CareSource

CareSource (Common Ground Healthcare) Silver $5000 Ded / $6000 Rx Ded - 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 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,000 individual/$10,000 family per Benefit Year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $6,000 individual/$12,000 family prescription drug deductible	You must pay all of the costs for these services up to the specific prescription drug deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$10,600 individual/$21,200 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balance billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.caresource.com/marketplace or call 877-514-2442 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 877-514-2442.
†Prior authorization may be required, for more details see www.caresource.com/mp-WI-pa.

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	Teladoc	No charge	Not covered	None
	Primary care visit to treat an injury or illness.	$35 copay	Not covered	None
	Specialist visit	$75 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: 30% coinsurance after deductible	Not covered	None
		Lab: 30% coinsurance after deductible		None
	Imaging (CT/PET scans, MRIs)	30% coinsurance 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 30-day supply for drugs filled at Retail and Specialty Drugs. Up to a 90-day supply for all other Mail Order. Any copays shown are for a 30-day supply. 90-day supplies available at 2 times the copay for Mail Order. Oral Chemotherapy Drugs apply to the medical deductible.
	Generic drugs	$10 copay	Not covered	
	Preferred brand drugs Preferred Insulin	$80 copay $15 copay	Not covered	
	Non-preferred brand drugs	30% coinsurance after Rx deductible	Not covered	
	Specialty drugs	40% coinsurance after Rx deductible	Not covered	
	Oral Chemotherapy Drugs	30% coinsurance after deductible	Not covered	
If you have outpatient surgery†	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	30% 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	Emergency room care	Facility 30% coinsurance after deductible Physician 30% coinsurance after deductible	Facility 30% coinsurance after deductible Physician 30% coinsurance after deductible	Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department.
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	Balance billing may apply to emergency ground transportation for out-of-network providers.
	Urgent care	30% coinsurance after deductible	30% coinsurance after deductible	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)	30% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	30% coinsurance after deductible	Not covered	1 visit per physician per day
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	$35 copay for office visits	Not covered	None
	Inpatient services	30% coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	30% coinsurance after deductible	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services†	30% coinsurance after deductible	Not covered	
	Childbirth/delivery facility services†	30% 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)	
If you need help recovering or have other special health needs	Home health care†	30% coinsurance after deductible	Not covered	60 visits per Benefit Year. Refer to your Certificate of Coverage for additional information.
	Rehabilitation services†			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.
	Physical/Occupational therapy	30% coinsurance after deductible	Not covered	
	Speech therapy	30% coinsurance after deductible	Not covered	
	Post-cochlear implant aural therapy	30% coinsurance after deductible	Not covered	
	All other services	30% coinsurance after deductible	Not covered	
	Habilitation services†			20 visits each per Benefit Year. Services for custodial care are excluded.
	Physical/Occupational therapy	30% coinsurance after deductible	Not covered	
	Speech therapy	30% coinsurance after deductible	Not covered	20 visits per Benefit Year
	Hearing aids	30% coinsurance after deductible	Not covered	1 hearing aid per hearing-impaired ear every 36 months.
	Skilled nursing care†	30% coinsurance after deductible	Not covered	30 day limit per stay
	Durable medical equipment†	30% coinsurance after deductible	Not covered	None
	Hospice services	30% coinsurance after deductible	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam per Benefit Year
	Children's eyewear	30% 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 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, kwiijigo holne' 877-514-2442.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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	$5,000
Specialist copayment	$75
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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)*

Total Example Cost	$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$90
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,650**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$5,000
Specialist copayment	$75
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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)*

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture

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

The plan's overall deductible	$5,000
Specialist copayment	$75
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,700**

The plan would be responsible for the other costs of these EXAMPLE covered services