

2024 Schedule of Benefits

Plan Name: CareSource Marketplace Core Silver 2 Dental, Vision, & Fitness



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: \$900 Family: \$1800
Coinsurance	20%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$2800 Family: \$5600




Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	\$15 copay	None
X-Ray/Radiology	\$150 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	\$200 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	\$150 copay after deductible	None
Inpatient Services		
Facility Fee	\$325 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	\$250 copay after deductible per stay	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	20% coinsurance after deductible	None
Physician/Surgeon Fees	20% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	\$35 copay	None
Inpatient Services	\$325 copay after deductible	None
Outpatient Services	20% coinsurance after deductible	None
Ambulance Services	20% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	\$325 copay 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	\$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

Learn more about CareSource and all our plan options at [www.caresource.com/marketplace](http://www.caresource.com/marketplace).

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services Manipulation Therapy Post-Cochlear Implant Aural Therapy Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	\$5 copay \$5 copay 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible	20 visits per Benefit Year 20 visits per Benefit Year 20 visits per Benefit Year 20 visits per Benefit Year 36 visits per Benefit Year 12 visits per Benefit Year Combined Limit with Speech Therapy Refer to your Evidence of Coverage
Chiropractor Services		







### Dependent Information

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

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