Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2023 – 12/31/2023**

Common Ground Healthcare Cooperative: CGHC Copay Bronze LCS - Envision Network (Dental/Vision Exam + Allergy Test) **Coverage For: Individual + Family | Plan Type: EPO**

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 www.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**	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?	**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?	**$9,100 individual / $18,200 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.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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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	**$15 Copay/Visit**	Not covered	-------none-------
	Specialist visit	**$200 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)	**$50 Copay/Visit**	Not covered	-------none-------
	Imaging (CT/PET scans, MRIs)	**$1,000 Copay/Visit**	Not covered	-------none-------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.commongroundhealth-care.org	Generic drugs	**$25 Copay/Script**	Not covered	For mail order prescriptions, a 90-day supply is available for two copays.
	Preferred brand drugs	**$125 Copay/Script**	Not covered	For mail order prescriptions, a 90-day supply is available for two copays.
	Non-preferred brand drugs	**Rx Deductible/50% Coins**	Not covered	For mail order prescriptions, a 90-day supply is available for two copays.
	Specialty drugs	**Rx Deductible/50% Coins**	Not covered	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**$200 Copay/Visit**	Not covered	-------none-------
	Physician/surgeon fees	**$200 Copay/Visit**	Not covered	-------none-------

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 need immediate medical attention	Emergency room care	**$1,800 Copay/Visit**	**$1,800 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.
	Emergency medical transportation	**Deductible/50% Coins**	**Deductible/50% Coins**	Services rendered out-of-network are paid at In-Network benefit level. Balance billing may apply to emergency ground transportation.
	Urgent care	**$200 Copay/Visit**	**$200 Copay/Visit**	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., ambulatory surgery center)	**$1,500 Per Day**	Not covered	-------none-------
	Physician/surgeon fees	**Deductible/50% Coins**	Not covered	-------none-------
If you need mental health, behavioral health , or substance abuse services	Outpatient services	**$15 Copay/Visit**	Not covered	-------none-------
	Inpatient services	**$1,500 Per Day**	Not covered	-------none-------
If you are pregnant	Office visits	**Deductible/50% Coins**	Not covered	-------none-------
	Childbirth/delivery professional services	**Deductible/50% Coins**	Not covered	-------none-------
	Childbirth/delivery facility services	**Deductible/50% Coins**	Not covered	-------none-------

* 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 need help recovering or have other special health needs	Home health care	Deductible/50% Coins	Not covered	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	$200 Copay/Visit	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	$200 Copay/Visit	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 Per Day	Not covered	Services for skilled nursing are limited to 30 days per stay.
	Durable medical equipment	Deductible/50% Coins	Not covered	--------none--------
	Hospice services	Deductible/50% 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/50% Coins	Not covered	Limited to one pair of glasses or contacts per year for children only.
	Children's dental check-up	Not covered, except select children's dental services are covered at No Charge	Not covered	Select covered services include two cleanings, two X-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit two per year), and sealants (up to age 14 on permanent molars only) per year.

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
- Infertility treatment
- Long-term care
- Non-emergency care when traveling
- 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.)

- Chiropractic Care
- Hearing Aids
- Dental care (Adult)
- Routine eye care (Adult)

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, 120 Bishop's Way, Suite 150, Brookfield, WI 53005 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, kwiijigo holne' 877-514-2442.

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	$0
Specialist [cost sharing]	$200
Hospital (facility) [cost sharing]	$1500 Per Day
Other [cost sharing]	50% after Ded

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	$0
Copayments	$2,100
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The Total Peg would pay is	**$4,160**

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 [cost sharing]	$200
Hospital (facility) [cost sharing]	$1500 Per Day
Other [cost sharing]	50% after Ded

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	$0
Copayments	$2,300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The Total Joe would pay is	**$2,720**

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

The plan's overall deductible	$0
Specialist [cost sharing]	$200
Hospital (facility) [cost sharing]	$1500 Per Day
Other [cost sharing]	50% after Ded

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	$0
Copayments	$1,200
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The Total Mia would pay is	**$2,000**

The plan would be responsible for the other costs of these EXAMPLE covered services.