



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 ?	\$9,200 individual / \$18,400 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-2025/	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. CGHC Formulary
	Tier 3 – Non-preferred drugs	50% Coins after Rx Ded	Not covered	
	Tier 4 – Specialty drugs	50% Coins after Rx Ded	Not covered	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)	
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	\$1,850 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.
	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 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).
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 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Abortion (except in cases of rape, incest, or when the life of the mother is endangered) Acupuncture Bariatric surgery Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult) Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> 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.)		
<ul style="list-style-type: none"> Chiropractic care 	<ul style="list-style-type: none"> Hearing aids 	<ul style="list-style-type: none"> Routine eye care (Adult)

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

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,400
Coinsurance	\$2,000
<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,600
Coinsurance	\$400
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

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

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

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



NOTICE OF NON-DISCRIMINATION AND AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

Common Ground Healthcare Cooperative (CGHC) complies with applicable Federal civil rights laws and does not discriminate. This means we do not exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy or related conditions; sexual characteristics, orientation, or stereotypes; intersex traits; gender identity) or any combination thereof.

CGHC provides reasonable modifications for people with disabilities so they may communicate effectively. This includes appropriate auxiliary aids and services, including qualified interpreters and information in alternate formats such as braille or large print. These services are provided free of charge and in a timely manner when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate.

CGHC provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency.

If you need any of the services listed above, please contact our Section 1557 Coordinator. If you believe that CGHC has failed to provide these services or discriminated in another way (as described above), you can file a grievance with our Section 1557 Coordinator. A grievance can be filed in person or by mail, fax, or email. If you need help filing a grievance, our Section 1557 Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. This can be done 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 Section 1557 Coordinator

Phone Number: 1-844-539-1732 (TTY: 711)

Fax Number: 1-844-417-6254

Email: CivilRightsCoordinator@CareSource.com

Mail: PO Box 1947, Dayton, Ohio 45401

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

www.hhs.gov/ocr/office/file/index.html

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-539-1732 (TTY: 711)	French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-539-1732 (TTY: 711)	Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-539-1732 (TTY: 711)	German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-539-1732 (TTY: 711).	Laotian ໂປດລາວ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໄດ້ຮັບຮັບຮອງຮັບ ຈຳນວນ ດ້ວຍບິນລິມະສິດ ທີ່ ບໍ່ ຈ່າຍ ຄ່າ. ໂທ 1-844-539-1732 (TTY: 711)
Hmong LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-539-1732 (TTY: 711)	Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-539-1732 (TTY: 711)	Arabic فوغللا كدعاسملا تامدخ نجف، وغلا ركذا تدمت تلك اذا بطوالم (TTY: 711) 1-844-539-1732 مقرب لصتا، ناجملاب كل رفاروت	Hindi ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुझ भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-539-1732 पर कॉल करें। (TTY:711)	Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-539-1732 (TTY: 711).
Pennsylvania Dutch Wann du [Deutsch] schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff. Call 1-844-539-1732 (TTY: 711)	Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-539-1732 (телетайп: 711)	Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-539-1732 (TTY: 711).	Thai หมายเหตุ: ถ้ามองพูดภาษาไทยคุณสามารถขอรับบริการช่วยเหลือทางภาษาไทยฟรี โทร 1-844-539-1732 (TTY: 711).	Albanian KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-844-539-1732 (TTY: 711)

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