




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](http://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](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> ?                                | \$3,000 individual / \$6,000 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> .  |
| 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?              | No  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$7,500 individual / \$15,000 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.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Premiums, <a href="#">out-of-network provider charges</a> , <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> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.CGCaes.org/Find-a-Doctor">www.CGCaes.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                                       | No  | You can see the in-network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .   |

| Important Questions                | Answers | Why This Matters: |
|------------------------------------|---------|-------------------|
| see a <a href="#">specialist</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<br>(You will pay the least) | Out-of-Network Provider<br>(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       | \$20 Copay/Visit                             | Not covered  | —————none—————   |
|   | <a href="#">Specialist</a> visit                       | \$60 Copay/Visit                             | Not covered  | No coverage for infertility services after confirmed diagnosis of infertility.   |
|   | <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)    | Deductible/20% Coins                         | Not covered  | —————none—————   |
|   | Imaging (CT/PET scans, MRIs)                           | Deductible/20% Coins                         | Not covered  | —————none—————   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.commongroundhealthcare.org">www.commongroundhealthcare.org</a> | 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.   |
|   | <a href="#">Specialty drugs</a>                        | Deductible/30% Coins                         | Not covered  | Infertility specialty drugs not covered.   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)         | Deductible/20% Coins                         | Not covered  | —————none—————   |
|   | Physician/surgeon fees                                 | Deductible/20% Coins                         | Not covered  | —————none—————   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>                    | \$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 level. |

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

| Common Medical Event   | Services You May Need                            | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|--|--|--|--|---|
|  |  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
|  | <a href="#">Emergency medical transportation</a> | Deductible/20% Coins                         | Deductible/20% Coins                               | Services are paid at In-Network benefit level. Balance billing may apply to emergency ground transportation.  |
|  | <a href="#">Urgent care</a>                      | \$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. |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)               | Deductible/20% Coins                         | Not covered  | —————none—————  |
|  | Physician/surgeon fees                           | Deductible/20% Coins                         | Not covered  | —————none—————  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | \$20 Copay/Visit                             | Not covered  | —————none—————  |
|  | Inpatient services                               | Deductible/20% Coins                         | Not covered  | —————none—————  |
| <b>If you are pregnant</b>   | 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—————  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>                 | Deductible/20% Coins                         | Not covered  | Services for home health care are limited to 60 visits per calendar year.   |
|  | <a href="#">Rehabilitation services</a>          | 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.  |
|  | <a href="#">Habilitation services</a>            | Deductible/20% Coins                         | Not covered  | Services for PT/OT/ST are limited to 20 visits each per calendar year. Services for   |

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| Common Medical Event                          | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|---|---|--|--|---|
|   |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
|   |   |  |  | custodial care are excluded.  |
|   | <a href="#">Skilled nursing care</a>      | Deductible/20% Coins                         | Not covered  | Services for skilled nursing are limited to 30 days per stay.                                     |
|   | <a href="#">Durable medical equipment</a> | Deductible/20% Coins                         | Not covered  |   |
|   | <a href="#">Hospice services</a>          | Deductible/20% 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                        | 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"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Routine eye care (Adult)</li> <li>• Routine dental care (Adult)</li> </ul> |
|--|---|--|

**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 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

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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

[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, 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](#) \$3,000
- [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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$3,000        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$1,900        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,970</b> |

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$3,000
- [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$900          |
| <a href="#">Copayments</a>        | \$600          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,520</b> |

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$3,000
- [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,100        |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,600</b> |

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