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: $0 person / $0 family For non-participating providers: $2,500 person / $5,000 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: $550 person / $1,100 family. For non-participating providers: $5,000 person / $10,000 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.	While a written referral is not required by this plan to see a specialist, you are strongly encouraged to coordinate all care through your Primary Care provider.
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.

- **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	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
	Specialist visit	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	No coverage for infertility services.
	Other practitioner office visit	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance for chiropractor	No coverage for chiropractic maintenance or long term-therapy. No coverage for acupuncture.
	Preventive care/screening/immunization	No charge	No Coverage	Services under the ACA guidelines will be covered as preventive.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CommonGroundHeathlcare.org.	Tier 1 Prescription Drugs	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	For mail order prescriptions, a 90 day supply is available for two copays.
	Tier 2 Prescription Drugs	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	For mail order prescriptions, a 90 day supply is available for two copays.
	Tier 3 Prescription Drugs	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	Deductible plus 20% coinsurance	Deductible plus 50% coinsurance	Infertility specialty drugs not covered.
If you have outpatient surgery	Facility fe (e.g., ambulatory surgery center)	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
	Physician/surgeon fees	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	Deductible plus 20% coinsurance	In-network deductible plus 20% coinsurance	Copay applies to emergency room fee (waived if admitted); all other charges related to visit are subject to deductible and coinsurance. Emergency room services are paid at In-Network benefit level.
	Emergency medical transportation	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
	Urgent care	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————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 a hospital stay	Facility fee (e.g., hospital room)	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
	Physician/surgeon fee	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
	Substance use disorder outpatient services	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
	Substance use disorder inpatient services	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	
If you are pregnant	Prenatal and postnatal care	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
	Delivery and all inpatient services	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	

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 need help recovering or have other special health needs	Home health care	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	Services for PT/OT/ST are limited to 20 visits each per calendar year. Services for custodial care are a policy exclusion.
	Skilled nursing care	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice service	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Non-network deductible plus 50% coinsurance	Limited to one exam every two years for adults; limited to one exam every year for children.
	Glasses	Deductible plus 20% coinsurance	Non-network deductible plus 50% coinsurance	Limited to one pair of glasses per year for children only.
	Dental check-up	No coverage	No coverage	Except as required by the Affordable Care Act 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.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,840
- **Patient pays** $700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$550
Limits or exclusions	$150
Total	**$700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,770
- **Patient pays** $630

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$550
Limits or exclusions	$80
Total	**$630**

Note: These numbers assume the patient has not met any part of his/her calendar year deductible and is using in-network providers.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.