CareSource

Value Gold EPO 3700 $20 PCP + Vision Exam & Allergy Test
87416WI005001000

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?	$3,700 individual/$7,400 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?	$9,600 individual/$19,200 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.

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 Health®	$0 Copay	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat an injury or illness.	$20 Copay	Not covered	None
	Specialist visit	$50 Copay	Not covered	None
	Preventive care/screening/immunization	$0 Copay	Not covered	Refer to your Evidence of Coverage
If you have a test†	Diagnostic test (x-ray, blood work)	X-ray: 15% Coinsurance after deductible	Not covered	None
		Lab: 15% Coinsurance after deductible		None
	Imaging (CT/PET scans, MRIs)	15% 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	$0 Copay	Not covered	Generic, Preferred Brand and Non-Preferred Brand Drugs: Up to 30-day supply per fill at Retail; up to 90-day supply for Mail Order Specialty Drugs: Up to 30-day supply per fill at Retail and Mail Order Displayed cost share is for a 30-day supply. 90-day supply is available at 2 times the cost of a 30-day supply.
	Generic drugs	Up to $2 Copay	Not covered	
	Preferred brand drugs	Up to $50 Copay	Not covered	
	Non-preferred brand drugs	50% Coinsurance after deductible	Not covered	
	Specialty drugs	60% Coinsurance after deductible	Not covered	
	Oral Chemotherapy Drugs	15% Coinsurance after deductible	Not covered	
If you have outpatient surgery†	Facility fee (e.g., ambulatory surgery center)	15% Coinsurance after deductible	Not covered	None
	Physician/surgeon fees	15% Coinsurance after deductible	Not covered	None
If you need immediate medical attention	Emergency room care	Facility: $300 Copay Physician: 15% Coinsurance after deductible	Facility: $300 Copay Physician: 15% Coinsurance after deductible	If admitted to the hospital directly from the Emergency Department, these services will be covered the same as inpatient services and the applicable copayment and coinsurance will apply.

*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)	
	Emergency medical transportation	15% Coinsurance after deductible	15% Coinsurance after deductible	Balance billing may apply to emergency ground transportation for out-of-network providers.
	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)	15% Coinsurance after deductible	Not covered	None
	Physician/surgeon fees	15% Coinsurance after deductible	Not covered	1 Visit Per Day Per Physician
If you need mental health, behavioral health, or substance abuse services†	Outpatient services	$20 Copay for office visits	Not covered	None
	Inpatient services	15% Coinsurance after deductible	Not covered	None
If you are pregnant	Office visits	15% 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†	15% Coinsurance after deductible	Not covered	
	Childbirth/delivery facility services†	15% 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†	15% Coinsurance after deductible	Not covered	60 Combined Home Infusion Therapy and Covered Services Per Year. A visit equals 4 hours or less.
	Rehabilitation services†			
	Physical (PT)/Occupational therapy (OT)	15% Coinsurance after deductible	Not covered	20 Visits Each Per Year
	Speech therapy (ST)	15% Coinsurance after deductible	Not covered	20 Visits Per Year
	Cognitive rehabilitation therapy	15% Coinsurance after deductible	Not covered	20 Visits Per Year
	All other services	15% Coinsurance after deductible	Not covered	Refer to your Evidence of Coverage
	Habilitation services†			
	Physical (PT)/Occupational therapy (OT)	15% Coinsurance after deductible	Not covered	20 Visits Each Per Year
	Speech therapy (ST)	15% Coinsurance after deductible	Not covered	20 Visits Per Year
	Hearing aids	15% Coinsurance after deductible	Not covered	1 Hearing Aid Every 36 Months Per Hearing Impaired Ear.
	Skilled nursing care†	15% Coinsurance after deductible	Not covered	30 Days Per Stay
	Durable medical equipment†	15% Coinsurance after deductible	Not covered	None
	Hospice services	15% Coinsurance after deductible	Not covered	None
If your child needs dental or eye care	Children's eye exam	$0 Copay	Not covered	1 Routine Eye Exam Per Year
	Children's eyewear	15% Coinsurance after deductible	Not covered	1 Pair of Glasses Per Year or 1 Choice of Contacts Per Year. Refer to your Evidence of Coverage for more detail.
	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.

*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.

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** **$3,700**
- **Specialist *Copayment*** **$50**
- **Hospital (facility) *Coinsurance*** **15%**
- **Other *coinsurance*** **15%**

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	$3,700
Copayments	$50
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,710**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$3,700**
- **Specialist *Copayment*** **$50**
- **Hospital (facility) *Coinsurance*** **15%**
- **Other *coinsurance*** **15%**

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	$3,700
Copayments	$300
Coinsurance	$50
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,070**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$3,700**
- **Specialist *Copayment*** **$50**
- **Hospital (facility) *Coinsurance*** **15%**
- **Other *coinsurance*** **15%**

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	$2,100
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,600**

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

CareSource

Get free help in your language with interpreters and other written materials. Get free aids and support if you have a disability. Call **1-877-514-2442** (TTY: 711).

Obtenga ayuda gratuita en su idioma a través de intérpretes y otros materiales en formato escrito. Obtenga ayudas y apoyo gratuitos si tiene una discapacidad. Llame al: **1-877-514-2442** (TTY: 711).

Jwenn èd gratis nan lang ou ak entèprèt ansanm ak lòt materyèl ekri. Jwenn èd ak sipò gratis si w gen yon andikap. Rele **1-877-514-2442** (TTY: 711).

احصل على مساعدة مجانية بلغتك من خلال المترجمين الفوريين والمواد المكتوبة الأخرى. إذا كنت من ذوي الاحتياجات الخاصة، ستحصل على المساعدات والدعم مجانًا. اتصل على الرقم **1-877-514-2442** (TTY "الهاتف النصيّ للصم وضعاف السمع": 711).

通过口译员和其他书面材料，获得您所使用语言的免费帮助。 如果您有残疾，可以获得免费的辅助设备和支持。 请致电： **1-877-514-2442** （听语障人士专用电话：711）。

Erhalten Sie kostenlose Hilfe in Ihrer Sprache durch Dolmetscher und andere schriftliche Unterlagen. Beziehen Sie kostenlose Hilfsmittel und Unterstützung, wenn Sie eine Behinderung haben. Rufen Sie folgende Telefonnummer an: **1-877-514-2442** (TTY: 711).

Obtenez une aide gratuite dans votre langue grâce à des interprètes et à d'autres documents écrits. Si vous souffrez d'un handicap, vous bénéficiez d'aides et d'assistance gratuites. Appelez le **1-877-514-2442** (ATS : 711).

Nhận trợ giúp miễn phí bằng ngôn ngữ của quý vị với thông dịch viên và các tài liệu bằng văn bản khác. Nhận trợ giúp và hỗ trợ miễn phí nếu quý vị bị khuyết tật. Gọi **1-877-514-2442** (TTY: 711).

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आपकी भाषा के इंटरप्रेटर तथा आपकी भाषा में अन्य लिखित सामग्रियों संबंधी फ्री मदद पाएं। यदि आपको कोई डिसएबिलिटी हो, तो मुफ्त सहायता और सपोर्ट प्राप्त करें। कॉल करें 1-877-514-2442 (TTY: 711).

통역사와 기타 서면 자료의 도움을 귀하의 언어로 무료로 받으세요. 장애가 있을 경우, 보조와 지원을 무료로 받으세요. **1-877-514-2442** (TTY: 711) 로 문의하세요.

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Gba ìrànlọ́wọ́ ọ̀fẹ́ ní èdè rẹ pẹ̀lú àwọn ògbifọ̀ àti àwọn ohun èlò míràn tí a kọ sílẹ̀. Gba àwọn ìrànlọ́wọ́ àti àtìlẹ́yìn ọ̀fẹ́ bí o bá ní àìlera kan. Pe **1-877-514-2442** (TTY: 711).

Makakuha ng libreng tulong sa wika mo gamit ang mga interpreter at mga ibang nakasulat na materyales. Makakuha ng mga libreng pantulong at suporta kung may kapansanan ka. Tumawag sa **1-877-514-2442** (TTY: 711).

په خپله ژبه کې د ژباړونکو او نورو لیکلي شوو موادو له لارې وړیا مرسته ترلاسه کړئ. که تاسو معلولیت لرئ نو وړیا ملاتړ او مرستې ترلاسه کړئ. دې شمېرې ته زنګ ووهئ **1-877-514-2442** (TTY: 711).

వ్యాఖ్యాతలు మరియు ఇతర రాతపూర్వక మెటీరియల్స్‌తో మీ భాషలో ఉచిత సహాయాన్ని పొందండి. ఒకవేళ మీకు వైకల్యం ఉంటే, ఉచిత ఉపకరణాలు మరియు మద్దతు పొందండి. కాల్ చేయండి: **1-877-514-2442** (TTY: 711).

दोभाषे र अन्य लिखित सामग्रीहरूको माध्यमद्वारा आफ्नो भाषामा निःशुल्क मद्दत प्राप्त गर्नुहोस्। तपाईंलाई अशक्तता छ भने निःशुल्क सहायता र समर्थन प्राप्त गर्नुहोस्। **1-877-514-2442** (TTY: 711) मा कल गर्नुहोस्।

သင့်ဘာသာစကားအတွက် စကားပြန်များနှင့် အခြားပုံနှိပ်စာရွက်များကို အခမဲ့အကူအညီရယူပါ။ သင်သည် မသန်စွမ်းသူတစ်ဦးဖြစ်ပါက အခမဲ့အကူအညီများနှင့် အထောက်အပံ့များ ရယူပါ။ ဖုန်းခေါ်ရန် **1-877-514-2442** (TTY: 711)

Bōk jibañ ilo an ejjelok wōnāān ikkijjien kajin eo am ibbān rukok ro im wāween ko jet ilo jeje. Bōk jerbalin jibañ ko ilo an ejjelok wōnāer im jibañ ko ñe ewōr am nañinmejin utamwe. Kalle **1-877- 514-2442** (TTY: 711).

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