2024 Schedule of Benefits
Plan Name: CareSource Marketplace Diabetes 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: $3,500 Family: $7,000
Coinsurance	50%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $9,450 Family: $18,900

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $3,500 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 $7,000 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 $3,500 up to the family maximum of $7,000. 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 $9,450. 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 Telehealth Partner Primary Includes Primary Care Provider, Behavioral Health/Substance Use	No charge	Refer to your Evidence of Coverage

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	$75 copay	None
X-Ray/Radiology	$250 copay after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	$300 copay after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	$250 copay after deductible	None
Inpatient Services		
Facility Fee	$600 copay after deductible per stay	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	50% coinsurance after deductible	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	50% coinsurance after deductible	None
Physician/Surgeon Fees	50% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$80 copay	None
Inpatient Services	$600 copay after deductible	None
Outpatient Services	50% coinsurance after deductible	None
Ambulance Services	50% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	$600 copay after deductible which also applies to out-of-network providers	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	$35 copay	25 visits per Benefit Year
Occupational Therapy	$35 copay	25 visits per Benefit Year

Covered Service	You Pay (Network Prov0Dg1rs Only)ice	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Private Duty Nursing	50% coinsurance after deductible	250 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	50% coinsurance after deductible	None
All Other Services	50% 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	Refer to your Evidence of Coverage
Diabetic Services		
Education	50% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	50% coinsurance after deductible	Refer to your Evidence of Coverage
Preferred Diabetic Drugs and Supplies	No charge	Refer to your Evidence of Coverage

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deductible

Dependent Information

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