




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 deductible ? | \$250/Individual or \$500/Family | 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. | 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 other deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$1,350/Individual or \$2,700/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, 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.togethercchp.org/find-a-doc or call 1-844-201-4672 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 in-network specialist you choose without a referral . |

 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 (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 | Primary care visit to treat an injury or illness | \$10/visit | Not covered. | None. |
| | Specialist visit | \$20/visit | Not covered. | None. |
| | Preventive care/screening/immunization | No charge. | Not covered. | You may have to pay for services that aren't <u>preventive</u> . Ask provider if services needed are <u>preventive</u> . Check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 5% after <u>deductible</u> | Not covered. | \$20 copay/visit for applicable laboratory tests. |
| | Imaging (CT/PET scans, MRIs) | 5% after <u>deductible</u> | Not covered. | Prior Authorization required for some services. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.togetherCCHP.org . | Generic drugs | \$5/prescription | Not covered. | Prior Authorization may be required. |
| | Preferred brand drugs | \$15/prescription | Not covered. | Prior Authorization may be required. |
| | Non-preferred brand drugs | 5% after <u>deductible</u> | Not covered. | Prior Authorization may be required. |
| | Specialty drugs | 5% after <u>deductible</u> | Not covered. | Prior Authorization may be required. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 5% after <u>deductible</u> | Not covered. | Prior Authorization required for some services. |
| | Physician/surgeon fees | 5% after <u>deductible</u> | Not covered. | Prior Authorization required for some services. |
| If you need immediate medical attention | Emergency room care | 5% after <u>deductible</u> | 5% after <u>deductible</u> | <u>Maximum allowed amount</u> applies. <u>Out-of-Network providers</u> may balance bill. |
| | Emergency medical transportation | 5% after <u>deductible</u> | 5% after <u>deductible</u> | <u>Maximum allowed amount</u> applies. <u>Out-of Network providers</u> may balance bill. |
| | Urgent care | 5% after <u>deductible</u> | 5% after <u>deductible</u> | If <u>deductible/coinsurance</u> has not been met, remaining billed charges will be applied until satisfied. <u>Maximum allowed amount</u> applies. <u>Out-of-network provider</u> may balance bill. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 5% after <u>deductible</u> | Not covered. | Prior Authorization required for some services. |
| | Physician/surgeon fees | 5% after <u>deductible</u> | Not covered. | Prior Authorization required for some services. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$10/visit | Not covered. | \$10 copay/office visit. 5% after <u>deductible</u> for other outpatient services. Prior Authorization required for some services. |
| | Inpatient services | 5% after <u>deductible</u> | Not covered. | Prior Authorization required for some services. |
| If you are pregnant | Office visits | 5% 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 | 5% after <u>deductible</u> | Not covered. | None. |
| | Childbirth/delivery facility services | 5% after <u>deductible</u> | Not covered. | None. |
| If you need help recovering or have other special health needs | Home health care | 5% after <u>deductible</u> | Not covered. | Limited to 60 visits per calendar year. Prior Authorization required. |
| | Rehabilitation services | 5% after <u>deductible</u> | Not covered. | Visit limits per calendar year: pulmonary = 20 visits; physical, occupational, and speech therapies = 20 visits each; cardiac rehabilitation = 36 visits. |
| | Habilitation services | 5% after <u>deductible</u> | Not covered. | Visit limits per calendar year: pulmonary = 20 visits; physical, occupational, and speech therapies = 20 visits each. |
| | Skilled nursing care | 5% 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. |
| | Durable medical equipment | 5% after <u>deductible</u> | Not covered. | Prior Authorization required for purchases or rentals over \$500. |
| | Hospice services | 5% after <u>deductible</u> | Not covered. | Prior Authorization required. |
| If your child needs dental or eye care | Children's eye exam | No charge. | Not covered. | Routine eye exam every 12 months. |
| | Children's glasses | 5% 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. | Pediatric dental plans are offered on www.healthcare.gov . |

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 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.

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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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](#) \$250
- [Specialist \[cost sharing\]](#) \$20
- Hospital (facility) [\[cost sharing\]](#) 5%
- Other [\[cost sharing\]](#) 5%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$250 |
| Copayments | \$300 |
| Coinsurance | \$400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,010 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist \[cost sharing\]](#) \$20
- Hospital (facility) [\[cost sharing\]](#) 5%
- Other [\[cost sharing\]](#) 5%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$250 |
| Copayments | \$300 |
| Coinsurance | \$30 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$600 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist \[cost sharing\]](#) \$20
- Hospital (facility) [\[cost sharing\]](#) 5%
- Other [\[cost sharing\]](#) 5%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$250 |
| Copayments | \$70 |
| Coinsurance | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$420 |

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