



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of the plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact your broker.

Summary of Benefits and Coverage		
Section	Description	Details
I. General Information	Plan Name	CareSource Marketplace Core Gold
II. Coverage	Covered Services	Medical, Prescription, Dental, Vision, Behavioral Health
III. Costs	Premium	Individual: \$150/month, Family: \$300/month
IV. Network	Network Type	HMO (Health Maintenance Organization)
V. Other Information	Contact Information	CareSource, 1-800-368-8686

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 <a href="#">provider's</a> office or clinic	Zero Cost Telemedicine Partner	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat injury or illness.	\$20 copay	Not covered	None
	<a href="#">Specialist</a> visit	\$60 copay	Not covered	None
	<a href="#">Preventive care/screening</a> /immunization	No charge	Not covered	You may have to pay for services that are not preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test†	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: 25% coinsurance after deductible Lab: \$30 copay	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible	Not covered	None
If you need drugs to treat your illness or condition to treat you				



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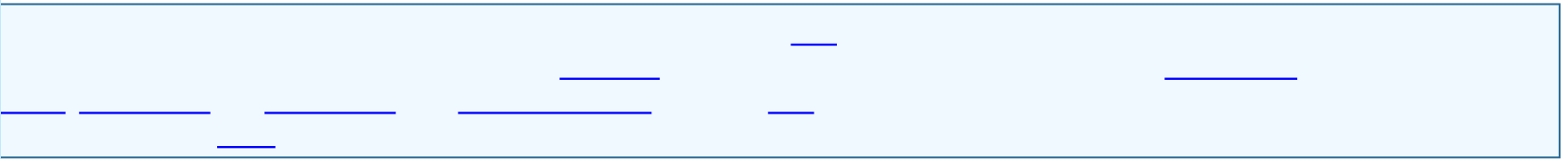
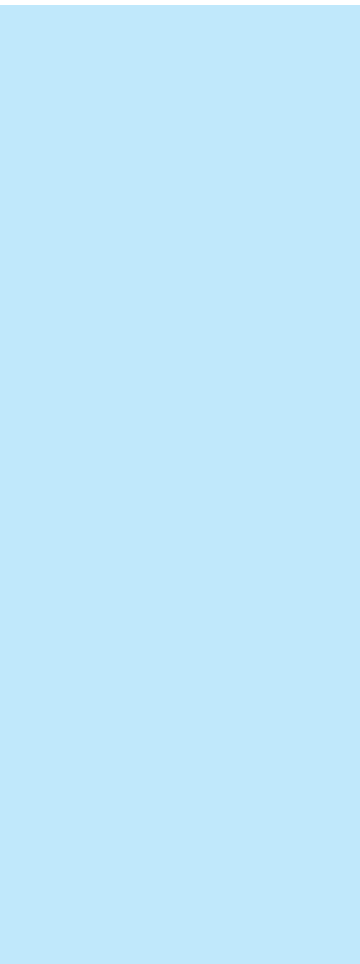
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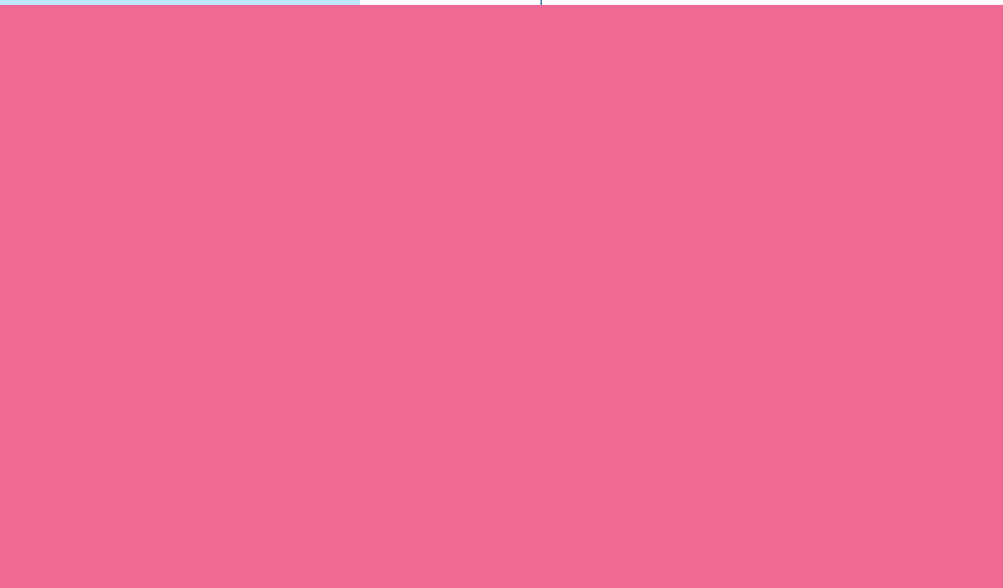
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