**CareSource**
**Silver Standard EPO 800 $20 PCP**
**87416WI003004205**

**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?** | $800 individual/$1,600 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?** | $3,600 individual/$7,200 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, deductible does not apply | Not covered | Refer to your Evidence of Coverage |
| | Primary care visit to treat an injury or illness. | $20 Copay, deductible does not apply | Not covered | None |
| | Specialist visit | $40 Copay, deductible does not apply | Not covered | None |
| | Preventive care/screening/immunization | $0 Copay, deductible does not apply | Not covered | Refer to your Evidence of Coverage |
| **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 | $0 Copay, deductible does not apply | 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<br>Specialty Drugs: Up to 30-day supply per fill at Retail and Mail Order<br>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 $10 Copay, deductible does not apply | Not covered | |
| | Preferred brand drugs | Up to $20 Copay, deductible does not apply | Not covered | |
| | Non-preferred brand drugs | Up to $60 Copay after deductible | Not covered | |
| | Specialty drugs | Up to $250 Copay after deductible | Not covered | |
| | Oral Chemotherapy Drugs | 30% Coinsurance after deductible | Not covered | |

*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 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 |
| **If you need immediate medical attention** | Emergency room care | Facility: 30% Coinsurance after deductible<br>Physician: 30% Coinsurance after deductible | Facility: 30% Coinsurance after deductible<br>Physician: 30% 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. |
| | 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 Copay, deductible does not apply | $30 Copay, deductible does not apply | 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 Day Per Physician |
| **If you need mental health, behavioral health, or substance abuse services†** | Outpatient services | $20 Copay for office visits, deductible does not apply | Not covered | None |
| | Inpatient services | 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 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. |
| **If you need help recovering or have other special health needs** | Home health care† | 30% 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) | $20 Copay Per Therapy Type Per Day, deductible does not apply | Not covered | 20 Visits Each Per Year |
| | Speech therapy (ST) | $20 Copay Per Therapy Type Per Day, deductible does not apply | Not covered | 20 Visits Per Year |
| | Cognitive rehabilitation therapy | $20 Copay Per Therapy Type Per Day, deductible does not apply | Not covered | 20 Visits Per Year |
| | All other services | 30% Coinsurance after deductible | Not covered | Refer to your Evidence of Coverage |
| | Habilitation services† | | | |
| | Physical (PT)/Occupational therapy (OT) | $20 Copay Per Therapy Type Per Day, deductible does not apply | Not covered | 20 Visits Each Per Year |

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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) | |
| | Speech therapy (ST) | $20 Copay Per Therapy Type Per Day, deductible does not apply | Not covered | 20 Visits Per Year |
| | Hearing aids | 30% Coinsurance after deductible | Not covered | 1 Hearing Aid Every 36 Months Per Hearing Impaired Ear. |
| | Skilled nursing care† | 30% Coinsurance after deductible | Not covered | 30 Days 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 | $0 Copay, deductible does not apply | Not covered | 1 Routine Eye Exam Per Year |
| | Children's eyewear | 30% 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 | |

Cost sharing shown applies to services received in-person or via telehealth

## 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 eye care (Adult)
- 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

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†Prior authorization may be required, for more details see www.caresource.com/mp-WI-pa.

**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 | $800 |
| Specialist *Copayment* | $40 |
| 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 | $800 |
| Copayments | $50 |
| Coinsurance | $2,700 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,610** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $800 |
| Specialist *Copayment* | $40 |
| 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 | $800 |
| Copayments | $400 |
| Coinsurance | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,220** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $800 |
| Specialist *Copayment* | $40 |
| 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 | $800 |
| Copayments | $200 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,400** |

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