

CareSource

CareSource (Common Ground Healthcare) Gold \$0 Ded - Vision Exam

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 ?	\$0 individual/\$0 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$9,000 individual/\$18,000 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 .

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	\$100 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: \$60 copay per service	Not covered	None
		Lab: \$50 copay per test		None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	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 brand name drugs filled at Retail and Specialty Drugs
	Generic drugs	\$2 copay	Not covered	
	Preferred brand drugs	\$60 copay	Not covered	Up to a 90-day supply for all other Retail and Mail Order.
	Preferred Insulin	\$15 copay		
	Non-preferred brand drugs	50% coinsurance	Not covered	Any copays shown are for a 30-day supply. 90-day supplies available at 3 times the copay for Retail and 2 times the copay for Mail Order.
	Specialty drugs	50% coinsurance	Not covered	
If you have outpatient surgery†	Oral Chemotherapy Drugs	20% coinsurance	Not covered	
	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	Facility \$600 copay Physician 20% coinsurance	Facility \$600 copay Physician 20% coinsurance	Emergency room copay or coinsurance is waived if you are admitted to the hospital directly from the Emergency Department.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Balance billing may apply to emergency ground transportation for out-of-network providers.

*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.

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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)	
	Urgent care	\$75 copay	\$75 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)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	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	20% coinsurance	Not covered	None
If you are pregnant	Office visits	20% coinsurance	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†	20% coinsurance	Not covered	
	Childbirth/delivery facility services†	20% coinsurance	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 †	20% coinsurance	Not covered	60 visits per Benefit Year. Refer to your Certificate of Coverage for additional information.
	Rehabilitation services †			
	Physical/Occupational therapy	\$70 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	\$70 copay per therapy type per day	Not covered	
	Post-cochlear implant aural therapy	20% coinsurance	Not covered	
	All other services	20% coinsurance	Not covered	
	Habilitation services †			
	Physical/Occupational therapy	\$70 copay per therapy type per day	Not covered	20 visits each per Benefit Year. Services for custodial care are excluded.
	Speech therapy	\$70 copay per therapy type per day	Not covered	20 visits per Benefit Year
If your child needs dental or eye care	Hearing aids	20% coinsurance	Not covered	1 hearing aid per hearing-impaired ear every 36 months.
	Skilled nursing care †	20% coinsurance	Not covered	30 day limit per stay
	Durable medical equipment †	20% coinsurance	Not covered	None
	Hospice services	20% coinsurance	Not covered	None
	Children's eye exam	No charge	Not covered	1 routine eye exam per Benefit Year
	Children's eyewear	20% coinsurance	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) | • Dental care (Adult) | • Private-duty nursing |
| • Acupuncture | • Infertility treatment | • Routine foot care |
| • Bariatric surgery | • Long-term care | • Weight loss programs |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S | |

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, kwijigo 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	\$0
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,960

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$100
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services