




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, visit commongroundhealthcare.org/coverage-details or call 877-514-2442. 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 www.healthcare.gov/sbc-glossary or call 1-877-514-2442 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$0 individual / \$0 family | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes. In network Preventive care is covered before you meet your deductible | 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? | Yes, \$2,250 individual / \$4,500 family prescription drug deductible | You must pay all of the costs for these services up to the specific prescription drug deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan ? | \$9,450 individual / \$18,900 family | 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, out-of-network provider charges, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain prior authorization for services or the difference in cost when a brand name drug is dispensed instead of its generic equivalent. | 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.CGCares.org/Find-a-Doctor or call 877-514-2442 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. |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| Do you need a referral to see a specialist ? | No | You can see the 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 | \$40 Copay | Not covered | Virtual visits (Telehealth) benefits available. No coverage for chiropractic wellness or maintenance therapy. See your Certificate of Coverage for exclusions and limitations. |
| | Specialist visit | \$100 Copay | Not covered | Virtual visits (Telehealth) benefits available. See your Certificate of Coverage for exclusions and limitations. |
| | Preventive care/screening/immunization | No Charge | Not covered | Services under the ACA guidelines will be covered as preventive. 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) | Lab: \$75 Copay/Test X-Ray: \$150 Copay/Service | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | \$1,075 Copay/Service | Not covered | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://commongroundhealthcare.org/formulary/ | Tier 1 – Typically generic drugs | \$35 Copay/Script | Not covered | For mail order prescriptions, a 90-day supply is available for two copays. CGHC Formulary |
| | Tier 2 – Preferred drugs | \$140 Copay/Script | Not covered | For mail order prescriptions, a 90-day supply is available for two copays. |
| | Tier 3 – Non-preferred drugs | 50% Coins after Rx Ded | Not covered | Additional costs may apply when a brand name drug is dispensed instead of its generic equivalent. CGHC Formulary |

* For more information about limitations and exceptions, see the [plan](#) or policy document at CommonGroundHealthcare.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) | |
| | Tier 4 – Specialty drugs | 50% Coins after Rx Ded | Not covered | CGHC Formulary |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$200 Copay | Not covered | Other significant expenses that may be associated with an outpatient surgery: 50% Coins after Ded for Anesthesia. \$1,075 Copay/Service for Imaging (See “If you have a Test”). 50% Coins after Ded for Implants and Supplies. |
| | Physician/surgeon fees | \$200 Copay | Not covered | |
| If you need immediate medical attention | Emergency room care | \$1,800 Copay** | \$1,800 Copay** | **Copay applies to ER facility fee (waived if admitted); For all other ER related charges, see your Schedule of Benefits. ER services are paid at In-Network benefit level. |
| | Emergency medical transportation | 50% Coins after Ded | 50% Coins after Ded | Balance billing may apply to emergency ground transportation for out-of-network providers. |
| | Urgent care | \$200 Copay | \$200 Copay | Medically necessary Urgent Care services at out-of-service-area providers are covered when a covered person is traveling, or a dependent resides outside of CGHC’s service area. Any follow-up care must be provided by an in-network provider. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$1,500 Copay Per Day | Not covered | Services described assume inpatient care. For outpatient cost sharing, see your Schedule of Benefits. |
| | Physician/surgeon fees | 50% Coins after Ded | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$40 Copay | Not covered | Services described assume clinic based care. For outpatient cost sharing, see your Schedule of Benefits. |
| | Inpatient services | \$1,500 Copay Per Day | Not covered | None |
| If you are pregnant | Office visits | 50% Coins after Ded | Not covered | Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible |
| | Childbirth/delivery professional services | 50% Coins after Ded | Not covered | |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Childbirth/delivery facility services | \$1,500 Copay Per Day | Not covered | may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| If you need help recovering or have other special health needs | Home health care | 50% Coins after Ded | Not covered | Services for home health care are limited to 60 visits per calendar year. |
| | Rehabilitation services | \$100 Copay Per Therapy Type Per Day | Not covered | Services for PT/OT/ST are limited to 20 visits each per calendar year. Services for custodial care are excluded. Services for cardiac rehabilitation are limited to 36 visits per calendar year. |
| | Habilitation services | \$100 Copay Per Therapy Type Per Day | Not covered | Services for PT/OT/ST are limited to 20 visits each per calendar year. Services for custodial care are excluded. |
| | Skilled nursing care | \$1,500 Copay Per Day | Not covered | Services for skilled nursing are limited to 30 days per stay. |
| | Durable medical equipment | 50% Coins after Ded | Not covered | None |
| | Hospice services | 50% Coins after Ded | Not covered | None |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not covered | Limited to one exam every year for children. |
| | Children's glasses | 50% Coins after Ded | Not covered | Limited to one pair of glasses or contacts per year for children only. |
| | Children's dental check-up | No Charge | Not covered | Limited to two cleanings, two X-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit two per year), and sealants (up to age 14 on permanent molars only) per year. |

Excluded Services & Other Covered Services:

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

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Dental care (Adult)
- Hearing aids
- Routine eye care (Adult)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or www.cciio.cms.gov, Wisconsin Office of the Commissioner of Insurance at 800-236-8517, or call Common Ground Healthcare Cooperative at 877-514-2442. 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: Common Ground Healthcare Cooperative Appeals and Grievances Department, 120 Bishop's Way, Suite 150, Brookfield, WI 53005 or call 877-514-2442. For state of Wisconsin assistance, contact Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, complaints@ociwi.state.us, phone 800-236-8517 or 608-266-0103.

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? Not Applicable

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 877-514-2442.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-514-2442.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码877-514-2442.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 877-514-2442.

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](#) \$0
- [Specialist copayments](#) \$100
- Hospital (facility) [copayments](#) \$1,500 Per Day
- Other [coinsurance](#) 50%

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 | \$0 |
| Copayments | \$2,400 |
| Coinsurance | \$2,000 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,460 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayments](#) \$100
- Hospital (facility) [copayments](#) \$1,500 Per Day
- Other [coinsurance](#) 50%

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 | \$0 |
| Copayments | \$2,600 |
| Coinsurance | \$400 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$3,020 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayments](#) \$100
- Hospital (facility) [copayments](#) \$1,500 Per Day
- Other [coinsurance](#) 50%

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 | \$0 |
| Copayments | \$1,100 |
| Coinsurance | \$800 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |

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

