

CGHC Silver \$0 CSR 94% (\$5 PCP Copay) -Envision Network (Vision Exam + Allergy Test)

Calendar Year Deductible (Runs Jan 1 – Dec 31) Colinsurance (applies only to certain services) 10% Assimum Out-of-Pocket (Includes deductible, coinsurance, copays) S2,750 single/55,500 family Office Visits Primary Care Provider Visit (to treat an iliness or injury) Aurora Quick Care or Bellin/ThedaCare Fast Care S0 Copay Obstetrics/Gynecology Visit S5 Copay Specialist Visit S202 Copay Chiropractic Visit S5 Copay Specialist Visit S5 Copay Chiropractic Visit Chiropractic Visit S5 Copay Chiropractic Visit S5 Copay Chiropractic Visit S5 Copay Chiropractic Visit Chiropractic Visit S5 Copay Chiropractic Visit	PA = Prior Authorization	In Network Benefits Only ⁷ (You Pay)
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Post-Cochlear Implant Aural Therapy (up to 30 visits/year) Deductible/Coinsurance		

Cognitive Rehabilitation Therapy (up to 20 visits/year)		Deductible/Coinsurance	
Autism Spectrum Disorders		Deductible/Coinsurance	
Skilled Nursing Facility (up to 30 days per stay)	PA	Deductible/Coinsurance	
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 ⁵	PA	Deductible/Coinsurance	
Routine Dental Care (Pediatric dental coverage or a stand-alone dental be purchased separately in Wisconsin)	services product can	Not Covered	
Accidental Dental Services		Deductible/Coinsurance	
Preventive Dental Services for Adults ¹⁰		Not Covered	
Preventive Dental Services for Children ¹⁰		Not Covered	
Allergy Testing		Deductible/Coinsurance	
Prescription Drugs			
Separate Rx Deductible		Does Not Apply; Under Medical Deductible.	
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 ⁶ (90-day supply) at coinsurance or 2 copays			
Preventative Drugs (30-day supply)		\$0 (See formulary for details)	
Tier CM - Oral Chemotherapy Drugs		Deductible Then Covered in Full	
Tier 1 - Generic Drugs		\$5 Copay	
Tier 2 - Preferred Brand Drugs		\$25 Copay	
Tier 2 - Preferred Insulin Copay		\$15 Copay	
Tier 3 - Non-Preferred Brand Drugs		Deductible/Coinsurance	
Tier 4 - Specialty Drugs	PA	Deductible/30% Coinsurance	
Supplies & Equipment			
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.

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

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

³The 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.

⁴Examples 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.

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

⁶Only certain Prescription Drug products are available through mail order.

⁷No 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.

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

⁹Refraction and dilation are not included in the adult eye exam.

¹⁰Preventive 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)