

EXCLUSIONS AND LIMITATIONS

We want you to understand what is not included in your plan. Below is a summary of services that are not covered by your plan. A full listing of exclusions and limitations can be found in your certificate of coverage.

DENTAL

- Dental care (including dental X-rays, supplies and appliances and all associated expenses).
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums
- Dental implants, bone grafts and other implant-related procedures.
- Dental braces (orthodontics).
- Treatment of congenitally missing, malpositioned or supernumerary teeth

MATERNITY SERVICES

- Elective abortions excluded except when performed to save the life/health of the mother and in instances of rape or incest.
- Birthing classes.
- Treatment, services, or supplies for a third party or nonmember traditional surrogate or gestational carrier.

MENTAL HEALTH

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practices.
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.

PHYSICAL APPEARANCE

- Cosmetic Procedures.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
- Botox (Botulinum toxin) as a treatment of skin wrinkles or other cosmetic indications.

PROCEDURES AND TREATMENTS

- Excision or elimination of hanging skin on any part of the body.
- Surgical and non-surgical treatment of obesity.
- Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998.

REPRODUCTION

- Health services and associated expenses for infertility treatments, including assisted reproductive technology.
- Surrogate parenting, donor eggs, donor sperm and host uterus.

- Storage and retrieval of all reproductive materials.
- The reversal of voluntary sterilization and related procedures.

SERVICES PROVIDED UNDER ANOTHER PLAN

- Health services for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.

SUBSTANCE USE DISORDERS

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.

ALL OTHER EXCLUSIONS

- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; Related to judicial or administrative proceedings or orders; Conducted for purposes of medical research; Required to obtain or maintain a license of any type.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy, or for which a provider, pharmaceutical manufacturer, or similar entity pays a portion of the charge. Such amounts will not be credited to your deductible, coinsurance, or maximum out of pocket.
- Health services for which billing is not received by us within 15 months of the date of service.
- Charges for which liability cannot be determined due to not receiving information requested within 30 days of a request, including authorization to release medical records, pending claims and other coverage information, network repricing information, complete and accurate information and any examination requested.
- In the event a Non-Network Provider waives Copayments, Coinsurance and / or any Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or Deductible are waived.

2017 EMPLOYER BENEFIT PLAN DESIGNS

COMMON GROUND HEALTHCARE COOPERATIVE

120 Bishop's Way, Suite 150, Brookfield, WI 53005

877.450.8497

www.CommonGroundHealthcare.org



HEALTHCARE COOPERATIVE

PEOPLE. NOT PROFIT.

Common Ground Healthcare Cooperative believes its members deserve honesty, compassion and exemplary service from their health insurer. We are committed to changing the health insurance experience through open dialogue, powerful advocacy and the delivery of trusted and understandable information.

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Common Ground Healthcare Cooperative complies with applicable Federal civil rights laws and does not discriminate on the basis of race,

color, national origin, age, disability, or sex. For more information, visit: www.CommonGroundHealthcare/LegalPrivacy

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

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.

CGHC.SB.1056-2015

2017 EMPLOYER BENEFIT PLAN DESIGNS

Common Ground Healthcare Cooperative is proud to partner with **Aurora Healthcare System**, **Bellin Health System** and the **Trilogy Health Network** for its provider network options.

SMALL GROUP PLANS

ENVISION/EMPOWER

	Calendar Year Deductible				Out-Of-Pocket Maximum				Coinsurance (You Pay)		In-Network Member Copay/Coinsurance			Aurora QuickCare/ Bellin FastCare	In- & Out-Of-Network Member Copay/Coinsurance	TeleHealth	In-Network Only	Prescription Drugs			
	In-Network		Out-Of-Network		In-Network		Out-Of-Network		In-Network	Out-of-Network	PCP ¹	Specialist	Urgent	Select Locations	Emergency ²	CGHC DoctorLine ³	Preventive ⁴	Tier 1	Tier 2	Tier 3	Specialty
	Single	Family	Single	Family	Single	Family	Single	Family													
<input type="checkbox"/> Gold 600/80	\$600	\$1,200	\$1,200	\$2,400	\$6,850	\$13,700	\$13,700	\$27,400	20%	50%	\$35 Copay	\$60 Copay	\$50 Copay	\$15 Copay	\$300 Copay	\$0 for 3; then \$35	\$0	\$10 Copay	\$45 Copay	\$75 Copay	Ded/Coins
<input type="checkbox"/> Gold 1000/80	\$1,000	\$2,000	\$2,000	\$4,000	\$3,500	\$7,000	\$7,000	\$14,000	20%	50%	\$35 Copay	\$60 Copay	\$50 Copay	\$15 Copay	\$300 Copay	\$0 for 3; then \$35	\$0	\$10 Copay	\$45 Copay	\$75 Copay	Ded/Coins
<input type="checkbox"/> Gold HSA 2300/100 <small>*See Deductibles Footnote</small>	\$2,300	\$4,600	\$4,600	\$9,200	\$2,300	\$4,600	\$9,200	\$18,400	0%	30%	Deductible	Deductible	Deductible	Ded/Coins	Deductible	\$40	\$0	Deductible	Deductible	Deductible	Deductible
<input type="checkbox"/> Gold 2700/100	\$2,700	\$5,400	\$5,400	\$10,800	\$2,700	\$5,400	\$10,800	\$21,600	0%	30%	\$35 Copay	\$60 Copay	\$50 Copay	\$15 Copay	\$300 Copay	\$0 for 3; then \$35	\$0	\$25 Copay	\$60 Copay	\$75 Copay	Deductible
<input type="checkbox"/> Silver 3600/80	\$3,600	\$7,200	\$7,200	\$14,400	\$6,850	\$13,700	\$13,700	\$27,400	20%	50%	\$35 Copay	\$60 Copay	\$50 Copay	\$15 Copay	\$300 Copay	\$0 for 3; then \$35	\$0	\$25 Copay	\$50 Copay	\$75 Copay	Ded/Coins
<input type="checkbox"/> Silver HSA 3600/100	\$3,600	\$7,200	\$7,200	\$14,400	\$3,600	\$7,200	\$14,400	\$28,800	0%	30%	Deductible	Deductible	Deductible	Ded/Coins	Deductible	\$40	\$0	Deductible	Deductible	Deductible	Deductible
<input type="checkbox"/> Silver 2400/80/Copay 35	\$2,400	\$4,800	\$4,800	\$9,600	\$6,850	\$13,700	\$13,700	\$27,400	20%	50%	\$35 Copay	\$75 Copay	\$50 Copay	\$15 Copay	\$300 Copay	\$0 for 3; then \$35	\$0	\$25 Copay	\$65 Copay	\$75 Copay	Ded/Coins
<input type="checkbox"/> Silver 2600/80	\$2,600	\$5,200	\$5,200	\$10,400	\$6,850	\$13,700	\$13,700	\$27,400	20%	50%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	\$0 for 3; then \$40	\$0	\$10 Copay	Ded/Coins	Ded/Coins	Ded/Coins
<input type="checkbox"/> Silver 2000/80	\$2,000	\$4,000	\$4,000	\$8,000	\$6,400	\$12,800	\$12,800	\$25,600	20%	50%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	\$0 for 3; then \$40	\$0	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
<input type="checkbox"/> Silver HSA 3000/80	\$3,000	\$6,000	\$6,000	\$12,000	\$4,500	\$9,000	\$9,000	\$18,000	20%	50%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	\$40	\$0	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
<input type="checkbox"/> Bronze 7000/100	\$7,000	\$14,000	\$14,000	\$28,000	\$7,000	\$14,000	\$28,000	\$56,000	0%	30%	\$35 for 3; then Ded	Deductible	Deductible	Counts as PCP	Deductible	\$0 for 3; then \$35	\$0	Deductible	Deductible	Deductible	Deductible
<input type="checkbox"/> Bronze HSA 5800/90	\$5,800	\$11,600	\$11,600	\$23,200	\$6,500	\$13,000	\$13,000	\$26,000	10%	40%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	\$40	\$0	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
<input type="checkbox"/> Bronze HSA 6400/100	\$6,400	\$12,800	\$12,800	\$25,600	\$6,400	\$12,800	\$25,600	\$51,200	0%	30%	Deductible	Deductible	Deductible	Deductible	Deductible	\$40	\$0	Deductible	Deductible	Deductible	Deductible

All of our small group plans come with the choice of two provider networks to help our small employer partners meet the health needs of employees and the financial needs of their business:

ENVISION: CGHC is proud to partner with [Aurora Healthcare System](#) and [Bellin Health System](#) to offer the Envision Integrated Care Network. An integrated care model is one where a patient's health care is coordinated among various types of providers (such as primary care doctors, specialists, hospitals and others) to achieve better outcomes and patient satisfaction.

EMPOWER: Our Empower plans put the ball in your court, giving you the freedom to choose your healthcare providers across the broad [Trilogy Health Network](#). With Empower, you gain the ability and opportunity to build your own team of doctors -- doctors you are most comfortable with, in locations most convenient for you, and in clinics and hospitals that span many different affiliations.

¹ **PCP** = Primary Care Provider (includes general pediatrics, internal medicine, OB/GYN, family practice, general medicine, chiropractor and geriatrics) **Urgent** = Urgent Care Services **Emergency** (ER) = Emergency Room Care Services

² **Services that meet the definition of emergency** are paid at the in-network rate even when care is delivered in a non-network ER. Because we do not have a contract with out of network ER facilities, we cannot prevent these facilities from billing our members for the balance of the charge. The copay applies to the facility charge only. All other charges related to ER visit are subject to deductible/coinsurance.

³ **CGHC Doctor Line** - This service makes available to our members phone calls with a licensed physician. For non-HSA compatible plans, the first 3 doctor line calls are provided at no cost. Total doctor line calls are capped at 3 within 3 months or 8 within 12 months.

⁴ **Preventive care** received out of network is not covered.

Our Deductibles, Explained: All plans have a January 1 to December 31 deductible. All deductibles, coinsurance, and copayments accumulate toward the out-of-pocket maximum. In-network and out-of-network deductibles and out-of-pocket maximums must be satisfied separately. All plans described on this page, with the exception of the Gold HSA plan, have embedded deductibles for family coverage. This means that if you are enrolled in 2-person or family coverage, an individual family member only has to satisfy the single person deductible before the plan begins to make payment for covered services for that family member. With the Gold HSA, we are required to "aggregate" the deductibles to meet the minimum requirements for HSAs. Aggregate deductibles require a single person in family coverage to meet the family deductible before non-preventive health services are covered.

