2024 Schedule of Benefits
Plan Name: CareSource Marketplace Silver 2

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
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
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	30% coinsurance after deductible	None
Inpatient Services		
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
Outpatient Services		
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$40 copay	None
Inpatient Services	30% coinsurance after deductible	None
Outpatient Services	30% coinsurance after deductible	None
Ambulance Services	30% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	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.
Habilitative Services		
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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
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
Pulmonary Rehabilitation	30% coinsurance after deductible	20 visits per Benefit Year
Cardiac Rehabilitation Services	30% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	30% coinsurance after deductible	12 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	$20 copay	Combined Limit with Speech Therapy
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	30% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Services	$40 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical Therapy	$20 copay	Combined limit with Habilitative Services
Occupational Therapy	$20 copay	Combined limit with Habilitative Services
Speech Therapy	$20 copay	Combined limit with Habilitative Services
Adaptive Behavior Treatment	$20 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	$20 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	30% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	30% coinsurance after deductible	None
Residential Services	30% coinsurance after deductible	
Opioid Treatment Program	30% coinsurance after deductible	
Inpatient Services	30% coinsurance 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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
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.
Hospice Care	30% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetic Services		
Education	30% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	30% coinsurance after deductible	Refer to your Evidence of Coverage
Supplies	30% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances		
Durable Medical Equipment		
Medical Supplies	30% coinsurance after deductible	Refer to your Evidence of Coverage
Orthotic Device		
Prosthetics		
Prescription Drugs		
Tier 0 (Preventive)	No charge	Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for drugs in Tiers 0-3
Tier 1 (Low Cost)	Up to $10 copay	
Tier 2 (Preferred)	Up to $20 copay	All others limited to a 30-day supply
Tier 3 (Non-Preferred)	Up to $60 copay after deductible	Any copays shown are for a 30-day supply. 90-day supplies for Retail are 3 times the copay and for Mail Order are 2.5 times the copay.
Tier 4 (Specialty)	Up to $250 copay after deductible	
Vision (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.
Other Dental Services		
Accidental Dental	30% coinsurance after deductible	$3,000 per tn38049 r ctible
Dental Anesthesia	30% coinsurance after deductible	

Dependent Information
