**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services
**Common Ground Healthcare Cooperative: CGHC Silver $5000 Ded / $5000 Rx Ded LCS - Envision Network (Vision Exam)**

**Coverage Period: 01/01/2024 – 12/31/2024**
**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 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?** | **$5,000 individual / $10,000 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, $5,000 individual / $10,000 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?** | **$9,450 individual / $18,900 family** | If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, out-of-network provider charges, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain prior authorization 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 out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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. |
| **Do you need a referral to see a specialist?** | No | You can see the 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 | $70 Copay | Not covered | Virtual visits (Telehealth) benefits available. No coverage for chiropractic wellness or maintenance therapy. See your Certificate of Coverage for exclusions and limitations. |
| | Specialist visit | $115 Copay | Not covered | Virtual visits (Telehealth) benefits available. See your Certificate of Coverage for exclusions and limitations. |
| | Preventive care/screening/ immunization | No Charge | Not covered | Services under the ACA guidelines will be covered as preventive.<br>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab: 30% Coins after Ded<br>X-Ray: 30% Coins after Ded | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 30% Coins after Ded | Not covered | None |
| **If you need drugs to treat your illness or condition** | Tier 1 – Typically generic drugs | $20 Copay/Script | Not covered | For mail order prescriptions, a 90-day supply is available for two copays.<br>CGHC Formulary |

| 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) | |
| More information about **prescription drug coverage** is available at https://commongroundhealthcare.org/formulary/ | Tier 2 – Preferred drugs | $100 Copay/Script | 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. CGHC Formulary |
| | Tier 3 – Non-preferred drugs | 30% Coins after Rx Ded | Not covered | |
| | Tier 4 – Specialty drugs | 40% Coins after Rx Ded | Not covered | CGHC Formulary |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% Coins after Ded | Not covered | Other significant expenses that may be associated with an outpatient surgery:<br>30% Coins after Ded for Anesthesia.<br>30% Coins after Ded for Imaging (See "If you have a Test").<br>30% Coins after Ded for Implants and Supplies. |
| | Physician/surgeon fees | 30% Coins after Ded | Not covered | |
| **If you need immediate medical attention** | Emergency room care | $250 Copay** | $250 Copay** | **Copay applies to ER facility fee (waived if admitted); For all other ER related charges, see your Schedule of Benefits. ER services are paid at In-Network benefit level. |
| | Emergency medical transportation | 30% Coins after Ded | 30% Coins after Ded | Balance billing may apply to emergency ground transportation for out-of-network providers. |
| | Urgent care | 30% Coins after Ded | 30% 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. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% Coins after Ded | Not covered | Services described assume inpatient care. For outpatient cost sharing, see your Schedule of Benefits. |
| | Physician/surgeon fees | 30% Coins after Ded | Not covered | None |
| **If you need mental health, behavioral health, or substance** | Outpatient services | $70 Copay | Not covered | Services described assume clinic based care. For outpatient cost sharing, see your Schedule of Benefits. |

| 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) |  |
| **abuse services** | Inpatient services | 30% Coins after Ded | Not covered | None |
| **If you are pregnant** | Office visits | 30% 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 | 30% Coins after Ded | Not covered |  |
|  | Childbirth/delivery facility services | 30% Coins after Ded | Not covered |  |
| **If you need help recovering or have other special health needs** | Home health care | 30% Coins after Ded | Not covered | Services for home health care are limited to 60 visits per calendar year. |
|  | Rehabilitation services | 30% 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. |
|  | Habilitation services | 30% 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. |
|  | Skilled nursing care | 30% Coins after Ded | Not covered | Services for skilled nursing are limited to 30 days per stay. |
|  | Durable medical equipment | 30% Coins after Ded | Not covered | None |
|  | Hospice services | 30% Coins after Ded | 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 | 30% 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:

**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 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, 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? 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, 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** | **$5,000** |
| **Specialist copayments** | **$115** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $5,000 |
| Copayments | $10 |
| Coinsurance | $2,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,370** |

### Managing Joe's Type 2 Diabetes

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

| | |
|---|---|
| **The plan's overall deductible** | **$5,000** |
| **Specialist copayments** | **$115** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $1,100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,020** |

### Mia's Simple Fracture

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

| | |
|---|---|
| **The plan's overall deductible** | **$5,000** |
| **Specialist copayments** | **$115** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,700** |

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

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

COMMON GROUND
HEALTHCARE COOPERATIVE

# NOTICE OF NON-DISCRIMINATION AND AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

Common Ground Healthcare Cooperative (CGHC) complies with complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). This means that CGHC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity).

CGHC provides free aids and services to people with disabilities so they may communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, and other formats)

CGHC provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services please contact the CGHC Civil Rights Coordinator.

**CGHC Civil Rights Coordinator**
Phone Number: 414.269.4684 (TTY: 711)
Fax Number: 414.433.4612
Email: CivilRights@CommonGroundHealthcare.org
Mail: 120 Bishop's Way, Suite 150, Brookfield, WI 53005-6271

If you believe that CGHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, or gender identity). You can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone.

**U.S. Department of Health and Human Services**
200 Independence Avenue SW, Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019 (TDD: 1.800.537.7697)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

| | | | | |
|---|---|---|---|---|
| **Spanish**<br>ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.514.2442 (TTY/TDD: 711) | **French**<br>ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1.877.514.2442 (TTY/TDD: 711) | **Chinese**<br>注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.877.514.2442 (TTY/TDD: 711) | **German**<br>ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.514.2442 (TTY/TDD: 711). | **Laotian**<br>ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.877.514.2442 (TTY/TDD: 711) |
| **Hmong**<br>LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.877.514.2442 (TTY/TDD: 711) | **Vietnamese**<br>CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.514.2442 (TTY/TDD: 711) | **Arabic**<br>ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.514.2442 (TTY/TDD: 711) | **Hindi**<br>ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.877.514.2442. पर कॉल करें। (TTY/TDD:711) | **Polish**<br>UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.877.514.2442 (TTY/TDD: 711). |
| **Pennsylvania Dutch**<br>Wann du [Deitsch] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.877.514.2442 (TTY/TDD: 711) | **Russian**<br>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.514.2442 (телетайп: 711) | **Tagalog**<br>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.514.2442 (TTY/TDD: 711). | **Thai**<br>เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1.877.514.2442 (TTY/TDD: 711). | **Albanian**<br>KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.877.514.2442. (TTY/TDD: 711) |