




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/coverage-details](http://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:   |
|---|---|---|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | <b>\$3,200 individual / \$6,400 family</b>  | 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>             | <b>No</b>   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | <b>\$3,200 individual / \$6,400 family</b>  | If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been 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="#">balance-billing</a> charges, healthcare this plan doesn't cover, and penalties for failure to obtain <a href="#">prior authorization</a> for services or the difference in cost when a brand name drug is dispensed instead of its generic equivalent. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |

| Important Questions  | Answers  | Why This Matters:   |
|--|--|---|
| Will you pay less if you use a <a href="#">network provider</a> ?            | 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 <a href="#">network providers</a> . | 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 <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<br>(You will pay the least)         | Out-of-Network Provider<br>(You will pay the most) |  |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | 0% Coins after Ded                                   | Not covered  | Virtual visits (Telehealth) benefits available. No coverage for chiropractic wellness or maintenance therapy. See your Certificate of Coverage for exclusions and limitations.   |
|  | <a href="#">Specialist</a> visit                       | 0% Coins after Ded                                   | Not covered  | Virtual visits (Telehealth) benefits available. See your Certificate of Coverage for exclusions and limitations.   |
|  | <a href="#">Preventive care/screening/immunization</a> | No Charge  | Not covered  | Services under the ACA guidelines will be covered as preventive. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | Lab: 0% Coins after Ded<br>X-Ray: 0% Coins after Ded | Not covered  | None   |
|  | Imaging (CT/PET scans, MRIs)                           | 0% Coins after Ded                                   | Not covered  | None   |
| If you need drugs to treat your illness or condition                   | Tier 1 – Typically generic drugs                       | 0% Coins after Ded                                   | Not covered  | For mail order prescriptions, a 90-day supply is available for two copays. <a href="#">CGHC Formulary</a>  |

\* 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| More information about <a href="https://commongroundhealthcare.org/formulary/">prescription drug coverage</a> is available at <a href="https://commongroundhealthcare.org/formulary/">https://commongroundhealthcare.org/formulary/</a> | Tier 2 – Preferred drugs                         | 0% Coins after Ded                           | Not covered  | For mail order prescriptions, a 90-day supply is available for two copays. Additional costs may apply when a brand name drug is dispensed instead of its generic equivalent. <a href="#">CGHC Formulary</a><br><a href="#">CGHC Formulary</a>   |
|   | Tier 3 – Non-preferred drugs                     | 0% Coins after Ded                           | Not covered  |   |
|   | Tier 4 – <a href="#">Specialty drugs</a>         | 0% Coins after Ded                           | Not covered  |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | 0% Coins after Ded                           | Not covered  | Other significant expenses that may be associated with an outpatient surgery:<br>0% Coins after Ded for Anesthesia.<br>0% Coins after Ded for Imaging (See “If you have a Test”).<br>0% Coins after Ded for Implants and Supplies.              |
|   | Physician/surgeon fees                           | 0% Coins after Ded                           | Not covered  |   |
| <b>If you need immediate medical attention</b>  | <a href="#">Emergency room care</a>              | 0% Coins after Ded                           | 0% Coins after Ded                                 | ER services are paid at In-Network benefit level.   |
|   | <a href="#">Emergency medical transportation</a> | 0% Coins after Ded                           | 0% Coins after Ded                                 | Balance billing may apply to emergency ground transportation for out-of-network providers.  |
|   | <a href="#">Urgent care</a>                      | 0% Coins after Ded                           | 0% Coins after Ded                                 | 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)               | 0% Coins after Ded                           | Not covered  | Services described assume inpatient care. For outpatient cost sharing, see your Schedule of Benefits.   |
|   | Physician/surgeon fees                           | 0% Coins after Ded                           | Not covered  | None  |
| <b>If you need mental health, behavioral health, or substance abuse services</b>  | Outpatient services                              | 0% Coins after Ded                           | Not covered  | Services described assume clinic based care. For outpatient cost sharing, see your Schedule of Benefits.  |
|   | Inpatient services                               | 0% Coins after Ded                           | Not covered  | None  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [CommonGroundHealthcare.org](https://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) |   |
| <b>If you are pregnant</b>  | Office visits                                 | 0% Coins after Ded                           | Not covered  | Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|   | Childbirth/delivery professional services     | 0% Coins after Ded                           | Not covered  |   |
|   | Childbirth/delivery facility services         | 0% Coins after Ded                           | Not covered  |   |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>              | 0% Coins after Ded                           | Not covered  | Services for home health care are limited to 60 visits per calendar year.   |
|   | <a href="#">Rehabilitation services</a>       | 0% Coins after Ded                           | 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>         | 0% Coins after Ded                           | 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>          | 0% Coins after Ded                           | Not covered  | Services for skilled nursing are limited to 30 days per stay.   |
|   | <a href="#">Durable medical equipment</a>     | 0% Coins after Ded                           | Not covered  | None  |
|   | <a href="#">Hospice services</a>              | 0% Coins after Ded                           | Not covered  | None  |
|   | <b>If your child needs dental or eye care</b> | Children's eye exam                          | No Charge  | Not covered   |
|   | Children's glasses                            | 0% Coins after Ded                           | 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:**

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

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- 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

**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? Not Applicable**

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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,200 |
| ■ <a href="#">Specialist coinsurance</a>                        | D/C     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

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>       | \$3,200        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,260</b> |

### Managing Joe's Type 2 Diabetes

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,200 |
| ■ <a href="#">Specialist coinsurance</a>                        | D/C     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

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>       | \$2,300        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,520</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,200 |
| ■ <a href="#">Specialist coinsurance</a>                        | D/C     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

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>       | \$2,800        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

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

