2024 Schedule of Benefits

Plan Name: CareSource Marketplace Diabetes Silver 3 Dental, Vision, & Fitness

Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services Lab X-Ray/Radiology	$30 copay	None

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	No charge	25 visits per Benefit Year
Occupational Therapy	No charge	25 visits per Benefit Year
Speech Therapy	15% coinsurance after deductible	25 visits per Benefit Year
Pulmonary Rehabilitation	15% coinsurance after deductible	25 visits per Benefit Year
Cardiac Rehabilitation Services	15% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	15% coinsurance after deductible	20 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	15% coinsurance after deductible	30 visits per Benefit Year
Cognitive Rehabilitation Therapy	15% coinsurance after deductible	20 visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	15% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Services	No charge	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical Therapy	No charge	None
Occupational Therapy	No charge	None
Speech Therapy	15% coinsurance after deductible	None
Adaptive Behavior Treatment	No charge	Includes Applied Behavior Analysis (ABA)
Behavioral Health Services		
Office Visits	No charge	
Outpatient Services		
Intensive Outpatient Program (IOP) Services	15% coinsurance after deductible	
Partial Hospitalization Program (PHP) Services	15% coinsurance after deductible	None
Residential Services	15% coinsurance after deductible	
Opioid Treatment Program	15% coinsurance after deductible	
Inpatient Services	$150 copay after deductible per stay	
Transplant Services	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Private Duty Nursing	15% coinsurance after deductible	250 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	15% coinsurance after deductible	None
All Other Services	15% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	No charge for in-network and out-of-network by Medicare approved providers	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Vision (adults) Eye Exam	No charge	1 routine eye exam per Benefit Year
Low Vision Testing and Aids	No charge	Limited to one

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.**