

CareSource

CareSource (Common Ground Healthcare) Gold Standard \$2000 - Vision Exam + Allergy Test

Coverage for: Individual and Family | Plan Type: EPO



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 this [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 [www.caresource.com/marketplace](http://www.caresource.com/marketplace) or call 877-514-2442. 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 [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary).

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$2,000 individual/\$4,000 family per Benefit Year	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$8,200 individual/\$16,400 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges (unless balance billing is prohibited), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.caresource.com/marketplace">www.caresource.com/marketplace</a> or call 877-514-2442 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

\*For more information about limitations and exceptions, see the plan or policy document at [www.caresource.com/marketplace](http://www.caresource.com/marketplace) or call 877-514-2442.

†Prior authorization may be required, for more details see [www.caresource.com/mp-WI-pa](http://www.caresource.com/mp-WI-pa).

WISBC26(Rev.1-26) - Gold 2000 VA

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 office</a> or clinic	Teladoc	No charge	Not covered	None
	Primary care visit to treat an injury or illness.	\$30 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 aren't preventive. Ask your <a href="#">provider</a> if the services needed 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	Not covered	None
		Lab: 25% coinsurance after deductible		None
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible	Not covered	None
If you need drugs to treat your illness or condition† More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caresource.com/marketplace">www.caresource.com/marketplace</a> .	Preventive drugs	No charge	Not covered	Up to a 30-day supply for drugs filled at Retail and Specialty Drugs.
	Generic drugs	\$15 copay	Not covered	
	Preferred brand drugs	\$30 copay	Not covered	Up to a 90-day supply for all other Mail Order.
	Preferred Insulin	\$15 copay		
	Non-preferred brand drugs	\$60 copay	Not covered	Any copays shown are for a 30-day supply. 90-day supplies available at 2 times the copay for Mail Order.
<a href="#">Specialty drugs</a>	\$250 copay	Not covered		
Oral Chemotherapy Drugs	25% coinsurance after deductible	Not covered		
If you have outpatient surgery†	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	25% coinsurance after deductible	Not covered	None

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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 need immediate medical attention	<a href="#">Emergency room care</a>	Facility 25% coinsurance after deductible Physician 25% coinsurance after deductible	Facility 25% coinsurance after deductible Physician 25% coinsurance after deductible	Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department.
	<a href="#">Emergency medical transportation</a>	25% coinsurance after deductible	25% coinsurance after deductible	Balance billing may apply to emergency ground transportation for out-of-network providers.
	<a href="#">Urgent care</a>	\$45 copay	\$45 copay	Medically necessary Urgent Care services at out-of-service-area providers are covered when a covered person is traveling, or a dependent resides outside of CareSource's service area. Any follow-up care must be provided by an in-network provider.
If you have a hospital stay†	Facility fee (e.g., hospital room)	25% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	25% coinsurance after deductible	Not covered	1 visit per physician per day
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	\$30 copay for office visits	Not covered	None
	Inpatient services	25% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	25% coinsurance after deductible	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services†	25% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services†	25% coinsurance after deductible	Not covered	Your cost for inpatient services only. See above for physician delivery charges.

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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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a> †	25% coinsurance after deductible	Not covered	60 visits per Benefit Year. Refer to your Certificate of Coverage for additional information.
	<a href="#">Rehabilitation services</a> †			
	Physical/Occupational therapy	\$30 copay per therapy type per day	Not covered	PT, OT, ST, Cognitive limited to 20 visits each per Benefit Year. Cardiac and Pulmonary limited to 36 visits each per Benefit Year. Post-cochlear implant aural therapy limited to 30 visits per Benefit Year. Services for custodial care are excluded.
	Speech therapy	\$30 copay per therapy type per day	Not covered	
	Post-cochlear implant aural therapy	25% coinsurance after deductible	Not covered	
	All other services	25% coinsurance after deductible	Not covered	
	<a href="#">Habilitation services</a> †			
	Physical/Occupational therapy	\$30 copay per therapy type per day	Not covered	20 visits each per Benefit Year. Services for custodial care are excluded.
Speech therapy	\$30 copay per therapy type per day	Not covered	20 visits per Benefit Year	
Hearing aids	25% coinsurance after deductible	Not covered	1 hearing aid per hearing-impaired ear every 36 months.	
<a href="#">Skilled nursing care</a> †	25% coinsurance after deductible	Not covered	30 day limit per stay	
<a href="#">Durable medical equipment</a> †	25% coinsurance after deductible	Not covered	None	
<a href="#">Hospice services</a>	25% coinsurance after deductible	Not covered	None	
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	1 routine eye exam per Benefit Year
	Children's eyewear	25% coinsurance after deductible	Not covered	Limited to one pair of glasses or a 12-month supply of contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed. Refer to your Certificate of Coverage for additional eyewear options that may have an additional charge.
	Children's dental check-up	Not covered	Not covered	

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## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-236-8517. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Wisconsin Office of the Commissioner of Insurance: 1-800-236-8517.

### Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the Minimum Value Standards? Not Applicable

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 877-514-2442

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-514-2442

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 877-514-2442

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 877-514-2442.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

\*For more information about limitations and exceptions, see the [plan](#) or policy document at [www.caresource.com/marketplace](http://www.caresource.com/marketplace) or call 877-514-2442.

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About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,800

*What isn't covered*

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$4,370</b>
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### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$1,620</b>
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### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$100

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$1,900</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services