Silver 2000-70 NCS

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

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

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: **$0** person / **$0** family For non-participating providers: **$0** person / **$0** 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: **$0** person / **$0** family. For non-participating providers: **$0** person / **$0** 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**.

- **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	No Charge	No Charge	———————none———————
	Specialist visit	No Charge	No Charge	No coverage for infertility services.
	Other practitioner office visit	No Charge	No Charge	No coverage for chiropractic maintenance or long term-therapy. No coverage for acupuncture.
	Preventive care/screening/immunization	No Charge	No Charge	Services under the ACA guidelines will be covered as preventive.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	———————none———————
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	———————none———————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CommonGround Heatlhcare.org.	Tier 1 Prescription Drugs	No Charge	No Charge	For mail order prescriptions, a 90 day supply is available for two copays.
	Tier 2 Prescription Drugs	No Charge	No Charge	For mail order prescriptions, a 90 day supply is available for two copays.
	Tier 3 Prescription Drugs	No Charge	No Charge	For mail order prescriptions, a 90 day supply is available for two copays.
	Specialty drugs	No Charge	No Charge	Infertility specialty drugs not covered.
	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	———————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	No Charge	No Charge	———none———
If you need immediate medical attention	Emergency room services	No Charge	No Charge	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	No Charge	No Charge	———none———
	Urgent care	No Charge	No Charge	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	———none———
	Physician/surgeon fee	No Charge	No Charge	———none———

If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	No Charge	———none———
	Mental/Behavioral health inpatient services	No Charge	No Charge	———none———
	Substance use disorder outpatient services	No Charge	No Charge	———none———
	Substance use disorder inpatient services	No Charge	No Charge	
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	———none———
	Delivery and all inpatient services	No Charge	No Charge	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Services for home health care are limited to 60 visits per calendar year.
	Rehabilitation services	No Charge	No Charge	Services for cardiac rehabilitation are limited to 36 visits per calendar year.
	Habilitation services	No Charge	No Charge	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	No Charge	No Charge	Services for skilled nursing are limited to 30 days per calendar year.
	Durable medical equipment	No Charge	No Charge	Durable medical equipment is limited to a single purchase per durable medical equipment type per 3 years.
	Hospice service	No Charge	No Charge	———none———

If your child needs dental or eye care	Eye exam	No Charge	No Charge	Limited to one exam every year for children.
	Glasses	No Charge	No Charge	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.

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:** $7540
- **Plan pays** $7390
- **Patient pays** $150

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7540**

Patient pays*:

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

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

- **Amount owed to providers:** $5400
- **Plan pays** $5320
- **Patient pays** $80

Sample care costs:

Prescriptions	$2900
Medical Equipment and Supplies	$1300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5400**

Patient pays*:

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

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.

COMMON GROUND HEALTHCARE COOPERATIVE

Common Ground Healthcare Cooperative (CGHC) is required by law to include the following information with any significant document we provide you:

Notice of Nondiscrimination and Availability of Language Assistance Services

CGHC complies with applicable Federal civil rights laws and does not discriminate. This means that we do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CGHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please call 877-514-2442.

If you believe that CGHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting:

Civil Rights Coordinator:	Wayne Creggett
Telephone Number:	414-269-4684
TTY:	844-472-2442
Mailing Address:	120 Bishop's Way, Suite 150 Brookfield, WI 53005-6271
Fax Number:	262-754-9690
Email Address:	civilrights@commongroundhealthcare.org

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance, Wayne Creggett, Civil Rights Coordinator, is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Foreign Language Assistance

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-514-2442.

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-514-2442.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-514-2442。

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-514-2442.

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-514-2442

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-514-2442.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-514-2442 번으로 전화해 주십시오.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-514-2442.

Pennsylvania Dutch
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-514-2442.

Laotian
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-514-2442..

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-514-2442.

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-514-2442.

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-514-2442. पर कॉल करें।

Albanian
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-514-2442.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-514-2442.