



**CGHC Copay Silver \$0 Ded CSR 94% -  
Envision Network (Vision Exam + Allergy Test)**

	PA = Prior Authorization	In Network Benefits Only <sup>7</sup> (You Pay)
Calendar Year Deductible (Runs Jan 1 – Dec 31)		\$0 single/\$0 family
Coinsurance (applies only to certain services)		10%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		\$1,100 single/\$2,200 family
<b>Office Visits</b>		
Primary Care Provider Visit (to treat an illness or injury) <sup>1</sup>		\$5 Copay
Aurora Quick Care or Bellin/ThedaCare Fast Care		\$0 Copay
Obstetrics/Gynecology Visit		\$5 Copay
Specialist Visit		\$20 Copay
Chiropractic Visit		\$5 Copay
Hearing Exam		\$5 Copay
<b>Diagnostic Services<sup>8</sup></b>		
Diagnostic Laboratory Tests		\$20 Copay
Diagnostic X-rays		\$20 Copay
Imaging (MRI, MRA, PET and CT Services only)	PA	\$75 Copay
<b>Mental/Behavioral Health &amp; Substance Abuse</b>		
Outpatient - Office / Physician Visit		\$5 Copay
Outpatient - Facility Fee		\$125 Copay
Outpatient - All Other Services		Deductible/Coinsurance
Transitional		Deductible/Coinsurance
Inpatient – Including Residential	PA	\$700 Copay Per Day
<b>Emergency Services</b>		
Emergency Room <sup>2</sup> (copay waived if admitted)		\$300 Copay
Physician Services		Deductible/Coinsurance
Urgent Care		\$30 Copay
Ambulance (ground and air)		Deductible/Coinsurance
<b>Hospital Services</b>		
Outpatient/Ambulatory Surgical Facility Fee	PA	\$125 Copay
Outpatient Surgical Services	PA	\$20 Copay
Inpatient Hospital Facility Fee	PA	\$700 Copay Per Day
Inpatient Physician and Surgical Services	PA	Deductible/Coinsurance
Inpatient Rehabilitation (limited to 60 days/year)	PA	\$700 Copay Per Day
<b>Maternity Services</b>		
Prenatal Care		Deductible/Coinsurance
Delivery and Inpatient Services	PA*	Deductible/Coinsurance
<b>Preventive Services</b>		
Preventive Services <sup>3</sup> - ACA Required		Covered in Full
Preventive Services - Not ACA Required		Deductible/Coinsurance
<b>Vision Services</b>		
Children's Vision Exam (1 exam per year)		Covered in Full
Children's Eye Glasses or Contacts (1 pair per year)		Deductible/Coinsurance
Routine Vision Exam for Adults <sup>9</sup> (1 exam/year)		Covered in Full
<b>Other Services</b>		
Transplants <sup>4</sup>	PA	Deductible/Coinsurance
Habilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)		\$20 Copay
Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)		\$20 Copay
Cardiac/Pulmonary Rehabilitation (up to 36 visits/year)		Deductible/Coinsurance
Post-Cochlear Implant Aural Therapy (up to 30 visits/year)		Deductible/Coinsurance

Cognitive Rehabilitation Therapy (up to 20 visits/year)		\$20 Copay
Autism Spectrum Disorders		Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per stay)	PA	\$700 Copay Per Day
Outpatient Chemotherapy		Deductible/Coinsurance
Outpatient Radiation Therapy		Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance
Home Health Services (up to 60 visits/year)		Deductible/Coinsurance
Specified Oral Surgical Procedures <sup>5</sup>	PA	Deductible/Coinsurance
Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin)		Not Covered
Accidental Dental Services		Deductible/Coinsurance
Preventive Dental Services for Adults <sup>10</sup>		Not Covered
Preventive Dental Services for Children <sup>10</sup>		Not Covered
Allergy Testing		Deductible/Coinsurance
<b>Prescription Drugs</b>		
Separate Rx Deductible		Does Not Apply; Under Medical Deductible.
<i>See formulary to determine tier and if medication is preventative. Diabetic test strips are included. Drugs are available in Retail setting (30-day supply) at coinsurance or 1 copay or using Mail Order<sup>6</sup> (90-day supply) at coinsurance or 2 copays</i>		
Preventative Drugs (30-day supply)		\$0 (See formulary for details)
Tier CM - Oral Chemotherapy Drugs		Deductible Then Covered in Full
Tier 1 - Generic Drugs		\$0 Copay
Tier 2 - Preferred Brand Drugs		\$20 Copay
Tier 2 - Preferred Insulin Copay		\$15 Copay
Tier 3 - Non-Preferred Brand Drugs		Deductible/Coinsurance
Tier 4 - Specialty Drugs	PA	Deductible/Coinsurance
<b>Supplies &amp; Equipment</b>		
Durable Medical Equipment	PA	Deductible/Coinsurance
Prosthetic Devices	PA	Deductible/Coinsurance
Diabetic Equipment	PA	Deductible/Coinsurance
Hearing Aids and Cochlear Implants (One aid per ear every 36 months)		Deductible/Coinsurance

***This Schedule of Benefits does not replace the legal contract or certificate which identifies all covered services, additional details, limitations and exclusions of the coverage. For a complete description of covered services, please see your Certificate of Coverage and any amendments to your Benefit Plan. If you have questions regarding Common Ground Healthcare Cooperative Benefits, please call us at 1-877-514-2442.***

PA indicates Prior Authorization is required for these services. Call 1-877-825-9293 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. (\*PA required when inpatient stay extends beyond the standard 48 hours (vaginal) to 96 hours (cesarean)).

When working with a health insurance broker, the broker is compensated \$20 per member per month.

<sup>1</sup>Primary Care Provider may include general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

<sup>2</sup>Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

<sup>3</sup>The Affordable Care Act (ACA) provides for coverage of certain preventive services based on age, gender and other health factors at no cost to the member. Visit <https://commongroundhealthcare.org/coverage-details> for a complete listing.

<sup>4</sup>Examples of transplants for which benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea when medically necessary and not experimental.

<sup>5</sup>Please refer to the Certificate of Coverage to determine what oral surgeries procedures are covered.

<sup>6</sup>Only certain Prescription Drug products are available through mail order.

<sup>7</sup>No payment will be made for out-of-network care except for emergency care, urgent care outside of our service area or when there is no in-network provider that can perform covered services and written approval is obtained as outlined in our certificate of coverage.

<sup>8</sup>When receiving covered services at an office or hospital visit, member may be subject to copay charges for both the facility and the service rendered.

<sup>9</sup>Refraction and dilation are not included in the adult eye exam.

<sup>10</sup>Preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), sealants (up to age 14 on permanent molars only)