




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](http://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](http://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 <a href="#">deductible</a> ?	<b>\$0 individual / \$0 family</b>	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In network <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	<b>Yes, \$2,250 individual / \$4,500 family prescription drug deductible</b>	You must pay all of the costs for these services up to the specific prescription drug <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$9,200 individual / \$18,400 family</b>	If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, <a href="#">out-of-network provider</a> charges, <a href="#">balance-billing</a> charges, healthcare this plan doesn't cover, and penalties for failure to obtain <a href="#">prior authorization</a> 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 <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.CGCares.org/Find-a-Doctor">www.CGCares.org/Find-a-Doctor</a> or call 877-514-2442 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

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

 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)	
<b>If you visit a health care provider's office or clinic</b>	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.
	<a href="#">Specialist</a> visit	\$100 Copay	Not covered	Virtual visits (Telehealth) benefits available. See your Certificate of Coverage for exclusions and limitations.
	<a href="#">Preventive care/screening/immunization</a>	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 <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (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
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://commongroundhealthcare.org/formulary-2025/">https://commongroundhealthcare.org/formulary-2025/</a>	Tier 1 – Typically generic drugs	\$35 Copay/Script	Not covered	For mail order prescriptions, a 90-day supply is available for two copays. <a href="#">CGHC Formulary</a>
	Tier 2 – Preferred drugs	\$140 Copay/Script	Not covered	For mail order prescriptions, a 90-day supply is available for two copays. <a href="#">CGHC Formulary</a>
	Tier 3 – Non-preferred drugs	50% Coins after Rx Ded	Not covered	
	Tier 4 – <a href="#">Specialty drugs</a>	50% Coins after Rx Ded	Not covered	<a href="#">CGHC Formulary</a>

\* 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)	
<b>If you have outpatient surgery</b>	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	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$1,850 Copay**	\$1,850 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.
	<a href="#">Emergency medical transportation</a>	50% Coins after Ded	50% Coins after Ded	Balance billing may apply to emergency ground transportation for out-of-network providers.
	<a href="#">Urgent care</a>	\$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.
<b>If you have a hospital stay</b>	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
<b>If you need mental health, behavioral health, or substance abuse services</b>	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
<b>If you are pregnant</b>	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 may apply. Maternity care may include tests and services described elsewhere in the
	Childbirth/delivery professional services	50% Coins after Ded	Not covered	
	Childbirth/delivery facility	\$1,500 Copay Per Day	Not covered	

\* 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)	
	services			SBC (i.e., ultrasound).
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	50% Coins after Ded	Not covered	Services for home health care are limited to 60 visits per calendar year.
	<a href="#">Rehabilitation services</a>	\$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.
	<a href="#">Habilitation services</a>	\$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.
	<a href="#">Skilled nursing care</a>	\$1,500 Copay Per Day	Not covered	Services for skilled nursing are limited to 30 days per stay.
	<a href="#">Durable medical equipment</a>	50% Coins after Ded	Not covered	None
	<a href="#">Hospice services</a>	50% Coins after Ded	Not covered	None
<b>If your child needs dental or eye care</b>	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 glasses (1 pair per year) or contacts (1 year supply) 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 stand-alone product.

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> </ul>

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

**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](http://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](http://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, PO Box 1630, Brookfield, WI 53008-1630 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](mailto: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, 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$2,400
<a href="#">Coinsurance</a>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,460</b>

### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$2,600
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,020</b>

### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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



