,800 Family: $11,600
Coinsurance	40%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $8,900 Family: $17,800

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $5,800 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 $11,600 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 $5,800 up to the family maximum of $11,600. 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 $8,900. 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	$40 copay	None
Specialist	$80 copay	None
	$60 copay	None

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	(Network Providers Only)	(If Applicable)
Physical Therapy	$40 copay	20 visits per Benefit Year
Occupational Therapy	$40 copay	20 visits per Benefit Year
Speech Therapy	$40 copay	20 visits per Benefit Year
Pulmonary Rehabilitation	40% coinsurance after deductible	20 visits per Benefit Year
Cardiac Rehabilitation Services	40% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	40% coinsurance after deductible	12 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	$40 copay	Combined Limit with Speech Therapy
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	40% coinsurance after deductible	Refer to your Evidence of Coverage
Physical Therapy	$40 copay	Combined limit with Habilitative Services
Occupational Therapy	$40 copay	Combined limit with Habilitative Services
Speech Therapy	$40 copay	Combined limit with Habilitative Services
Adaptive Behavior Treatment	$40 copay	Includes Applied Behavior Analysis (ABA)
Office Visits	$40 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	40% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	40% coinsurance after deductible	None
Residential Services	40% coinsurance after deductible	
Opioid Treatment Program	40% coinsurance after deductible	
Inpatient Services	40% coinsurance after deductible	
	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
	Covered the same as office visits, inpatient services, and outpatient services	None

	(Network Providers Only)	(Non-Network Providers)
Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	40% coinsurance after deductible	Refer to your Evidence of Coverage
(pediatric) Children's Eye Exam Low Vision Testing and Aids Children's Eyewear	 No charge No charge No charge	 1 routine eye exam per Benefit Year Limited to one evaluation and aid per Benefit Year. Limited to one pair of glasses or contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed.

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

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