2024 Schedule of Benefits
Plan Name: CareSource Marketplace 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: $5,900 Family: $11,800
Coinsurance	40%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $9,100 Family: $18,200

* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first $5,900 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 $11,800 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 $5,900 up to the family maximum of $11,800. 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 $9,100. 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	No charge	Refer to your Evidence of Coverage
Primary		
Includes Primary Care Provider, Behavioral Health/Substance Use Disorder, Psychiatrist, and Retail Clinics	$40 copay	None
Specialist	$80 copay	None
Urgent Care	$60 copay	None

Learn more about CareSource and all our plan options at **www.caresource.com/marketplace.**

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	40% coinsurance after deductible	None
X-Ray/Radiology	40% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	40% coinsurance after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	40% coinsurance after deductible	None
Inpatient Services		
Facility Fee	40% coinsurance after deductible	None
Physician/Surgeon Fees	40% coinsurance after deductible	1 visit per physician per day
Skilled Nursing Facility	40% coinsurance after deductible	90 Day limit per Benefit Year
Outpatient Services		
Facility Fee	40% coinsurance after deductible	None
Physician/Surgeon Fees	40% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	$80 copay	None
Inpatient Services	40% coinsurance after deductible	None
Outpatient Services	40% coinsurance after deductible	None
Ambulance Services	40% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services	40% coinsurance 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	$40 copay	25 visits per Benefit Year
Occupational Therapy	$40 copay	25 visits per Benefit Year
Speech Therapy	$40 copay	25 visits per Benefit Year Visit limits do not apply to Behavioral Health/Substance Use Disorder services

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical Therapy	$40 copay	25 visits per Benefit Year
Occupational Therapy	$40 copay	25 visits per Benefit Year
Speech Therapy	$40 copay	25 visits per Benefit Year
Pulmonary Rehabilitation	40% coinsurance after deductible	25 visits per Benefit Year
Cardiac Rehabilitation Services	40% coinsurance after deductible	36 visits per Benefit Year
Manipulation Therapy	40% coinsurance after deductible	20 visits per Benefit Year
Post-Cochlear Implant Aural Therapy	$40 copay	30 visits per Benefit Year
Cognitive Rehabilitation Therapy	40% coinsurance after deductible	20 visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	40% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Services	$40 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical Therapy	$40 copay	None
Occupational Therapy	$40 copay	None
Speech Therapy	$40 copay	None
Adaptive Behavior Treatment	$40 copay	40% coinsurance after deductible
None	40% coinsurance after deductible	None

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health		
Private Duty Nursing	40% coinsurance after deductible	250 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.

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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