Covered Service	You Pay (Network Providers Only)	Limit (If Applicisg810 1.237150m0

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$0 for first three visits then no charge after deductible	20 visits per Benefit Year
Occupational Therapy	$0 for first three visits then no charge after deductible	20 visits per Benefit Year
Speech Therapy	No charge after deductible	20 visits per Benefit Year
Pulmonary Rehabilitation	No charge after deductible	20 visits per Benefit Year
Cardiac Rehabilitation Services	No charge after deductible	36 visits per Benefit Year
Manipulation Therapy	No charge after deductible	12 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	No charge after deductible	Combined Limit with Speech Therapy
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	No charge after deductible	Refer to your Evidence of Coverage
Chiropractor Services	No charge after deductible	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical Therapy	$0 for first three visits then no charge after deductible	Combined limit with Habilitative Services
Occupational Therapy	$0 for first three visits then no charge after deductible	Combined limit with Habilitative Services
Speech Therapy	No charge after deductible	Combined limit with Habilitative Services
Adaptive Behavior Treatment	$0 for first three visits then no charge after deductible	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	$0 for first three visits then no charge after deductible	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	No charge after deductible	
Partial Hospitalization Program (PHP) Services	No charge after deductible	None
Residential Services	No charge after deductible	
Opioid Treatment Program	No charge after deductible	
Inpatient Services	No charge after deductible	
Transplant Services	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services, and outpatient services	None

Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2024]

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