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.

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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$4000/Individual or $8000/Family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$8150/Individual or $16300/Family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See togethercchp.org/find-a-doc or call 1-800-201-4672 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the in-network specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$35/visit</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$70/visit</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No charge</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% after deductible</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% after deductible</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$15/prescription</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$50/prescription</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>20% after deductible</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% after deductible</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% after deductible</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% after deductible</td>
<td>Not covered.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$70/visit, then 20% after deductible</td>
<td>$70/visit, then 20% after deductible</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% after deductible</td>
<td>Not covered.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% after deductible</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at www.togetherCCHP.org.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td><strong>Outpatient services</strong></td>
<td>Network Provider (You will pay the least) $35/visit</td>
<td>Not covered. $35 copay/office visit 20% after deductible for other outpatient services. Prior Authorization required for some services.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% after deductible</td>
<td>Not covered. Prior Authorization required for some services.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td><strong>Office visits</strong></td>
<td>20% after deductible</td>
<td>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.)</td>
</tr>
<tr>
<td></td>
<td><strong>Childbirth/delivery professional services</strong></td>
<td>20% after deductible</td>
<td>Not covered. None.</td>
</tr>
<tr>
<td></td>
<td><strong>Childbirth/delivery facility services</strong></td>
<td>20% after deductible</td>
<td>Not covered. None.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td><strong>Home health care</strong></td>
<td>20% after deductible</td>
<td>Not covered. Visit limits per calendar year: pulmonary = 20 visits, physical, occupational and speech therapies = 20 visits each, cardiac rehabilitation = 36 visits.</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>20% after deductible</td>
<td>Not covered. Visit limits per calendar year: pulmonary = 20 visits, physical, occupational and speech therapies = 20 visits each.</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>20% after deductible</td>
<td>Not covered. Visit limits per calendar year: pulmonary = 20 visits, physical, occupational and speech therapies = 20 visits each.</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>20% after deductible</td>
<td>Not covered. Limited to 30 days per calendar year in a skilled nursing facility &amp; 60 days per calendar year in an inpatient rehabilitation facility. Prior Authorization required.</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>20% after deductible</td>
<td>Not covered. Prior Authorization required for purchases or rentals over $500.</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>20% after deductible</td>
<td>Not covered. Prior Authorization required.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td><strong>Children’s eye exam</strong></td>
<td>No charge.</td>
<td>Not covered. 1 routine eye exam every 12 months.</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s glasses</strong></td>
<td>20% after deductible</td>
<td>Not covered. 1 pair of lenses every 12 months, 1 pair of frames every two years (in the Pediatric Eyewear Collection).</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s dental check-up</strong></td>
<td>Not covered.</td>
<td>Not covered. Pediatric dental plans are offered on healthcare.gov.</td>
</tr>
</tbody>
</table>

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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 | • 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 |

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**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 [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.
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.

---

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(9 months of in-network pre-natal care and a hospital delivery)</strong></td>
<td><strong>(a year of routine in-network care of a well-controlled condition)</strong></td>
<td><strong>(in-network emergency room visit and follow up care)</strong></td>
</tr>
<tr>
<td>- The plan’s overall deductible</td>
<td>- The plan’s overall deductible</td>
<td>- The plan’s overall deductible</td>
</tr>
<tr>
<td>$4000</td>
<td>$4000</td>
<td>$4000</td>
</tr>
<tr>
<td>- Specialist [cost sharing]</td>
<td>- Specialist [cost sharing]</td>
<td>- Specialist [cost sharing]</td>
</tr>
<tr>
<td>$70</td>
<td>$70</td>
<td>$70</td>
</tr>
<tr>
<td>- Hospital (facility) [cost sharing]</td>
<td>- Hospital (facility) [cost sharing]</td>
<td>- Hospital (facility) [cost sharing]</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>- Other [cost sharing]</td>
<td>- Other [cost sharing]</td>
<td>- Other [cost sharing]</td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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 $12755

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$4000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$480</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1025</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td><strong>$5565</strong></td>
</tr>
</tbody>
</table>

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 $7465

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1728</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1593</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>The total Joe would pay is</strong></td>
<td><strong>$3376</strong></td>
</tr>
</tbody>
</table>

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 $1925

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1632</td>
</tr>
<tr>
<td>Copayments</td>
<td>$210</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>The total Mia would pay is</strong></td>
<td><strong>$1842</strong></td>
</tr>
</tbody>
</table>

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