




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, please contact 1-844-201-4672. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-844-201-4672 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | \$750/Individual or \$1,500/Family  | 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> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes.  | This plan 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 plan covers certain preventive services 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> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet other deductibles for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$2,900/Individual or \$5,800/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 plan, 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.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this plan doesn't cover.  | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://chorushealthplans.org/find-a-doc">chorushealthplans.org/find-a-doc</a> or call 1-844-201-4672 for a list of <a href="#">network providers</a> . | 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 <a href="#">out-of-network provider</a> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan 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 provider before you get services.             |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.   | You can see the in-network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .   |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event  | Services You May Need                                  | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you visit a health care provider's office or clinic</b>   | Primary care visit to treat an injury or illness       | \$30/visit                                   | Not covered.                                       | None.   |
|   | <a href="#">Specialist</a> visit                       | \$70/visit                                   | Not covered.                                       | None.   |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge.                                   | Not covered.                                       | You may have to pay for services that aren't <a href="#">preventive</a> . Ask provider if services needed are <a href="#">preventive</a> . Check what your plan will pay for. |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% after <a href="#">deductible</a>         | Not covered.                                       | None.   |
|   | Imaging (CT/PET scans, MRIs)                           | 20% after <a href="#">deductible</a>         | Not covered.                                       | Prior Authorization required for some services.   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://chorushealthplans.org">chorushealthplans.org</a> . | Generic drugs  | \$10/prescription                            | Not covered.                                       | Prior Authorization may be required.  |
|   | Preferred brand drugs                                  | \$50/prescription                            | Not covered.                                       | Prior Authorization may be required.  |
|   | Non-preferred brand drugs                              | 20% after <a href="#">deductible</a>         | Not covered.                                       | Prior Authorization may be required.  |
|   | <a href="#">Specialty drugs</a>                        | 20% after <a href="#">deductible</a>         | Not covered.                                       | Prior Authorization may be required.  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)         | 20% after <a href="#">deductible</a>         | Not covered.                                       | Prior Authorization required for some services.   |
|   | Physician/surgeon fees                                 | 20% after <a href="#">deductible</a>         | Not covered.                                       | Prior Authorization required for some services.   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>                    | 20% after <a href="#">deductible</a>         | 20% after <a href="#">deductible</a>               | <a href="#">Maximum allowed amount</a> applies.   |
|   | <a href="#">Emergency medical transportation</a>       | 20% after <a href="#">deductible</a>         | 20% after <a href="#">deductible</a>               | <a href="#">Maximum allowed amount</a> applies.   |
|   | <a href="#">Urgent care</a>                            | 20% after <a href="#">deductible</a>         | 20% after <a href="#">deductible</a>               | If <a href="#">deductible/coinsurance</a> has not been met, remaining billed charges will be applied until satisfied. <a href="#">Maximum allowed amount</a> applies.         |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)                     | 20% after <a href="#">deductible</a>         | Not covered.                                       | Prior Authorization required for some services.   |
|   | Physician/surgeon fees                                 | 20% after <a href="#">deductible</a>         | Not covered.                                       | Prior Authorization required for some services.   |

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.chorushealthplans.org](http://www.chorushealthplans.org).]

| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|--|---|--|--|---|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$30/visit                                   | Not covered.                                       | \$30 copay/office visit. 20% after <u>deductible</u> for other outpatient services. Prior Authorization required for some services.                                 |
|  | Inpatient services                        | 20% after <u>deductible</u>                  | Not covered.                                       | Prior Authorization required for some services.   |
| <b>If you are pregnant</b>   | Office visits                             | 20% after <u>deductible</u>                  | Not covered.                                       | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). |
|  | Childbirth/delivery professional services | 20% after <u>deductible</u>                  | Not covered.                                       | None.   |
|  | Childbirth/delivery facility services     | 20% after <u>deductible</u>                  | Not covered.                                       | None.   |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 20% after <u>deductible</u>                  | Not covered.                                       | Limited to 60 visits per calendar year. Prior Authorization required.   |
|  | <a href="#">Rehabilitation services</a>   | 20% after <u>deductible</u>                  | Not covered.                                       | Visit limits per calendar year: pulmonary = 20 visits; physical, occupational, and speech therapies = 30 visits each; cardiac rehabilitation = 36 visits.           |
|  | <a href="#">Habilitation services</a>     | 20% after <u>deductible</u>                  | Not covered.                                       | Visit limits per calendar year: pulmonary = 20 visits; physical, occupational, and speech therapies = 30 visits each.   |
|  | <a href="#">Skilled nursing care</a>      | 20% after <u>deductible</u>                  | Not covered.                                       | Limited to 30 days per stay in a skilled nursing facility & 60 days per calendar year in an inpatient rehabilitation facility. Prior Authorization required.        |
|  | <a href="#">Durable medical equipment</a> | 20% after <u>deductible</u>                  | Not covered.                                       | Prior Authorization required for purchases or rentals over \$500.   |
|  | <a href="#">Hospice services</a>          | 20% after <u>deductible</u>                  | Not covered.                                       | Prior Authorization required.   |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | No charge.                                   | Not covered.                                       | Routine eye exam every 12 months.   |
|  | Children's glasses                        | 20% after <u>deductible</u>                  | Not covered.                                       | 1 pair of lenses every 12 months, 1 pair of frames (in the Pediatric Eyewear Collection) every two years.   |
|  | Children's dental check-up                | Not covered.                                 | Not covered.                                       | Chorus Community Health Plans dental is available at <a href="http://chorushealthplans.org">chorushealthplans.org</a> .   |

## 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](#).)

- Acupuncture
- Dental Care
- Non-emergency care when travelling outside the US
- Routine foot care
- Bariatric surgery
- Infertility treatment
- Private-duty nursing
- Weight loss programs
- Cosmetic surgery
- Long-term care
- Routine eye care (for adults)

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

- Chiropractic care
- Hearing aids

**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: Wisconsin Office of the Commissioner of Insurance – 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: 1-844-201-4672. You may also contact your state insurance department at 1-800-236-8517 or [www.oci.wi.gov/oci\\_home.htm](http://www.oci.wi.gov/oci_home.htm).

### 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? Yes

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 1-844-201-4672.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-201-4672.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-201-4672.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-201-4672.]

*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 pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist \[cost sharing\]](#) \$70
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$750          |
| <a href="#">Copayments</a>        | \$80           |
| <a href="#">Coinsurance</a>       | \$1,800        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,690</b> |

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist \[cost sharing\]](#) \$70
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$750          |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$30           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,300</b> |

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist \[cost sharing\]](#) \$70
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$750          |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$300          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,250</b> |

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