




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 ? | \$2,000/Individual or \$4,000/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 ? | \$8,700/Individual or \$17,400/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 chorushealthplans.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 | \$30/visit | Not covered. | None. |
| | Specialist visit | \$60/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 your 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) | 25% after deductible | Not covered. | None. |
| | Imaging (CT/PET scans, MRIs) | 25% after deductible | 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 chorushealthplans.org | Generic drugs | \$15/prescription | Not covered. | Prior Authorization may be required. |
| | Preferred brand drugs | \$30/prescription | Not covered. | Prior Authorization may be required. |
| | Non-preferred brand drugs | \$60/prescription | Not covered. | Prior Authorization may be required. |
| | Specialty drugs | \$250/prescription | Not covered. | Prior Authorization may be required. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% after deductible | Not covered. | Prior Authorization required for some services. |
| | Physician/surgeon fees | 25% after deductible | Not covered. | Prior Authorization required for some services. |
| If you need immediate medical attention | Emergency room care | 25% after deductible | 25% after deductible | None. |
| | Emergency medical transportation | 25% after deductible | 25% after deductible | <u>Balance billing</u> may apply to emergency ground transportation. |
| | Urgent care | \$45/visit | \$45/visit | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 25% after deductible | Not covered. | Prior Authorization required for some services. |
| | Physician/surgeon fees | 25% after deductible | Not covered. | Prior Authorization required for some services. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30/office visit or 25% after deductible for other services. | Not covered. | Prior Authorization required for some services. |
| | Inpatient services | 25% after deductible | Not covered. | Prior Authorization required for some services. |

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

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|--|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | \$30/visit | 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 | 25% after <u>deductible</u> | Not covered. | None. |
| | Childbirth/delivery facility services | 25% after <u>deductible</u> | Not covered. | None. |
| If you need help recovering or have other special health needs | Home health care | 25% after <u>deductible</u> | Not covered. | Limited to 60 visits per calendar year. Prior Authorization required. |
| | Rehabilitation services | Physical, occupational, and speech therapy = \$30/visit. Other therapies = 25% 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. |
| | Habilitation services | Physical, occupational, and speech therapy = \$30/visit. Other therapies = 25% after <u>deductible</u> | Not covered. | Visit limits per calendar year: pulmonary = 20 visits; physical, occupational, and speech therapies = 30 visits each. |
| | Skilled nursing care | 25% 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 | 25% after <u>deductible</u> | Not covered. | Prior Authorization required for purchases or rentals over \$500. |
| | Hospice services | 25% 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 | 25% 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. | Plans available at chorushealthplans.org . |

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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](#).)

- 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.

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

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) [\[cost sharing\]](#) 25%
- Other [\[cost sharing\]](#) 25%

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 | \$5,300 |
| Copayments | \$70 |
| Coinsurance | \$1,200 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$6,630 |

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) [\[cost sharing\]](#) 25%
- Other [\[cost sharing\]](#) 25%

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 | \$1,100 |
| Copayments | \$500 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,620 |

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) [\[cost sharing\]](#) 25%
- Other [\[cost sharing\]](#) 25%

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 | \$2,500 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,700 |

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