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 http://www.cciio.cms.gov or call 1-800-201-4672 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3250/Individual or $6500/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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	$8150/Individual or $16300/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 togethercchp.org/find-a-doc or call 1-800-201-4672 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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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	$35/visit	Not covered.	None.
	Specialist visit	$80/visit	Not covered.	None.
	Preventive care/screening/ immunization	No charge	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% after deductible	Not covered.	None.
	Imaging (CT/PET scans, MRIs)	40% 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 togetherCCHP.org.	Generic drugs	$15/prescription	Not covered.	Prior Authorization may be required.
	Preferred brand drugs	$55/prescription	Not covered.	Prior Authorization may be required.
	Non-preferred brand drugs	40% after deductible	Not covered.	Prior Authorization may be required.
	Specialty drugs	40% after deductible	Not covered.	Prior Authorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% after deductible	Not covered.	Prior Authorization required for some services.
	Physician/surgeon fees	40% after deductible	Not covered.	Prior Authorization required for some services.
If you need immediate medical attention	Emergency room care	40% after deductible	40% after deductible	Maximum allowed amount applies. Out-of-network providers may balance bill.
	Emergency medical transportation	40% after deductible	40% after deductible	Maximum allowed amount applies. Out-of-network providers may balance bill.
	Urgent care	$80/visit, then 40% after deductible	$80/visit, then 40% after deductible	Copayment taken at time of visit. If deductible/coinsurance has not been met, remaining billed charges will be applied until satisfied. Maximum allowed amount applies. Out-of-network providers may balance bill.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% after deductible	Not covered.	Prior Authorization required for some services.
	Physician/surgeon fees	40% after deductible	Not covered.	Prior Authorization required for some services.

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	$35/visit	Not covered.	$35 copay/office visit 40% after deductible for other outpatient services. Prior Authorization required for some services.
	Inpatient services	40% after deductible	Not covered.	Prior Authorization required for some services.
If you are pregnant	Office visits	40% after deductible	Not covered.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	40% after deductible	Not covered.	None.
	Childbirth/delivery facility services	40% after deductible	Not covered.	None.
If you need help recovering or have other special health needs	Home health care	40% after deductible	Not covered.	Limited to 60 visits per calendar year. Prior Authorization required.
	Rehabilitation services	40% after deductible	Not covered.	Visit limits per calendar year: pulmonary = 20 visits, physical, occupational and speech therapies = 20 visits each, cardiac rehabilitation = 36 visits.
	Habilitation services	40% after deductible	Not covered.	Visit limits per calendar year: pulmonary = 20 visits, physical, occupational and speech therapies = 20 visits each.
	Skilled nursing care	40% after deductible	Not covered.	Limited to 30 days per calendar year in a skilled nursing facility & 60 days per calendar year in an inpatient rehabilitation facility. Prior Authorization required.
	Durable medical equipment	40% after deductible	Not covered.	Prior Authorization required for purchases or rentals over $500.
	Hospice services	40% after deductible	Not covered.	Prior Authorization required.
If your child needs dental or eye care	Children's eye exam	No charge.	Not covered.	1 routine eye exam every 12 months.
	Children's glasses	40% after deductible	Not covered.	1 pair of lenses every 12 months, 1 pair of frames every two years (in the Pediatric Eyewear Collection).
	Children's dental check-up	Not covered.	Not covered.	Pediatric dental plans are offered on 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	• Bariatric surgery	• Cosmetic surgery
• Dental care	• Infertility treatment	• Long-term care
• Non-emergency care when traveling outside the US	• 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

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: WI 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 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 oci.wi.gov/oci_home.htm.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de ***Together with CCHP***, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-201-4672.

CHINESE：如果您，或是您正在協助的對象，有關於[插入項目的名稱***Together with CCHP***
方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字1-844-201-4672.

HMONG: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog ***Together with CCHP***, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-201-4672.

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

GERMAN: Falls Sie oder jemand, dem Sie helfen, Fragen zum ***Together with CCHP*** haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-201-4672 an.

ARABIC: إن كان لديك أو لدى شخص ما حاجة إلى مساعدته بخصوص أسئلة تتعلق بـ ***Together with CCHP*** (، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون مقابل. اتصل بمترجم للتحدث بلغتك. 1-844-201-4672)

FRENCH: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ***Together with CCHP*** vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-201-4672.

TAGALOG: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa ***Together with CCHP***, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-201-4672.

ALBAINIAN: Nëse ju, ose dikush që po ndihmoni, ka pyetje për ***Together with CCHP***, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-844-201-4672.

HINDI: यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के ***Together with CCHP*** के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िुभाषषए से बात करने के लिए 1-844-201-4672.पर कॉि करें।

POLISH: Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie ***Together with CCHP***, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-201-4672.

VIETNAMESE: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về ***Together with CCHP***, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-201-4672.

PENNSYLVANIA DUTCH: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut ***Together with CCHP***, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-201-4672 uffrufe.

LAOTIAN: ້າທ່ານ, ຫ ຼືຄົນທ ່ທ່ານກໍາລັງຊ່ວຍເຫ ຼືອ, ມ ຄໍາຖາມກ່ຽວກັບ ***Together with CCHP***, ທ່ານມ ສິດທ ່ຈະໄດ້ຮັບການຊ່ວຍເຫ ຼືອແລະຂໍ້ມູນຂ່າວສານທ ່ເປັນພາສາຂອງທ່ານບ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-844-201-4672.

KOREAN: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이***Together with CCHP*** 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-844-201-4672 로 전화하십시오.

RUSSIAN: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу ***Together with CCHP***, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-201-4672.

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.togetherCCHP.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	$3250
Specialist *[cost sharing]*	$80
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	**$12731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3250
Copayments	$186
Coinsurance	$2702
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6198**

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

The plan's overall deductible	$3250
Specialist *[cost sharing]*	$80
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	**$8010**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1862
Copayments	$1544
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3461**

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

The plan's overall deductible	$3250
Specialist *[cost sharing)*	$80
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	**$2874**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1632
Copayments	$233
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1865**

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