2024 Schedule of Benefits
Plan Name: CareSource Marketplace Low Premium Silver 2

Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2024]
Last Coverage Change Date	[01/01/2023]

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

Highlights

Annual Deductible*	Individual: $1,000 Family: $2,000
Coinsurance	20%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $2,700 Family: $5,400

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $1,000 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 $2,000 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 $1,000 up to the family maximum of $2,000. 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 $2,700. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

Covered Service	You Pay (Network Providers Only)	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services Lab X-Ray/Radiology Advanced Imaging (PET,		

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$5 copay	20 visits per Benefit Year
Occupational Therapy	$5 copay	20 visits per Benefit Year
Speech Therapy	20% coinsurance after deductible	20 visits per Benefit Year
Pulmonary Rehabilitation	20% coinsurance after deductible	20 visits per Benefit Year
Cardiac Rehabilitation Services	20% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	20% coinsurance after deductible	12 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	20% coinsurance after deductible	Combined Limit with Speech Therapy
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	20% 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	$5 copay	Combined limit with Habilitative Services
Occupational Therapy	$5 copay	Combined limit with Habilitative Services
Speech Therapy	20% coinsurance after deductible	Combined limit with Habilitative Services
Adaptive Behavior Treatment	$5 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	$5 copay	None
Outpatient Services		
Intensive Outpatient Program (IOP) Services	20% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	20% coinsurance after deductible	
Residential Services	$300 copay after deductible per stay	
Opioid Treatment Program	20% coinsurance after deductible	
Inpatient Services	$350 copay after deductible per stay	
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

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

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Private Duty Nursing	20% coinsurance after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	20% coinsurance after deductible	None
All Other Services	20% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	20% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetic Services		
Education	20% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	20% coinsurance after deductible	Refer to your Evidence of Coverage
Supplies	20% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equip ment, and Appliances Appliances Durable Medical Equipment Medical Supplies Orthotic Device Prosthetics	20% coinsurance after deductible	Refer to your Evidence of Coverage
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 $2 copay	
Tier 2 (Preferred)	Up to $40 copay	All others limited to a 30-day supply
Tier 3 (Non-Preferred)	40% coinsurance 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)	45% coinsurance 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	20% coinsurance after deductible	$3,000 per Member Per Injury All Services combined
Dental Anesthesia	20% coinsurance after deductible	Refer to your Evidence of Coverage

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Dental (pediatric) Class I - Diagnostic/Preventive Class II - Minor Restorative Class III - Major/Comprehensive		

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 .