

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 Silver \$0 Ded CSR 94% - Envision Network (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](http://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](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 <b>deductible</b> ?	\$0 individual / \$0 family	Generally, you must pay all of the costs from providers up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
Are there services covered before you meet your <b>deductible</b> ?	Yes. In network <b>Preventive care</b> is covered before you meet your <b>deductible</b>	This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain <b>preventive services</b> without <b>cost-sharing</b> and before you meet your <b>deductible</b> . See a list of covered <b>preventive services</b> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <b>deductibles</b> for specific services?	No	<b>You don't have to meet deductibles for specific services.</b>
What is the <b>out-of-pocket limit</b> for this <b>plan</b> ?	\$1,100 individual / \$2,200 family	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family <b>out-of-pocket limit</b> must be met.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, <b>out-of-network provider</b> charges, <b>copayments</b> for certain services, <b>balance-billing</b> charges, healthcare this plan doesn't cover, and penalties for failure to obtain <b>prior authorization</b> for services.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <b>network provider</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 <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the plan's <b>network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the provider's charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.

Important Questions	Answers	Why This Matters:
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> .

 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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$5 Copay/Visit	Not covered	-----none-----
	<a href="#">Specialist</a> visit	\$20 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
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$20 Copay/Visit	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$75 Copay/Visit	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.commongroundhealthcare.org">www.commongroundhealthcare.org</a>	Generic drugs	\$0 Copay/Script	Not covered	For mail order prescriptions, a 90-day supply is available for two copays.
	Preferred brand drugs	\$20 Copay/Script	Not covered	For mail order prescriptions, a 90-day supply is available for two copays.
	Non-preferred brand drugs	Deductible/10% Coins	Not covered	For mail order prescriptions, a 90-day supply is available for two copays.
	<a href="#">Specialty drugs</a>	Deductible/10% Coins	Not covered	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125 Copay/Visit	Not covered	-----none-----
	Physician/surgeon fees	\$20 Copay/Visit	Not covered	-----none-----

\* 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<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.
	<a href="#">Emergency medical transportation</a>	Deductible/10% Coins	Deductible/10% Coins	Services rendered out-of-network are paid at In-Network benefit level. Balance billing may apply to emergency ground transportation.
	<a href="#">Urgent care</a>	\$30 Copay/Visit	\$30 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)	\$700 Per Day	Not covered	-----none-----
	Physician/surgeon fees	Deductible/10% Coins	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 Copay/Visit	Not covered	-----none-----
	Inpatient services	\$700 Per Day	Not covered	-----none-----
If you are pregnant	Office visits	Deductible/10% Coins	Not covered	-----none-----
	Childbirth/delivery professional services	Deductible/10% Coins	Not covered	-----none-----
	Childbirth/delivery facility services	Deductible/10% Coins	Not covered	-----none-----

\* 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Deductible/10% Coins	Not covered	Services for home health care are limited to 60 visits per calendar year.
	<a href="#">Rehabilitation services</a>	\$20 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.
	<a href="#">Habilitation services</a>	\$20 Copay/Visit	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>	\$700 Per Day	Not covered	Services for skilled nursing are limited to 30 days per stay.
	<a href="#">Durable medical equipment</a>	Deductible/10% Coins	Not covered	-----none-----
	<a href="#">Hospice services</a>	Deductible/10% 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/10% 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.

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

## 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](#)] \$20
- Hospital (facility) \$700 Per Day [[cost sharing](#)]
- Other [[cost sharing](#)] 10% 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
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**In this example, Peg would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$400
What isn't covered	
Limits or exclusions	\$60

The Total Peg would pay is	\$1,160
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### 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](#)] \$20
- Hospital (facility) \$700 Per Day [[cost sharing](#)]
- Other [[cost sharing](#)] 10% 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
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**In this example, Joe would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$80
What isn't covered	
Limits or exclusions	\$20

The Total Joe would pay is	\$500
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### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [[cost sharing](#)] \$20
- Hospital (facility) \$700 Per Day [[cost sharing](#)]
- Other [[cost sharing](#)] 10% 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
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**In this example, Mia would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$0

The Total Mia would pay is	\$700
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