ASPIRUS ARISE
Small Group Plan Summary

Health Maintenance Organization (HMO) Plans	You Pay**											
Metal Tier	Individual deductible*	Coinsurance	Individual Annual Max Out of Pocket*	Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Emergency Room	Outpatient Lab/X-ray	Outpatient Surgery	Hospitalization	
Platinum	$500	20%	$1,650	No charge	$10	$25	$50	$250	20% after deductible			
Gold	$1,000	20%	$4,500	No charge	$10	$25	$50	$250	20% after deductible			
Gold	$1,500	10%	$6,000	No charge	$10	$25	$50	$250	10% after deductible			
Gold	$2,000	0%	$3,000	No charge	$10	$25	$50	$250	No charge after deductible			
Gold	$2,000	20%	$4,400	No charge	$10	$25	$50	$250	20% after deductible			
Gold	$2,500	0%	$3,500	No charge	$10	$25	$50	$250	No charge after deductible			
Silver	$2,500	20%	$7,150	No charge	$10	$35	$70	$300	20% after deductible			
Silver	$3,000	0%	$6,500	No charge	$10	$35	$70	$300	No charge after deductible			
Silver	$3,000	20%	$7,150	No charge	$10	$35	$70	$300	20% after deductible			
Silver	$3,500	10%	$7,150	No charge	$10	$35	$70	$300	10% after deductible			
Silver	$4,500	20%	$7,150	No charge	$10	$35	$70	$300	20% after deductible			

Platinum and Gold Prescription Drugs: Preventive and Preferred Generics: $0—Non-Preferred Generics: $15—Preferred Brand: $40—Non-Preferred Brand: $65—Specialty Drugs: 25% to $500

Silver Prescription Drugs: Preventive and Preferred Generics: $0—Non-Preferred Generics: $20—Preferred Brand: $50—Non-Preferred Brand: $80—Specialty Drugs: 30% to $500

Health Maintenance Organization (HMO) High-Deductible Health Plans	You Pay**											
Metal Tier	Individual deductible*	Coinsurance	Individual Annual Max Out of Pocket*	Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Emergency Room	Outpatient Lab/X-ray	Outpatient Surgery	Hospitalization	
Gold+	$2,000	0%	$2,000	No charge after deductible								
Silver++	$1,500	30%	$6,550	30% after deductible								
Silver++	$2,200	20%	$5,000	20% after deductible								
Silver	$2,600	20%	$6,550	20% after deductible								
Silver	$3,600	0%	$3,600	No charge after deductible								
Bronze	$5,050	30%	$6,550	30% after deductible								
Bronze	$6,550	0%	$6,550	No charge after deductible								

Prescription Drugs: Preventive: $0—All others: deductible and coinsurance

ASPIRUS ARISE
Small Group Plan Summary

Point-of-Service (POS) Plans	You Pay													
Metal Tier	Individual deductible*		Coinsurance		Individual Annual Max Out of Pocket*		At Participating Providers**							
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Emergency Room	Outpatient Lab/X-ray	Outpatient Surgery	Hospitalization
Platinum	$500	$1,000	20%	50%	$1,650	$11,000	No charge	$10	$25	$50	$250	20% after deductible		
Gold	$1,000	$2,000	20%	50%	$4,500	$12,000	No charge	$10	$25	$50	$250	20% after deductible		
Gold	$1,500	$3,000	10%	40%	$6,000	$11,000	No charge	$10	$25	$50	$250	10% after deductible		
Gold	$2,000	$4,000	0%	30%	$3,000	$10,000	No charge	$10	$25	$50	$250	No charge after deductible		
Gold	$2,000	$4,000	20%	50%	$4,400	$14,000	No charge	$10	$25	$50	$250	20% after deductible		
Gold	$2,500	$5,000	0%	30%	$3,500	$11,000	No charge	$10	$25	$50	$250	No charge after deductible		
Silver	$2,500	$5,000	20%	50%	$7,150	$15,000	No charge	$10	$35	$70	$300	20% after deductible		
Silver	$3,000	$6,000	0%	30%	$6,500	$12,000	No charge	$10	$35	$70	$300	No charge after deductible		
Silver	$3,000	$6,000	20%	50%	$7,150	$16,000	No charge	$10	$35	$70	$300	20% after deductible		
Silver	$3,500	$7,000	10%	40%	$7,150	$15,000	No charge	$10	$35	$70	$300	10% after deductible		
Silver	$4,500	$9,000	20%	50%	$7,150	$19,000	No charge	$10	$35	$70	$300	20% after deductible		

Platinum and Gold Prescription Drugs: Preventive and Preferred Generics: $0—Non-Preferred Generics: $15—Preferred Brand: $40— Non-Preferred Brand: $65—Specialty Drugs: 25% to $500

Silver Prescription Drugs: Preventive and Preferred Generics: $0—Non-Preferred Generics: $20— Preferred Brand: $50—Non-Preferred Brand: $80—Specialty Drugs: 30% to $500

Point-of-Service (POS) High-Deductible Health Plans	You Pay													
Metal Tier	Individual deductible*		Coinsurance		Individual Annual Max Out of Pocket*		At Participating Providers**							
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Emergency Room	Outpatient Lab/X-ray	Outpatient Surgery	Hospitalization
Gold+	$2,000	$4,000	0%	30%	$2,000	$10,000	No charge after deductible							
Silver++	$1,500	$3,000	30%	50%	$6,550	$13,000	30% after deductible							
Silver++	$2,200	$4,400	20%	50%	$5,000	$14,400	20% after deductible							
Silver	$2,600	$5,200	20%	50%	$6,550	$15,200	20% after deductible							
Silver	$3,600	$7,200	0%	30%	$3,600	$13,200	No charge after deductible							
Bronze	$5,050	$10,100	30%	50%	$6,550	$20,100	30% after deductible							
Bronze	$6,550	$13,100	0%	30%	$6,550	$19,100	No charge after deductible							

Prescription Drugs: Preventive: $0—All others: deductible and coinsurance

Covered preventive services are provided at no cost to members.
*Family deductibles and out-of-pocket limits are 2x the individual amounts.
**Services performed out of network under the POS plan options are subject to the out of network deductible and coinsurance. Out of network services are not covered under HMO plan options except in emergency situations. See policy for details.
+ Non-Embedded Deductible and Out of Pocket Limit: This plan features a non-embedded deductible and out of pocket limit. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. If an employee has family coverage, the family out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. One person can satisfy the family out-of-pocket limit. Deductibles and out of pocket maximums apply annually.
++ Non-Embedded Deductible and Embedded Out of Pocket: This plan features a non-embedded deductible. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. This plan features an embedded out of pocket limit. The individual out of pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out of pocket maximums apply annually.
Unless otherwise noted, plans have an Embedded Deductible and Embedded Out of Pocket Limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits. These plans feature an embedded out of pocket limit where the out of pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out of pocket maximums apply annually.

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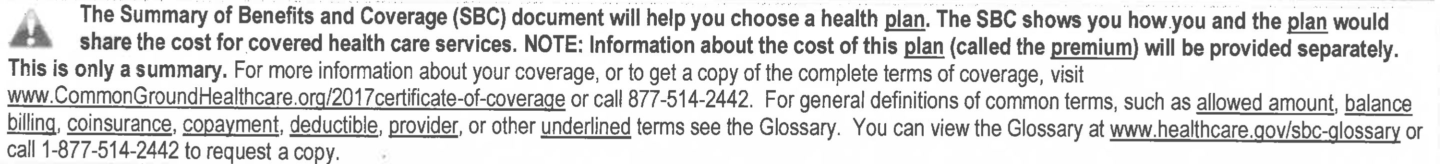
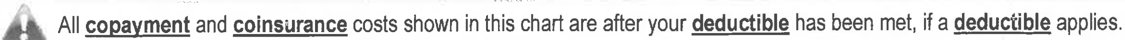


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

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/2017certificate-of-coverage 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?	For in-network providers: **$7000** individual / **$14000** family For out-of-network providers: **$14000** individual / **$28000** 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. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: **$7000** individual / **$14000** family For out-of-network providers: **$28000** individual / **$56000** 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, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-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.
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	$35 for first 3 visits, then Ded/Coins	Ded/30% Coins	———none———
	Specialist visit	Ded/0% Coins	Ded/30% Coins	No coverage for infertility services.
	Preventive care/screening/ immunization	No Charge	Ded/30% Coins	Services under the ACA guidelines will be covered as preventive
If you have a test	Diagnostic test (x-ray, blood work)	Ded/0% Coins	Ded/30% Coins	———none———
	Imaging (CT/PET scans, MRIs)	Ded/0% Coins	Ded/30% Coins	———none———
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.CGCares.org/formulary	Generic drugs	Ded/0% Coins	Ded/0% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	Ded/0% Coins	Ded/0% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Non-preferred brand drugs	Ded/0% Coins	Ded/0% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Ded/0% Coins	Ded/30% Coins	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded/0% Coins	Ded/30% Coins	———none———
	Physician/surgeon fees	Ded/0% Coins	Ded/30% Coins	———none———
If you need immediate medical attention	Emergency room care	Ded/0% Coins	Ded/0% Coins	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/0% Coins	Ded/0% Coins	———none———
	Urgent care	Ded/0% Coins	Ded/30% Coins	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/0% Coins	Ded/30% Coins	———none———
	Physician/surgeon fees	Ded/0% Coins	Ded/30% Coins	———none———

* For more information about limitations and exceptions, see the plan or policy document at www.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 mental health, behavioral health, or substance abuse services	Outpatient services	$35 for first 3 visits, then Ded/Coins	Ded/30% Coins	——none——
	Inpatient services	Ded/0% Coins	Ded/30% Coins	——none——
If you are pregnant	Office visits	Ded/0% Coins	Ded/30% Coins	——none——
	Childbirth/delivery professional services	Ded/0% Coins	Ded/30% Coins	
	Childbirth/delivery facility services	Ded/0% Coins	Ded/30% Coins	
If you need help recovering or have other special health needs	Home health care	Ded/0% Coins	Ded/30% Coins	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Ded/0% Coins	Ded/30% Coins	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Ded/0% Coins	Ded/30% Coins	Services for PT/OT/ST and manipulation therapy are limited to 20 visits each per calendar year. Services for custodial care are excluded.
	Skilled nursing care	Ded/0% Coins	Ded/30% Coins	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Ded/0% Coins	Ded/30% Coins	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice services	Ded/0% Coins	Ded/30% Coins	——none——
If your child needs dental or eye care	Children's eye exam	No Charge	Ded/30% Coins	Limited to one exam every year for children.
	Children's glasses	Ded/0% Coins	Ded/30% Coins	Limited to one pair of glasses per year for children only.
	Children's dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

* For more information about limitations and exceptions, see the plan or policy document at www.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 • Pediatric* and Adult Dental care	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Services and supplies not medically necessary • 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 — may be covered with limitations	• Routine eye care (Adult) — 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, 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 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 Grievance Unit, PO Box 1630, Brookfield, WI 53008-1630 or call 877-514-2442.

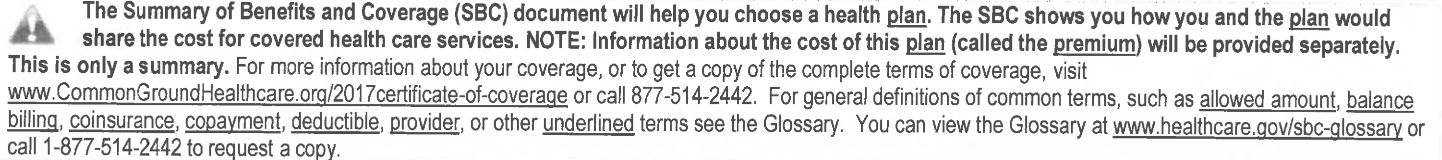
For state of Wisconsin assistance, contact Office of the Commissioner of Insurance, Complaints Department, PO Box 7873, Madison, WI 53707-7873, complaints@ociwi.state.us, phone 800-236-8517 or 608-266-0103.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

——————To see examples of how this plan might cover costs for a sample medical situation, see the next section.——————

* For more information about limitations and exceptions, see the plan or policy document at www.CommonGroundHealthcare.org.


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/2017certificate-of-coverage 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?	For in-network providers: **$600** individual / **$1200** family For out-of-network providers: **$1200** individual / **$2400** 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. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: **$6850** individual / **$13700** family For out-of-network providers: **$13700** individual / **$27400** 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, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-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.
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	$35 Copay/Visit	Ded/50% Coins	——————none——————
	Specialist visit	$60 Copay/Visit	Ded/50% Coins	No coverage for infertility services.
	Preventive care/screening/ immunization	No Charge	Ded/50% Coins	Services under the ACA guidelines will be covered as preventive
If you have a test	Diagnostic test (x-ray, blood work)	Ded/20% Coins	Ded/50% Coins	——————none——————
	Imaging (CT/PET scans, MRIs)	Ded/20% Coins	Ded/50% Coins	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CGCares.org/formulary	Generic drugs	$10 Copay/Script	$10 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	$45 Copay/Script	$45 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Non-preferred brand drugs	$75 Copay/Script	$75 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Ded/20% Coins	Ded/50% Coins	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded/20% Coins	Ded/50% Coins	——————none——————
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	——————none——————
If you need immediate medical attention	Emergency room care	$300 Copay/Visit	$300 Copay/Visit	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/20% Coins	Ded/20% Coins	——————none——————
	Urgent care	$50 Copay/Visit	Ded/50% Coins	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/20% Coins	Ded/50% Coins	——————none——————
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	——————none——————

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 Copay/Visit	Ded/50% Coins	——————none——————
	Inpatient services	Ded/20% Coins	Ded/50% Coins	——————none——————
If you are pregnant	Office visits	$60 Copay/Visit	Ded/50% Coins	——————none——————
	Childbirth/delivery professional services	Ded/20% Coins	Ded/50% Coins	
	Childbirth/delivery facility services	Ded/20% Coins	Ded/50% Coins	
If you need help recovering or have other special health needs	Home health care	Ded/20% Coins	Ded/50% Coins	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Ded/20% Coins	Ded/50% Coins	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Ded/20% Coins	Ded/50% Coins	Services for PT/OT/ST and manipulation therapy are limited to 20 visits each per calendar year. Services for custodial care are excluded.
	Skilled nursing care	Ded/20% Coins	Ded/50% Coins	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Ded/20% Coins	Ded/50% Coins	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice services	Ded/20% Coins	Ded/50% Coins	——————none——————
If your child needs dental or eye care	Children's eye exam	No Charge	Ded/50% Coins	Limited to one exam every year for children.
	Children's glasses	Ded/20% Coins	Ded/50% Coins	Limited to one pair of glasses per year for children only.
	Children's dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

* For more information about limitations and exceptions, see the plan or policy document at www.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 • Pediatric* and Adult Dental care	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Services and supplies not medically necessary • 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 — may be covered with limitations	• Routine eye care (Adult) — may be covered with limitations

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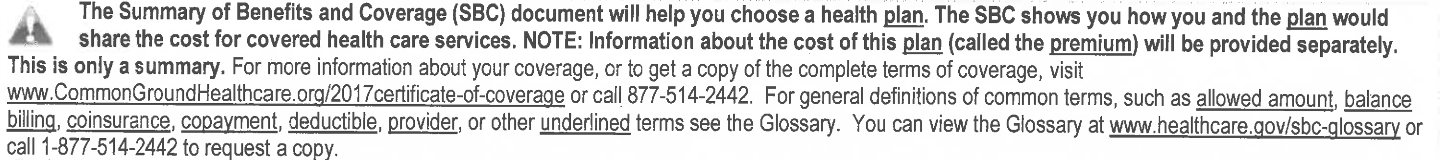

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This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.CommonGroundHealthcare.org/2017certificate-of-coverage or call 877-514-2442. For general definitions of common terms, such 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?	For in-network providers: **$1000** individual / **$2000** family For out-of-network providers: **$2000** individual / **$4000** 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. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: **$3500** individual / **$7000** family For out-of-network providers: **$7000** individual / **$14000** 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, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-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.
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	$35 Copay/Visit	Ded/50% Coins	——————none——————
	Specialist visit	$60 Copay/Visit	Ded/50% Coins	No coverage for infertility services.
	Preventive care/screening/ immunization	No Charge	Ded/50% Coins	Services under the ACA guidelines will be covered as preventive
If you have a test	Diagnostic test (x-ray, blood work)	Ded/20% Coins	Ded/50% Coins	——————none——————
	Imaging (CT/PET scans, MRIs)	Ded/20% Coins	Ded/50% Coins	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CGCares.org/formulary	Generic drugs	$10 Copay/Script	$10 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	$45 Copay/Script	$45 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Non-preferred brand drugs	$75 Copay/Script	$75 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Ded/20% Coins	Ded/50% Coins	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded/20% Coins	Ded/50% Coins	——————none——————
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	——————none——————
If you need immediate medical attention	Emergency room care	$300 Copay/Visit	$300 Copay/Visit	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/20% Coins	Ded/20% Coins	——————none——————
	Urgent care	$50 Copay/Visit	Ded/50% Coins	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/20% Coins	Ded/50% Coins	——————none——————
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	——————none——————

* For more information about limitations and exceptions, see the plan or policy document at www.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 mental health, behavioral health, or substance abuse services	Outpatient services	$35 Copay/Visit	Ded/50% Coins	————none————
	Inpatient services	Ded/20% Coins	Ded/50% Coins	————none————
If you are pregnant	Office visits	$60 Copay/Visit	Ded/50% Coins	————none————
	Childbirth/delivery professional services	Ded/20% Coins	Ded/50% Coins	
	Childbirth/delivery facility services	Ded/20% Coins	Ded/50% Coins	
If you need help recovering or have other special health needs	Home health care	Ded/20% Coins	Ded/50% Coins	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Ded/20% Coins	Ded/50% Coins	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Ded/20% Coins	Ded/50% Coins	Services for PT/OT/ST and manipulation therapy are limited to 20 visits each per calendar year. Services for custodial care are excluded.
	Skilled nursing care	Ded/20% Coins	Ded/50% Coins	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Ded/20% Coins	Ded/50% Coins	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice services	Ded/20% Coins	Ded/50% Coins	————none————
If your child needs dental or eye care	Children's eye exam	No Charge	Ded/50% Coins	Limited to one exam every year for children.
	Children's glasses	Ded/20% Coins	Ded/50% Coins	Limited to one pair of glasses per year for children only.
	Children's dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

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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 • Pediatric* and Adult Dental care	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Services and supplies not medically necessary • 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 — may be covered with limitations	• Routine eye care (Adult) — may be covered with limitations

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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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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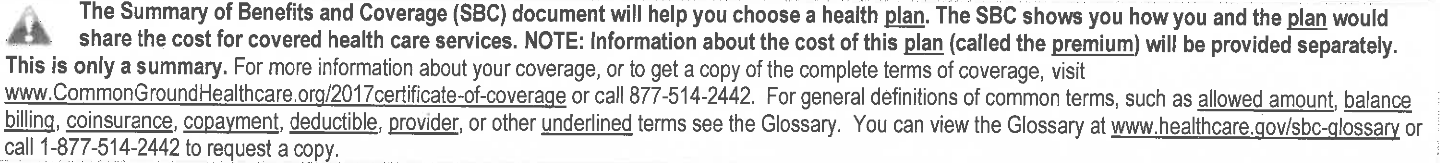

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$2700** individual / **$5400** family For out-of-network providers: **$5400** individual / **$10800** family	Generally, you must pay all of the 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. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: **$2700** individual / **$5400** family For out-of-network providers: **$10800** individual / **$21600** 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, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-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.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 Copay/Visit	Ded/30% Coins	———none———
	Specialist visit	$60 Copay/Visit	Ded/30% Coins	No coverage for infertility services.
	Preventive care/screening/ immunization	No Charge	Ded/30% Coins	Services under the ACA guidelines will be covered as preventive
If you have a test	Diagnostic test (x-ray, blood work)	Ded/0% Coins	Ded/30% Coins	———none———
	Imaging (CT/PET scans, MRIs)	Ded/0% Coins	Ded/30% Coins	———none———
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.CGCares.org/formulary	Generic drugs	$25 Copay/Script	$25 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	$60 Copay/Script	$60 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Non-preferred brand drugs	$75 Copay/Script	$75 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Ded/0% Coins	Ded/30% Coins	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded/0% Coins	Ded/30% Coins	———none———
	Physician/surgeon fees	Ded/0% Coins	Ded/30% Coins	———none———
If you need immediate medical attention	Emergency room care	$300 Copay/Visit	$300 Copay/Visit	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/0% Coins	Ded/0% Coins	———none———
	Urgent care	$50 Copay/Visit	Ded/30% Coins	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/0% Coins	Ded/30% Coins	———none———
	Physician/surgeon fees	Ded/0% Coins	Ded/30% Coins	———none———

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 Copay/Visit	Ded/30% Coins	——————none——————
	Inpatient services	Ded/0% Coins	Ded/30% Coins	——————none——————
If you are pregnant	Office visits	$60 Copay/Visit	Ded/30% Coins	——————none——————
	Childbirth/delivery professional services	Ded/0% Coins	Ded/30% Coins	
	Childbirth/delivery facility services	Ded/0% Coins	Ded/30% Coins	
If you need help recovering or have other special health needs	Home health care	Ded/0% Coins	Ded/30% Coins	Services for home health care are limited to 60 visits per calendar year.
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If your child needs dental or eye care	Children's eye exam	No Charge	Ded/30% Coins	Limited to one exam every year for children.
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	Children's dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

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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	• Routine eye care (Adult) — may be covered with limitations

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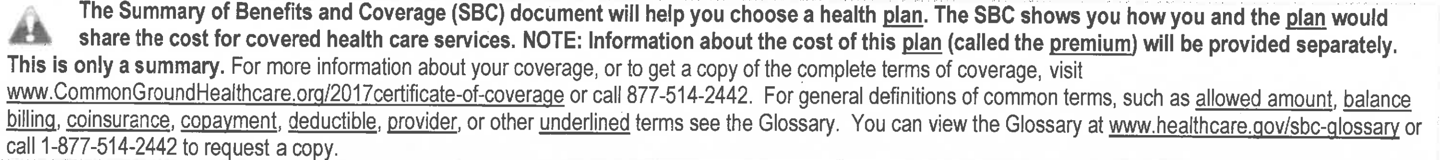

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$5800** individual / **$11600** family For out-of-network providers: **$11600** individual / **$23200** family	Generally, you must pay all of 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. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: **$6500** individual / **$13000** family For out-of-network providers: **$13000** individual / **$26000** 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, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-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.
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		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	Ded/10% Coins	Ded/40% Coins	——none——
	Specialist visit	Ded/10% Coins	Ded/40% Coins	No coverage for infertility services.
	Preventive care/screening/ immunization	No Charge	Ded/40% Coins	Services under the ACA guidelines will be covered as preventive
If you have a test	Diagnostic test (x-ray, blood work)	Ded/10% Coins	Ded/40% Coins	——none——
	Imaging (CT/PET scans, MRIs)	Ded/10% Coins	Ded/40% Coins	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CGCares.org/formulary	Generic drugs	Ded/10% Coins	Ded/10% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	Ded/10% Coins	Ded/10% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded/10% Coins	Ded/40% Coins	——none——
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If you need immediate medical attention	Emergency room care	Ded/10% Coins	Ded/10% Coins	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/10% Coins	Ded/10% Coins	——none——
	Urgent care	Ded/10% Coins	Ded/40% Coins	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/10% Coins	Ded/40% Coins	——none——
	Physician/surgeon fees	Ded/10% Coins	Ded/40% Coins	——none——

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If you need mental health, behavioral health, or substance abuse services	Outpatient services	Ded/10% Coins	Ded/40% Coins	——————none——————
	Inpatient services	Ded/10% Coins	Ded/40% Coins	——————none——————
If you are pregnant	Office visits	Ded/10% Coins	Ded/40% Coins	——————none——————
	Childbirth/delivery professional services	Ded/10% Coins	Ded/40% Coins	
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If you need help recovering or have other special health needs	Home health care	Ded/10% Coins	Ded/40% Coins	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Ded/10% Coins	Ded/40% Coins	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Ded/10% Coins	Ded/40% Coins	Services for PT/OT/ST and manipulation therapy are limited to 20 visits each per calendar year. Services for custodial care are excluded.
	Skilled nursing care	Ded/10% Coins	Ded/40% Coins	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Ded/10% Coins	Ded/40% Coins	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice services	Ded/10% Coins	Ded/40% Coins	——————none——————
If your child needs dental or eye care	Children's eye exam	No Charge	Ded/40% Coins	Limited to one exam every year for children.
	Children's glasses	Ded/10% Coins	Ded/40% Coins	Limited to one pair of glasses per year for children only.
	Children's dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

* For more information about limitations and exceptions, see the plan or policy document at www.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 • Pediatric* and Adult Dental care	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Services and supplies not medically necessary • 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 — may be covered with limitations	• Routine eye care (Adult) — 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, 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.

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Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

——To see examples of how this plan might cover costs for a sample medical situation, see the next section.——

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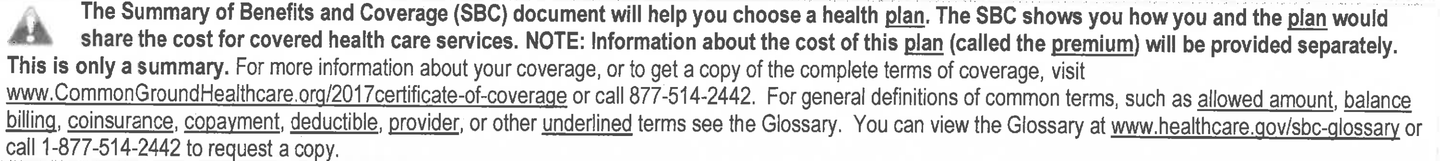

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$2300** individual / **$4600** family For out-of-network providers: **$4600** individual / **$9200** family	Generally, you must pay all of the 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. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: **$2300** individual / **$4600** family For out-of-network providers: **$9200** individual / **$18400** 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, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-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.
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	Ded/0% Coins	Ded/30% Coins	——none——
	Specialist visit	Ded/0% Coins	Ded/30% Coins	No coverage for infertility services.
	Preventive care/screening/ immunization	No Charge	Ded/30% Coins	Services under the ACA guidelines will be covered as preventive
If you have a test	Diagnostic test (x-ray, blood work)	Ded/0% Coins	Ded/30% Coins	——none——
	Imaging (CT/PET scans, MRIs)	Ded/0% Coins	Ded/30% Coins	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CGCares.org/formulary	Generic drugs	Ded/0% Coins	Ded/0% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	Ded/0% Coins	Ded/0% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Non-preferred brand drugs	Ded/0% Coins	Ded/0% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Ded/0% Coins	Ded/30% Coins	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded/0% Coins	Ded/30% Coins	——none——
	Physician/surgeon fees	Ded/0% Coins	Ded/30% Coins	——none——
If you need immediate medical attention	Emergency room care	Ded/0% Coins	Ded/0% Coins	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/0% Coins	Ded/0% Coins	——none——
	Urgent care	Ded/0% Coins	Ded/30% Coins	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/0% Coins	Ded/30% Coins	——none——
	Physician/surgeon fees	Ded/0% Coins	Ded/30% Coins	——none——

* For more information about limitations and exceptions, see the plan or policy document at www.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 mental health, behavioral health, or substance abuse services	Outpatient services	Ded/0% Coins	Ded/30% Coins	——————none——————
	Inpatient services	Ded/0% Coins	Ded/30% Coins	——————none——————
If you are pregnant	Office visits	Ded/0% Coins	Ded/30% Coins	——————none——————
	Childbirth/delivery professional services	Ded/0% Coins	Ded/30% Coins	
	Childbirth/delivery facility services	Ded/0% Coins	Ded/30% Coins	
If you need help recovering or have other special health needs	Home health care	Ded/0% Coins	Ded/30% Coins	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Ded/0% Coins	Ded/30% Coins	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Ded/0% Coins	Ded/30% Coins	Services for PT/OT/ST and manipulation therapy are limited to 20 visits each per calendar year. Services for custodial care are excluded.
	Skilled nursing care	Ded/0% Coins	Ded/30% Coins	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Ded/0% Coins	Ded/30% Coins	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice services	Ded/0% Coins	Ded/30% Coins	——————none——————
If your child needs dental or eye care	Children's eye exam	No Charge	Ded/30% Coins	Limited to one exam every year for children.
	Children's glasses	Ded/0% Coins	Ded/30% Coins	Limited to one pair of glasses per year for children only.
	Children's dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

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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 • Pediatric* and Adult Dental care	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Services and supplies not medically necessary • 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 — may be covered with limitations	• Routine eye care (Adult) — may be covered with limitations

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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.

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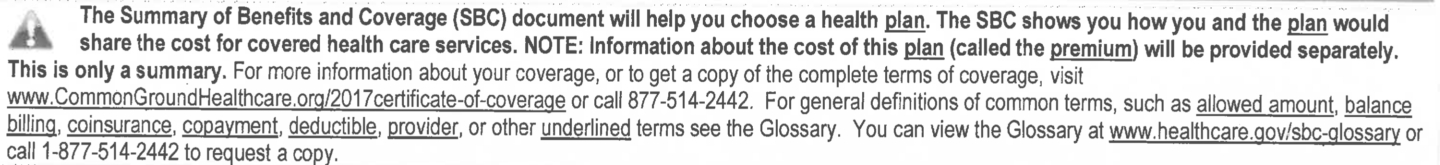

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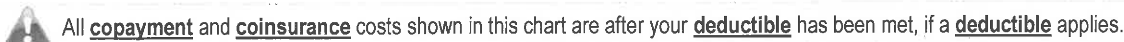
Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$3000** individual / **$6000** family For out-of-network providers: **$6000** individual / **$12000** family	Generally, you must pay all of the costs from providers up to the deductible amount before 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. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: **$4500** individual / **$9000** family For out-of-network providers: **$9000** individual / **$18000** 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, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-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.
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	Ded/20% Coins	Ded/50% Coins	——none——
	Specialist visit	Ded/20% Coins	Ded/50% Coins	No coverage for infertility services.
	Preventive care/screening/ immunization	No Charge	Ded/50% Coins	Services under the ACA guidelines will be covered as preventive
If you have a test	Diagnostic test (x-ray, blood work)	Ded/20% Coins	Ded/50% Coins	——none——
	Imaging (CT/PET scans, MRIs)	Ded/20% Coins	Ded/50% Coins	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CGCares.org/formulary	Generic drugs	Ded/20% Coins	Ded/20% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	Ded/20% Coins	Ded/20% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Non-preferred brand drugs	Ded/20% Coins	Ded/20% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Ded/20% Coins	Ded/50% Coins	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded/20% Coins	Ded/50% Coins	——none——
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	——none——
If you need immediate medical attention	Emergency room care	Ded/20% Coins	Ded/20% Coins	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/20% Coins	Ded/20% Coins	——none——
	Urgent care	Ded/20% Coins	Ded/50% Coins	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/20% Coins	Ded/50% Coins	——none——
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	——none——

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Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Ded/20% Coins	Ded/50% Coins	———none———
	Inpatient services	Ded/20% Coins	Ded/50% Coins	———none———
If you are pregnant	Office visits	Ded/20% Coins	Ded/50% Coins	———none———
	Childbirth/delivery professional services	Ded/20% Coins	Ded/50% Coins	
	Childbirth/delivery facility services	Ded/20% Coins	Ded/50% Coins	
If you need help recovering or have other special health needs	Home health care	Ded/20% Coins	Ded/50% Coins	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Ded/20% Coins	Ded/50% Coins	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Ded/20% Coins	Ded/50% Coins	Services for PT/OT/ST and manipulation therapy are limited to 20 visits each per calendar year. Services for custodial care are excluded.
	Skilled nursing care	Ded/20% Coins	Ded/50% Coins	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Ded/20% Coins	Ded/50% Coins	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice services	Ded/20% Coins	Ded/50% Coins	———none———
If your child needs dental or eye care	Children's eye exam	No Charge	Ded/50% Coins	Limited to one exam every year for children.
	Children's glasses	Ded/20% Coins	Ded/50% Coins	Limited to one pair of glasses per year for children only.
	Children's dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

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.)		
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• Chiropractic care	• Hearing aids — may be covered with limitations	• Routine eye care (Adult) — may be covered with limitations

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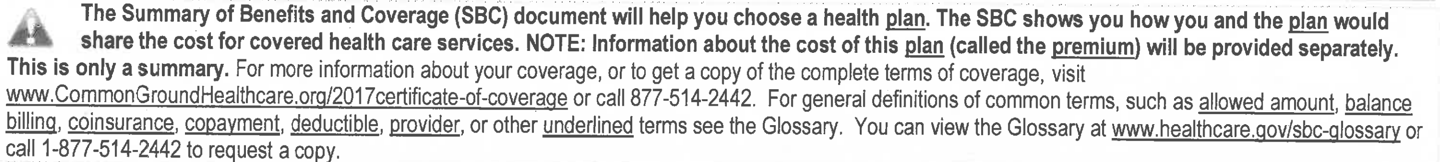

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$2000** individual / **$4000** family For out-of-network providers: **$4000** individual / **$8000** family	Generally, you must pay all of the 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. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: **$6400** individual / **$12800** family For out-of-network providers: **$12800** individual / **$25600** 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, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-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.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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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	Ded/20% Coins	Ded/50% Coins	——none——
	Specialist visit	Ded/20% Coins	Ded/50% Coins	No coverage for infertility services.
	Preventive care/screening/ immunization	No Charge	Ded/50% Coins	Services under the ACA guidelines will be covered as preventive
If you have a test	Diagnostic test (x-ray, blood work)	Ded/20% Coins	Ded/50% Coins	——none——
	Imaging (CT/PET scans, MRIs)	Ded/20% Coins	Ded/50% Coins	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CGCares.org/formulary	Generic drugs	Ded/20% Coins	Ded/20% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	Ded/20% Coins	Ded/20% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Non-preferred brand drugs	Ded/20% Coins	Ded/20% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Ded/20% Coins	Ded/50% Coins	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded/20% Coins	Ded/50% Coins	——none——
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	——none——
If you need immediate medical attention	Emergency room care	Ded/20% Coins	Ded/20% Coins	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/20% Coins	Ded/20% Coins	——none——
	Urgent care	Ded/20% Coins	Ded/50% Coins	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/20% Coins	Ded/50% Coins	——none——
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	——none——

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Ded/20% Coins	Ded/50% Coins	————none————
	Inpatient services	Ded/20% Coins	Ded/50% Coins	————none————
If you are pregnant	Office visits	Ded/20% Coins	Ded/50% Coins	————none————
	Childbirth/delivery professional services	Ded/20% Coins	Ded/50% Coins	
	Childbirth/delivery facility services	Ded/20% Coins	Ded/50% Coins	
If you need help recovering or have other special health needs	Home health care	Ded/20% Coins	Ded/50% Coins	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Ded/20% Coins	Ded/50% Coins	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Ded/20% Coins	Ded/50% Coins	Services for PT/OT/ST and manipulation therapy are limited to 20 visits each per calendar year. Services for custodial care are excluded.
	Skilled nursing care	Ded/20% Coins	Ded/50% Coins	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Ded/20% Coins	Ded/50% Coins	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice services	Ded/20% Coins	Ded/50% Coins	————none————
If your child needs dental or eye care	Children's eye exam	No Charge	Ded/50% Coins	Limited to one exam every year for children.
	Children's glasses	Ded/20% Coins	Ded/50% Coins	Limited to one pair of glasses per year for children only.
	Children's dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

* For more information about limitations and exceptions, see the plan or policy document at www.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 • Pediatric* and Adult Dental care	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Services and supplies not medically necessary • 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 — may be covered with limitations	• Routine eye care (Adult) — 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, 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 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 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, phone 800-236-8517 or 608-266-0103.

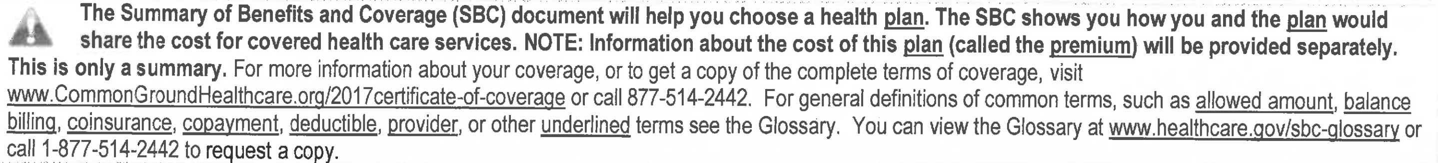
Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Common Ground Healthcare Cooperative: Small Group Envision Silver 2400-80-Copay35

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Individual + Family | Plan Type: PPO



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/2017certificate-of-coverage 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?	For in-network providers: **$2400** individual / **$4800** family For out-of-network providers: **$4800** individual / **$9600** 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. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: **$6850** individual / **$13700** family For out-of-network providers: **$13700** individual / **$27400** 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, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-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.
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	$35 Copay/Visit	Ded/50% Coins	————none————
	Specialist visit	$75 Copay/Visit	Ded/50% Coins	No coverage for infertility services.
	Preventive care/screening/ immunization	No Charge	Ded/50% Coins	Services under the ACA guidelines will be covered as preventive
If you have a test	Diagnostic test (x-ray, blood work)	Ded/20% Coins	Ded/50% Coins	————none————
	Imaging (CT/PET scans, MRIs)	Ded/20% Coins	Ded/50% Coins	————none————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CGCares.org/formulary	Generic drugs	$25 Copay/Script	$25 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	$65 Copay/Script	$65 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Non-preferred brand drugs	$75 Copay/Script	$75 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Ded/20% Coins	Ded/50% Coins	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded/20% Coins	Ded/50% Coins	————none————
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	————none————
If you need immediate medical attention	Emergency room care	$300 Copay/Visit	$300 Copay/Visit	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/20% Coins	Ded/20% Coins	————none————
	Urgent care	$50 Copay/Visit	Ded/50% Coins	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/20% Coins	Ded/50% Coins	————none————
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	————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 mental health, behavioral health, or substance abuse services	Outpatient services	$35 Copay/Visit	Ded/50% Coins	——————none——————
	Inpatient services	Ded/20% Coins	Ded/50% Coins	——————none——————
If you are pregnant	Office visits	$75 Copay/Visit	Ded/50% Coins	——————none——————
	Childbirth/delivery professional services	Ded/20% Coins	Ded/50% Coins	
	Childbirth/delivery facility services	Ded/20% Coins	Ded/50% Coins	
If you need help recovering or have other special health needs	Home health care	Ded/20% Coins	Ded/50% Coins	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Ded/20% Coins	Ded/50% Coins	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Ded/20% Coins	Ded/50% Coins	Services for PT/OT/ST and manipulation therapy are limited to 20 visits each per calendar year. Services for custodial care are excluded.
	Skilled nursing care	Ded/20% Coins	Ded/50% Coins	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Ded/20% Coins	Ded/50% Coins	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice services	Ded/20% Coins	Ded/50% Coins	——————none——————
If your child needs dental or eye care	Children's eye exam	No Charge	Ded/50% Coins	Limited to one exam every year for children.
	Children's glasses	Ded/20% Coins	Ded/50% Coins	Limited to one pair of glasses per year for children only.
	Children's dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

* For more information about limitations and exceptions, see the plan or policy document at www.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 • Pediatric* and Adult Dental care	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Services and supplies not medically necessary • 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 — may be covered with limitations	• Routine eye care (Adult) — may be covered with limitations

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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 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 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, phone 800-236-8517 or 608-266-0103.

Does this plan provide Minimum Essential Coverage? Yes

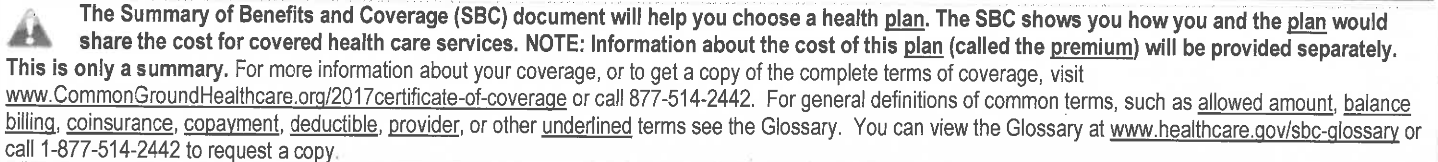
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.CommonGroundHealthcare.org.



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/2017certificate-of-coverage 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?	For in-network providers: **$3600** individual / **$7200** family For out-of-network providers: **$7200** individual / **$14400** 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. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: **$6850** individual / **$13700** family For out-of-network providers: **$13700** individual / **$27400** 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, balance-billing charges, healthcare this plan doesn't cover, and penalties for failure to obtain pre-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.
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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 Copay/Visit	Ded/50% Coins	——none——
	Specialist visit	$60 Copay/Visit	Ded/50% Coins	No coverage for infertility services.
	Preventive care/screening/ immunization	No Charge	Ded/50% Coins	Services under the ACA guidelines will be covered as preventive
If you have a test	Diagnostic test (x-ray, blood work)	Ded/20% Coins	Ded/50% Coins	——none——
	Imaging (CT/PET scans, MRIs)	Ded/20% Coins	Ded/50% Coins	——none——
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CGCares.org/formulary	Generic drugs	$25 Copay/Script	$25 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Preferred brand drugs	$50 Copay/Script	$50 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Non-preferred brand drugs	$75 Copay/Script	$75 Copay/Script	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Ded/20% Coins	Ded/50% Coins	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded/20% Coins	Ded/50% Coins	——none——
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	——none——
If you need immediate medical attention	Emergency room care	$300 Copay/Visit	$300 Copay/Visit	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/20% Coins	Ded/20% Coins	——none——
	Urgent care	$50 Copay/Visit	Ded/50% Coins	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/20% Coins	Ded/50% Coins	——none——
	Physician/surgeon fees	Ded/20% Coins	Ded/50% Coins	——none——

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 Copay/Visit	Ded/50% Coins	————none————
	Inpatient services	Ded/20% Coins	Ded/50% Coins	————none————
If you are pregnant	Office visits	$60 Copay/Visit	Ded/50% Coins	————none————
	Childbirth/delivery professional services	Ded/20% Coins	Ded/50% Coins	
	Childbirth/delivery facility services	Ded/20% Coins	Ded/50% Coins	
If you need help recovering or have other special health needs	Home health care	Ded/20% Coins	Ded/50% Coins	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Ded/20% Coins	Ded/50% Coins	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Ded/20% Coins	Ded/50% Coins	Services for PT/OT/ST and manipulation therapy are limited to 20 visits each per calendar year. Services for custodial care are excluded.
	Skilled nursing care	Ded/20% Coins	Ded/50% Coins	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Ded/20% Coins	Ded/50% Coins	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice services	Ded/20% Coins	Ded/50% Coins	————none————
If your child needs dental or eye care	Children's eye exam	No Charge	Ded/50% Coins	Limited to one exam every year for children.
	Children's glasses	Ded/20% Coins	Ded/50% Coins	Limited to one pair of glasses per year for children only.
	Children's dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

* For more information about limitations and exceptions, see the plan or policy document at www.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 • Pediatric* and Adult Dental care	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Services and supplies not medically necessary • 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 — may be covered with limitations	• Routine eye care (Adult) — 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, 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 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 Grievance Unit, PO Box 1630, Brookfield, WI 53008-1630 or call 877-514-2442.

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Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.CommonGroundHealthcare.org.

Small Group Envision HSA Silver 3600-100

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.CommonGroundHealthcare.org/assets/pdf/Certificate-of-Coverage.pdf or by calling 1-877-514-CGHC (2442).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers: **$3600** person / **$7200** family For non-participating providers: **$7200** person / **$14400** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over on January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet specific **deductible** for specific services but see the chart starting on page 2 of other costs for services this **plan** covers.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers: **$3600** person / **$7200** family. For non-participating providers: **$14400** person / **$28800** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, dental, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see **CommonGroundHealthcare.org** or call 1-877-514-CGHC (2442).	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

HSA Silver 3600-100

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Small Group | **Plan Type:** PPO

- **Copayments** are fixed dollar amounts (for example, $30) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Ded/0% Coins	Ded/30% Coins	——————none——————
	Specialist visit	Ded/0% Coins	Ded/30% Coins	No coverage for infertility services.
	Other practitioner office visit	Ded/0% Coins	Ded/30% Coins	No coverage for chiropractic maintenance or long term-therapy. No coverage for acupuncture.
	Preventive care/screening/immunization	No Charge	Ded/30% Coins	Services under the ACA guidelines will be covered as preventive.
If you have a test	Diagnostic test (x-ray, blood work)	Ded/0% Coins	Ded/30% Coins	——————none——————
	Imaging (CT/PET scans, MRIs)	Ded/0% Coins	Ded/30% Coins	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CommonGround Healthcare.org	Tier 1 Prescription Drugs	Ded/0% Coins	Ded/0% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Tier 2 Prescription Drugs	Ded/0% Coins	Ded/0% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Tier 3 Prescription Drugs	Ded/0% Coins	Ded/0% Coins	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Ded/0% Coins	Ded/30% Coins	Infertility specialty drugs not covered.
	Facility fee (e.g., ambulatory surgery center)	Ded/0% Coins	Ded/30% Coins	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Physician/surgeon fees	Ded/0% Coins	Ded/30% Coins	———none———
If you need immediate medical attention	Emergency room services	Ded/0% Coins	Ded/0% Coins	Copay applies to ER fee (waived if admitted); other charges are subject to deductible and coinsurance. ER services are paid at In-Network benefit level.
	Emergency medical transportation	Ded/0% Coins	Ded/0% Coins	———none———
	Urgent care	Ded/0% Coins	Ded/30% Coins	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded/0% Coins	Ded/30% Coins	———none———
	Physician/surgeon fee	Ded/0% Coins	Ded/30% Coins	———none———

If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Ded/0% Coins	Ded/30% Coins	———none———
	Mental/Behavioral health inpatient services	Ded/0% Coins	Ded/30% Coins	———none———
	Substance use disorder outpatient services	Ded/0% Coins	Ded/30% Coins	———none———
	Substance use disorder inpatient services	Ded/0% Coins	Ded/30% Coins	
If you are pregnant	Prenatal and postnatal care	Ded/0% Coins	Ded/30% Coins	———none———
	Delivery and all inpatient services	Ded/0% Coins	Ded/30% Coins	
If you need help recovering or have other special health needs	Home health care	Ded/0% Coins	Ded/30% Coins	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Ded/0% Coins	Ded/30% Coins	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Ded/0% Coins	Ded/30% Coins	Services for PT/OT/ST and manipulation therapy are limited to 20 visits each per calendar year. Services for custodial care are excluded.
	Skilled nursing care	Ded/0% Coins	Ded/30% Coins	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Ded/0% Coins	Ded/30% Coins	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice service	Ded/0% Coins	Ded/30% Coins	———none———

If your child needs dental or eye care	Eye exam	No Charge	Ded/30% Coins	Limited to one exam every year for children.
	Glasses	Ded/0% Coins	Ded/30% Coins	Limited to one pair of glasses per year for children only.
	Dental check-up	No Coverage	No Coverage	Except as required by federal guidelines for preventive services.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Pediatric* and Adult Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Services and supplies not medically necessary
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids — may be covered with limitations
- Routine eye care (Adult) — may be covered with limitations

* This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

Your Rights to Continue Coverage:

For an Individual health insurance policy —

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 877-514-CGHC (2442). You may also contact your state insurance department at 800-236-8517.

OR

For a Group health coverage policy —

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 877-514-CGHC (2442). You may also contact your state insurance department at 800-236-8517, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact in writing: Common Ground Healthcare Cooperative Appeals and Grievance Unit, P.O. Box 1630, Brookfield, WI 53008-1630 or call 877-514-CGHC (2442).

For state of Wisconsin assistance contact Office of the Commissioner of Insurance, Complaints Department, P.O. Box 7873, Madison, WI 53707-7873, complaints@ociwi.state.us, phone 800-236-8517 or 608-266-0103.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.