2024 Schedule of Benefits
Plan Name: CareSource Marketplace Core Silver 1

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: $5,700 Family: $11,400
Coinsurance	40%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $7,500 Family: $15,000

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $5,700 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 $11,400 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 $5,700 up to the family maximum of $11,400. 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 $7,500. Your Evidence of Coverage explains which benefits accrue to your Out-of-Pocket Maximum.

Covered Service	**You Pay** (Network Providers Only)	**Limit** (If Applicable)
Preventive Services As defined by federal & state law	No charge	Refer to your Evidence of Coverage
Office Visits Zero Cost Telemedicine Partner	No charge	Refer to your Evidence of Coverage
Primary		
Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	$30 copay	None
Specialist	$70 copay	None
Urgent Care	$50 copay	None

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$30 copay	20 visits per Benefit Year
Occupational Therapy	$30 copay	20 visits per Benefit Year
Speech Therapy	40% coinsurance after deductible	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% coinsurance after deductible	Combined Limit with Speech Therapy
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	40% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Services	$70 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical Therapy	$30 copay	Combined limit with Habilitative Services
Occupational Therapy	$30 copay	Combined limit with Habilitative Services
Speech Therapy	40% coinsurance after deductible	Combined limit with Habilitative Services
Adaptive Behavior Treatment	$30 copay	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	$30 copay	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	40% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	40% coinsurance after deductible	
Residential Services	$400 copay after deductible per stay	
Opioid Treatment Program	40% coinsurance after deductible	
Inpatient Services		

Dependent Information

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