




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/certificate 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 ? | \$3,600 individual / \$7,200 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| 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? | No | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$8,700 individual / \$17,400 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. |
| What is not included in the out-of-pocket limit ? | Premiums, out-of-network provider charges, copayments for certain services, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain prior authorization for services. | 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.CGCaes.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 in-network 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 | \$30 Copay/Visit | Not covered | —————none————— |
| | Specialist visit | \$60 Copay/Visit | Not covered | No coverage for infertility services after confirmed diagnosis of infertility. |
| | Preventive care/screening/immunization | No Charge | Not covered | Services under the ACA guidelines will be covered as preventive |
| If you have a test | Diagnostic test (x-ray, blood work) | Deductible/20% Coins | Not covered | —————none————— |
| | Imaging (CT/PET scans, MRIs) | Deductible/20% Coins | Not covered | —————none————— |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.commongroundhealthcare.org | Generic drugs | \$15 Copay/Script | Not covered | For mail order prescriptions, a 90-day supply is available for two copays. |
| | Preferred brand drugs | \$50 Copay/Script | Not covered | For mail order prescriptions, a 90-day supply is available for two copays. |
| | Non-preferred brand drugs | \$100 Copay/Script after Deductible | Not covered | For mail order prescriptions, a 90-day supply is available for two copays. |
| | Specialty drugs | Deductible/30% Coins | Not covered | Infertility specialty drugs not covered. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Deductible/20% Coins | Not covered | —————none————— |
| | Physician/surgeon fees | Deductible/20% Coins | Not covered | —————none————— |
| If you need immediate medical attention | Emergency room care | \$300 Copay/Visit | \$300 Copay/Visit | Copay applies to ER facility (waived if admitted); other professional charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit |

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|--|--|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | level. |
| | Emergency medical transportation | Deductible/20% Coins | Deductible/20% Coins | Services are paid at In-Network benefit level. Balance billing may apply to emergency ground transportation. |
| | Urgent care | \$75 Copay/Visit | \$75 Copay/Visit | 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) | Deductible/20% Coins | Not covered | _____none_____ |
| | Physician/surgeon fees | Deductible/20% Coins | Not covered | _____none_____ |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 Copay/Visit | Not covered | _____none_____ |
| | Inpatient services | Deductible/20% Coins | Not covered | _____none_____ |
| If you are pregnant | Office visits | Deductible/20% Coins | Not covered | _____none_____ |
| | Childbirth/delivery professional services | Deductible/20% Coins | Not covered | _____none_____ |
| | Childbirth/delivery facility services | Deductible/20% Coins | Not covered | _____none_____ |
| If you need help recovering or have other special health needs | Home health care | Deductible/20% Coins | Not covered | Services for home health care are limited to 60 visits per calendar year. |
| | Rehabilitation services | Deductible/20% Coins | 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 | Deductible/20% Coins | Not covered | Services for PT/OT/ST are limited to 20 |

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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | visits each per calendar year. Services for custodial care are excluded. |
| | Skilled nursing care | Deductible/20% Coins | Not covered | Services for skilled nursing are limited to 30 days per stay. |
| | Durable medical equipment | Deductible/20% Coins | Not covered | |
| | Hospice services | Deductible/20% Coins | 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 | Deductible/20% Coins | 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 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"> Acupuncture Bariatric surgery Cosmetic surgery Private-duty nursing | <ul style="list-style-type: none"> Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. Weight loss programs | <ul style="list-style-type: none"> Routine foot care Routine dental care (adult) | |
| 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 – 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, 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

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

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 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, 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? 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](#).

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, kwijjigo 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 | \$3,600 |
| ■ Specialist [cost sharing] | \$50 |
| ■ Hospital (facility) [cost sharing] | 20% |
| ■ Other [cost sharing] | 20% |

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 | \$3,600 |
| Copayments | \$10 |
| Coinsurance | \$1,800 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$5,470 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$3,600 |
| ■ Specialist [cost sharing] | \$50 |
| ■ Hospital (facility) [cost sharing] | 20% |
| ■ Other [cost sharing] | 20% |

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 | \$900 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,620 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$3,600 |
| ■ Specialist [cost sharing] | \$50 |
| ■ Hospital (facility) [cost sharing] | 20% |
| ■ Other [cost sharing] | 20% |

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 | \$2,100 |
| Copayments | \$500 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,600 |

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