

2023 Schedule of Benefits

Plan Name: CareSource Marketplace Bronze



Plan Information

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]

[Dependent information can be found at the end of this document.]

Highlights

Annual Deductible*	Individual: \$9,100 Family: \$18,200
Coinsurance	



Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services Lab X-Ray/Radiology Advanced Imaging (PET, MRI, MRA, CT, SPECT)	No charge after deductible No charge after deductible No charge after deductible	None None None
Mammograms (Outpatient) Preventive Diagnostic	No charge No charge after deductible	Refer to your Evidence of Coverage None
Inpatient Services Facility Fee Physician/Surgeon Fees Skilled Nursing Facility	No charge after deductible No charge after deductible No charge after deductible	None 1 visit per physician per day 90 Day limit per Benefit Year



Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Speech ThePulmon m0 255..5 762TJ3.961 -1.15 cm0 0 2161herapy		





Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Dental (pediatric) Class I – Diagnostic/Preventive Class II – Minor Restorative Class III - Major/Comprehensive Class IV - Orthodontics	No charge No charge after deductible for all services No charge after deductible No charge after deductible for all services	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage Refer to your Evidence of Coverage Refer to your Evidence of Coverage Refer to your Evidence of Coverage

Prior Authorization: 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 [addit and ctems ry.\]TJ0not/10\(age r0\)5ihealonalh0eingSerln\(\)10\(-26.05iet15ivt15iet15ine15it \)25\(1\(ove0\(ty \)5ioied e\)1\(e\)ancyov](#)



Dependent Information

Dependent Name	

