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 <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> 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 <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$9,450 individual / \$18,900 family	If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.		
What is not included in the out-of-pocket limit?	Premiums, <u>out-of-network provider</u> charges, <u>balance-billing</u> charges, healthcare this plan doesn't cover, and penalties for failure to obtain <u>prior authorization</u> 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 <u>network provider</u> ?	Yes. See www.CGCares.org/Find-a-Doctor or call 877-514-2442 for a list of			

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the specialist you choose without a referral.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	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.
If you visit a health care provider's office or	Specialist visit	\$100 Copay	Not covered	Virtual visits (Telehealth) benefits available. See your Certificate of Coverage for exclusions and limitations.
clinic	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 If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://commongroundhealthcare.org/formulary/	<u>Diagnostic test</u> (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
	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 <u>plan</u> or policy document at CommonGroundHealthcare.org.

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Tier 4 – Specialty drugs	50% Coins after Rx Ded	Not covered	CGHC Formulary	
If you have outpatient	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.	
surgery	Physician/surgeon fees	\$200 Copay	Not covered	\$1,075 Copay/Service for Imaging (See "If you have a Test"). 50% Coins after Ded for Implants and Supplies.	
	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.	
If you need immediate medical attention	Emergency medical transportation	50% Coins after Ded	50% Coins after Ded	Balance billing may apply to emergency ground transportation for out-of-network providers.	
	<u>Urgent care</u>	\$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	Outpatient services	\$40 Copay	Not covered	Services described assume clinic based care. For outpatient cost sharing, see your Schedule of Benefits.	
abuse services	Inpatient services	\$1,500 Copay Per Day	Not covered	None	
lf	Office visits	50% Coins after Ded	Not covered	Cost sharing does not apply for preventive	
If you are pregnant	Childbirth/delivery professional services	50% Coins after Ded	Not covered	services. Depending on the type of services, a copayment, coinsurance, or deductible	

 $^{^{\}star} \ \text{For more information about limitations and exceptions, see the } \underline{\text{plan}} \ \text{or policy document at CommonGroundHealthcare.org.}$

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	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).
	Home health care	50% Coins after Ded	Not covered	Services for home health care are limited to 60 visits per calendar year.
If you need help recovering or have other special health needs	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.
	<u>Durable medical equipment</u>	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	Not Covered	Not covered	This coverage is available in the insurance market and can be purchased as a standalone product.

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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Dental care (Adult)Infertility treatment

Private-duty nursingRoutine foot care

Acupuncture

• Long-term care

Weight loss programs

Bariatric surgery
Cosmetic surgery

Non-emergency care when traveling outside the U.S.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at CommonGroundHealthcare.org.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Chiropractic care

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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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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^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at CommonGroundHealthcare.org.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u> \$

■ Specialist copayments \$100

Hospital (facility) copayments \$1,500 Per Day

Other coinsurance

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

Total Example Cost	Ψ12,700		
In this example, Peg would pay:			
Cost Sharing			
<u>Deductibles</u>	\$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 <u>plan's</u> overall <u>deductible</u>

■ Specialist copayments

■ Hospital (facility) <u>copayments</u> \$1,500 Per Day

\$100

50%

\$5,600

Other coinsurance

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Total Example Cost

50%

\$12 700

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	ψ5,000		
In this example, Joe would pay:			
Cost Sharing			
<u>Deductibles</u>	\$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 <u>plan's</u> overall <u>deductible</u> \$

■ <u>Specialist copayments</u> \$100

■ Hospital (facility) <u>copayments</u> \$1,500 Per Day

■ Other coinsurance 50%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (*x-ray*)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
Copayments	\$1,100	
Coinsurance	\$800	
What isn't covered		
Limits or exclusions		
The total Mia would pay is	\$1,900	



HEALTHCARE COOPERATIVE

NOTICE OF NON-DISCRIMINATION AND AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

Common Ground Healthcare Cooperative (CGHC) complies with complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). This means that CGHC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity).

CGHC provides free aids and services to people with disabilities so they may communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, and other formats)

CGHC provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services please contact the CGHC Civil Rights Coordinator.

If you believe that CGHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, or gender identity). You can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone.

CGHC Civil Rights Coordinator

Phone Number: 414.269.4684 (TTY: 711)

Fax Number: 414,433,4612

Email: CivilRights@CommonGroundHealthcare.org

Mail: 120 Bishop's Way, Suite 150, Brookfield, WI 53005-6271

U.S. Department of Health and Human Services

200 Independence Avenue SW, Room 509F, HHH Building Washington, DC 20201

1.800.368.1019 (TDD: 1.800.537.7697)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.514.2442 (TTY/TDD: 711)	French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1.877.514.2442 (TTY/TDD: 711)	Chinese 注意:如果您使用繁體中文,您可以 免费獲得語言援助服務。請致電 1.877.514.2442 (TTY/TDD: 711)	German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.514.2442 (TTY/TDD: 711).	Laotian ໂປດຊາບ: ຖ້າວ່າ ທ່ານ ເດືອ້ າພາສາ ລາວ, ການປົລການຊ່ ວຍ ເດືອງ ອດ້ານພາສາ, ໂດຍ ົບເຮັງອຳ, ແມ່ນມືອມໃຫ້ທ່ານ. ໂທຣ 1.877.514.2442 (TTY/TDD: 711)
Hmong LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.877.514.2442 (TTY/TDD: 711)	Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.514.2442 (TTY/TDD: 711)	Arabic تامدخ بات ، ﴿ عَلَا اللّٰهُ عَلَى اللّٰهِ اللّٰهِ عَلَى اللّٰهِ اللّٰمِلْلِي اللّٰهِ الللّٰمِ الللّٰهِ اللّٰهِ اللّٰهِ اللّٰمِلْمِ الللّٰهِ اللّٰهِ الللّٰمِ اللّٰهِ	Hindi धयान द : य द आप �हंद� बोलते ह तो आपके िलए मू त म भाषा सहायता सेवाएं उपलबध ह । 1.877.514.2442. पर कॉल कर । (TTY/TDD:711)	Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.877.514.2442 (TTY/TDD: 711).
Pennsylvania Dutch Wann du [Deitsch] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.877.514.2442 (TTY/TDD: 711)	Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.514.2442 (телетайп: 711)	Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.514.2442 (TTY/TDD: 711).	Thai อิยน: ลาอั คุณเพลภาษาไทยคุณสามารถไชบอั รการชาว่ ยเหลออี ทางภาษาไทฟอั ร ไทร 1.877.514.2442 (TTY/TOD: 711).	Albanian KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.877.514.2442. (TTY/TDD: 711)

CGHC.EO.2034a-2023-02

CGHC.PB.2051-2023-07