
 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 <http://www.commongroundhealthcare.org/2020certificate-of-coverage> 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:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$3000</b> individual / <b>\$6000</b> family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	[You don't have to meet <a href="#">deductibles</a> for specific services.] [You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.]
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$6500</b> individual / <b>\$13000</b> family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family <a href="#">out-of-pocket limit</a> must be met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Premiums, <a href="#">out-of-network provider</a> charges, <a href="#">copayments</a> for certain services, <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.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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 network providers.	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.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the in-network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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 <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$40 Copay/Visit	Not covered	—————none—————
	<a href="#">Specialist</a> visit	\$80 Copay/Visit	Not covered	No coverage for infertility services.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not covered	Services under the ACA guidelines will be covered as preventive
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Ded/25% Coins	Not covered	—————none—————
	Imaging (CT/PET scans, MRIs)	Ded/25% Coins	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="http://www.CGCares.org/formulary">www.CGCares.org/formulary</a>	Generic drugs	\$20 Copay/Script	Not covered	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	\$75 Copay/Script	Not covered	For mail order prescriptions, a 90 day supply is available for two copays.
	Non-preferred brand drugs	Ded/25% Coins	Not covered	For mail order prescriptions, a 90 day supply is available for two copays.
	<a href="#">Specialty drugs</a>	Ded/30% Coins	Not covered	Infertility specialty drugs not covered.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Ded/25% Coins	Not covered	—————none—————
	Physician/surgeon fees	Ded/25% Coins	Not covered	—————none—————
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Ded/25% Coins	NA	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	<a href="#">Emergency medical transportation</a>	Ded/25% Coins	NA	—————none—————
	<a href="#">Urgent care</a>	\$75 Copay/Visit	NA	—————none—————
	Facility fee (e.g., hospital room)	Ded/25% Coins	Not covered	—————none—————

\* For more information about limitations and exceptions, see the plan or policy document at [www.CommonGroundHealthcare.org](http://www.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 a hospital stay</b>	Physician/surgeon fees	Ded/25% Coins	Not covered	—————none—————
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40 Copay/Visit	Not covered	—————none—————
	Inpatient services	Ded/25% Coins	Not covered	—————none—————
<b>If you are pregnant</b>	Office visits	Ded/25% Coins	Not covered	—————none—————
	Childbirth/delivery professional services	Ded/25% Coins	Not covered	
	Childbirth/delivery facility services	Ded/25% Coins	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Ded/25% Coins	Not covered	Services for home health care are limited to 60 visits per calendar year.
	<a href="#">Rehabilitation services</a>	Ded/25% Coins	Not covered	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	<a href="#">Habilitation services</a>	Ded/25% Coins	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>	Ded/25% Coins	Not covered	Services for skilled nursing are limited to 30 days per calendar year.
	<a href="#">Durable medical equipment</a>	Ded/25% Coins	Not covered	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	<a href="#">Hospice services</a>	Ded/25% Coins	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	Ded/25% Coins	Not covered	Limited to one pair of glasses 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 stand-alone product.

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

## 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 (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 — may be covered with limitations

**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 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 Grievance Unit, 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**

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](#).

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

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](#) **\$3000**
- [Specialist Copayment](#) **\$80**
- Hospital (facility) [Coinsurance](#) **25%**
- Other [Coinsurance](#) **25%**

**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>\$12775</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3000
Copayments	\$160
Coinsurance	\$3100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6320</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) **\$3000**
- [Specialist Copayment](#) **\$80**
- Hospital (facility) [Coinsurance](#) **25%**
- Other [Coinsurance](#) **25%**

**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>\$7583</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3000
Copayments	\$1100
Coinsurance	\$1361
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$5516</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) **\$3000**
- [Specialist Copayment](#) **\$80**
- Hospital (facility) [Coinsurance](#) **25%**
- Other [Coinsurance](#) **25%**

**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>\$1932</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1224
Copayments	\$240
Coinsurance	\$408
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1872</b>