separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact www.caresource.com/marketplace or call 833-230-2099. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.caresource.com/marketplace or call 833-230-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Zero Cost Telemedicine Partner	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat an injury or illness.	$30 copay	Not covered	None
	Specialist visit	$70 copay	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test†	Diagnostic test (x-ray, blood work)	X-ray: $200 copay after deductible	Not covered	None
		Lab: $40 copay		None
	Imaging (CT/PET scans, MRIs)	$250 copay after deductible	Not covered	None
If you need drugs to treat your illness or condition† More information about prescription drug coverage is available at www.caresource.com/marketplace.	Preventive drugs	No charge	Not covered	Up to a 90-day supply when filled at: Retail for Generic Drugs in Tiers 0-3 Mail Order for any drug in Tiers 0-3 All others limited to a 30-da l
	Generic drugs	Up to $15 copay	Not covered	
	Preferred brand drugs	Up to $75 copay	Not covered	
	Non-preferred brand drugs	40% coinsurance after deductible	Not covered	
	Specialty drugs	50% coinsurance after deductible	Not covered	
	_____			
	_____ _____			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$50 copay	$50 copay	If you receive services in addition to urgent care, additional copayments, _____ _____
				_____
	_____			
	_____			

Common Medical Event	Services You May Need			

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 833-230-2099.
†Prior authorization may be required, for more details see www.caresource.com/mp-IN-pa.