2024 Schedule of Benefits
Plan Name: CareSource Marketplace Core Silver

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: $6,000 Family: $12,000
Coinsurance	40%
Annual Out-of-Pocket Maximum** (incnp*	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services Physical Therapy Occupational Therapy Speech Therapy Pulmonary Rehabilitation Cardiac Rehabilitation Services		

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Private Duty Nursing	40% coinsurance after deductible	100 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	40% coinsurance after deductible	None
All Other Services	40% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	40% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetic Services		
Education	40% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	40% coinsurance after deductible	Refer to your Evidence of Coverage
Supplies	40% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances		
Durable Medical Equipment		
Medical Supplies	40% 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 $3 copay	
Tier 2 (Preferred)	Up to $70 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)	50% 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	40% coinsurance after deductible	$3,000 per Member Per Injury All Services combined
Dental Anesthesia	40% coinsurance after deductible	Refer to your Evidence of Coverage

Dependent Information

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