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——————

* 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	$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

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.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2400
Specialist *Copayment*	$75
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12795**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2400
Copayments	$170
Coinsurance	$2480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5110**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2400
Specialist *Copayment*	$75
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7712**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1489
Copayments	$2050
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3966**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2400
Specialist *Copayment*	$75
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$3783**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1857
Copayments	$1305
Coinsurance	$225
What isn't covered	
Limits or exclusions	$326
The total Mia would pay is	**$3713**

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

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:	Judy Zarnowski
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.