




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> ?	\$2,000/Individual or \$4,000/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> ?	\$6,500/Individual or \$13,000/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="http://www.togethercchp.org/find-a-doc">www.togethercchp.org/find-a-doc</a> 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 <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 (You will pay the least)	Out-of-Network Provider (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	\$60/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 <u>preventive</u> . Ask your provider if services needed are <u>preventive</u> . 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 <u>deductible</u>	Not covered.	None.
	Imaging (CT/PET scans, MRIs)	20% after <u>deductible</u>	Not covered.	Prior Authorization required for some services.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.togetherCCHP.org">www.togetherCCHP.org</a> .	Generic drugs	\$10/prescription	Not covered.	Prior Authorization may be required.
	Preferred brand drugs	\$55/prescription	Not covered.	Prior Authorization may be required.
	Non-preferred brand drugs	20% after <u>deductible</u>	Not covered.	Prior Authorization may be required.
	<a href="#">Specialty drugs</a>	20% after <u>deductible</u>	Not covered.	Prior Authorization may be required.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% after <u>deductible</u>	Not covered.	Prior Authorization required for some services.
	Physician/surgeon fees	20% after <u>deductible</u>	Not covered.	Prior Authorization required for some services.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% after <u>deductible</u>	20% after <u>deductible</u>	<u>Maximum allowed amount</u> applies. <u>Out-of-Network providers</u> may balance bill.
	<a href="#">Emergency medical transportation</a>	20% after <u>deductible</u>	20% after <u>deductible</u>	<u>Maximum allowed amount</u> applies. <u>Out-of-Network providers</u> may balance bill.
	<a href="#">Urgent care</a>	20% after <u>deductible</u>	20% 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.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% after <u>deductible</u>	Not covered.	Prior Authorization required for some services.
	Physician/surgeon fees	20% 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](http://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)	
<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 = 20 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 = 20 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.	Pediatric dental plans are offered on <a href="http://www.healthcare.gov">www.healthcare.gov</a> .

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

## 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](#) \$2,000
- [Specialist \[cost sharing\]](#) \$60
- 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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$1,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,730</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist \[cost sharing\]](#) \$60
- 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>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,420</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist \[cost sharing\]](#) \$60
- 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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,290</b>

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