

2024 Schedule of Benefits

Plan Name: CareSource Marketplace Silver 2



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: \$700 Family: \$1,400
Coinsurance	30%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$3,000 Family: \$6,000



* See Section 2: Evidence of Coverage for the Definition of Annual Deductible or Deductible. For individual coverage, you are responsible for paying the first \$700 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 \$1,400 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 \$700 up to the family maximum of \$1,400. 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 \$3,000. 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 and Mental Health/Substance Abuse	\$20 copay	None
Specialist	\$40 copay	None
Urgent Care	\$30 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services		
Lab	30% coinsurance after deductible	None
X-Ray/Radiology	30% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	30% coinsurance after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic	30% coinsurance after deductible	None
Inpatient Services		
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	1 visit per physician per day
Skilled Nursing Facility	30% coinsurance after deductible	None
Outpatient Services		
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	None
Maternity Services		
Prenatal Visit, Office Visits, and Postpartum Care	\$40 copay	None
Inpatient Services	30% coinsurance after deductible	None
Outpatient Services	30% coinsurance after deductible	None
Ambulance Services	30% coinsurance after deductible	None
Emergency Health Care Services	30% coinsurance 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	\$20 copay	30 visits per Benefit Year
Occupational Therapy	\$20 copay	30 visits per Benefit Year
Speech Therapy	\$20 copay	None
Manipulation Therapy	30% coinsurance after deductible	30 visits per Benefit Year

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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	\$20 copay \$20 copay \$20 copay 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible \$20 copay 30% coinsurance after deductible	30 visits per Benefit Year 30 visits per Benefit Year None 30 visits per Benefit Year 36 visits per Benefit Year 30 visits per Benefit Year None Refer to your Evidence of Coverage
Chiropractor Services	\$40 copay	Limits for Physical Therapy and Manipulation apply
Chronic Pain Treatment	\$20 copay	20 combined visits per event, in addition to any Rehabilitative and Habilitative visits
Autism Spectrum Disorder Services Physical Therapy Occupational Therapy Speech Therapy Adaptive Behavior Treatment	\$20 copay \$20 copay \$20 copay \$20 copay	Combined limit with Habilitative Services Combined limit with Habilitative Services Combined limit with Habilitative Services Includes Applied Behavior Analysis (ABA)
Behavioral Health Services Office Visits Outpatient Services Intensive Outpatient Program (IOP) Services Partial Hospitalization Program (PHP) Services Residential Services Opioid Treatment Program Inpatient Services	\$20 copay 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible	None
Transplant Services	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services, and outpatient services	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Home Health Private Duty Nursing	30% coinsurance after deductible	35 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	30% coinsurance after deductible	Included in all other services limits
All Other Services	30% coinsurance after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	30% coinsurance after deductible	Refer to your Evidence of Coverage
Diabetic Services Education	30% coinsurance after deductible	Refer to your Evidence of Coverage
Equipment	30% coinsurance after deductible	Refer to your Evidence of Coverage
Supplies	30% coinsurance after deductible	Diabetic device cost share not to exceed \$100 per 30-day supply in aggregate.
Medical Supplies, Durable Medical Equipment, and Appliances Appliances	30% coinsurance after deductible	Refer to your Evidence of Coverage
Durable Medical Equipment		
Medical Supplies		
Orthotic Device		
Prosthetics		
Prescription Drugs Tier 0 (Preventive)	No charge	Up to a 90-day supply when filled at: Retail or Mail Order for drugs in Tiers 0-3 All others limited to a 30-day supply Any copays shown are for a 30-day supply. 90-day supplies are 3 times the copay. Insulin cost share not to exceed \$35 per 30-day supply in aggregate.
Tier 1 (Low Cost)	Up to \$10 copay	
Tier 2 (Preferred)	Up to \$20 copay	
Tier 3 (Non-Preferred)	Up to \$60 copay after deductible	
Tier 4 (Specialty)	Up to \$250 copay after deductible	
Vision (pediatric) Children's Eye Exam	No charge	1 routine eye exam per Benefit Year Limited to one evaluation and aid per Benefit Year. Limited to one pair of glasses or contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed.
Low Vision Testing and Aids	No charge	
Children's Eyewear	No charge	
Other Dental Services Accidental Dental	30% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury. Refer to your Evidence of Coverage
Dental Anesthesia	30% coinsurance after deductible	

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Dental (pediatric) Class I - Diagnostic/Preventive Class II - Minor Restorative Class III - Major/Comprehensive Class IV - Orthodontics	No charge 20% coinsurance after deductible 40% coinsurance after deductible 50% coinsurance after deductible	2 check-ups per Benefit Year. Additional benefits available. Refer to your Evidence of Coverage Refer to your Evidence of Coverage Refer to your Evidence of Coverage Refer to your Evidence of Coverage

Prior Authorization: Some services and items require prior authorization, which is the process used by the Plan to determine if it meets medical necessity and coverage requirements prior to the service being provided. The provider, or the member when using an out-of-network provider, is responsible for obtaining prior authorization for the services and items described on the prior authorization list. Please refer to the prior authorization list attached to your Evidence of Coverage for additional detail or you can obtain the list at www.caresource.com/mp-WV-pa.

This Schedule of Benefits is a summary of your financial responsibility when you receive health care services from a physician, pharmacy, facility, or other provider. All Covered Services are subject to the conditions, exclusions, limitations, terms, and rules of the Evidence of Coverage including any rider/enhancements or amendments. Except as otherwise provided in the Evidence of Coverage, Covered Services must be provided to you by a network provider and medically necessary. The Plan does not cover all health care service expenses. In the event of any discrepancy between this Schedule of Benefits and your Evidence of Coverage, the Evidence of Coverage shall control. For more detailed information about your Covered Services, please refer to the Evidence of Coverage at www.caresource.com/marketplace.

For Covered Services listed in the Evidence of Coverage that are not specifically listed on this Schedule of Benefits, the cost sharing is equal to the coinsurance after the deductible.

You may view the Access Plan required by Health Benefit Plan Network Access and Adequacy Act online at [CareSource.com]. You may also contact us at 1-855-202-0622 to request a copy.

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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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