



**CGHC Silver \$700 CSR 87% -  
Envision Network**

|   | PA = Prior<br>Authorization | In Network Benefits Only <sup>7</sup><br>(You Pay) |
|---|-----------------------------|--|
| Calendar Year Deductible (Runs Jan 1 – Dec 31)  |                             | \$700 single/\$1,400 family                        |
| Coinsurance (applies only to certain services)  |                             | 20%  |
| Maximum Out-of-Pocket (includes deductible, coinsurance, copays)  |                             | \$3,000 single/\$6,000 family                      |
| <b>Office Visits</b>  |                             |  |
| Primary Care Provider Visit (to treat an illness or injury) <sup>1</sup>                                  |                             | \$30 Copay   |
| Aurora Quick Care or Bellin/ThedaCare Fast Care   |                             | \$20 Copay   |
| Obstetrics/Gynecology Visit   |                             | \$30 Copay   |
| Specialist Visit  |                             | \$50 Copay   |
| Chiropractic Visit  |                             | \$30 Copay   |
| Hearing Exam  |                             | \$30 Copay   |
| <b>Diagnostic Services<sup>8</sup></b>  |                             |  |
| Diagnostic Laboratory Tests   |                             | Deductible/Coinsurance                             |
| Diagnostic X-rays   |                             | Deductible/Coinsurance                             |
| Imaging (MRI, MRA, PET and CT Services only)  | PA                          | Deductible/Coinsurance                             |
| <b>Mental/Behavioral Health &amp; Substance Abuse</b>   |                             |  |
| Outpatient - Office / Physician Visit   |                             | \$30 Copay   |
| Outpatient - Facility Fee   |                             | Deductible/Coinsurance                             |
| Outpatient - All Other Services   |                             | Deductible/Coinsurance                             |
| Transitional  |                             | Deductible/Coinsurance                             |
| Inpatient – Including Residential   | PA                          | Deductible/Coinsurance                             |
| <b>Emergency Services</b>   |                             |  |
| Emergency Room <sup>2</sup> (copay waived if admitted)  |                             | Deductible/Coinsurance                             |
| Physician Services  |                             | Deductible/Coinsurance                             |
| Urgent Care   |                             | \$60 Copay   |
| Ambulance (ground and air)  |                             | Deductible/Coinsurance                             |
| <b>Hospital Services</b>  |                             |  |
| Outpatient/Ambulatory Surgical Facility Fee   | PA                          | Deductible/Coinsurance                             |
| Outpatient Surgical Services  | PA                          | Deductible/Coinsurance                             |
| Inpatient Hospital Facility Fee   | PA                          | Deductible/Coinsurance                             |
| Inpatient Physician and Surgical Services   | PA                          | Deductible/Coinsurance                             |
| Inpatient Rehabilitation (limited to 60 days/year)  | PA                          | Deductible/Coinsurance                             |
| <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)   |                             | Not Covered  |
| <b>Other Services</b>   |                             |  |
| Transplants <sup>4</sup>  | PA                          | Deductible/Coinsurance                             |
| Habilitative Services<br>(Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)   |                             | Deductible/Coinsurance                             |
| Rehabilitative Services<br>(Physical, Speech, Occupational Therapy - 20 visits per therapy type per year) |                             | Deductible/Coinsurance                             |
| 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)   |    | 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 <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   |    | Not Covered                               |
| <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.<br/>Drugs are available in Retail setting (30-day supply) at coinsurance or 1 copay<br/>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  |    | \$10 Copay                                |
| Tier 2 - Preferred Brand Drugs  |    | \$60 Copay                                |
| Tier 2 - Preferred Insulin Copay  |    | \$15 Copay                                |
| Tier 3 - Non-Preferred Brand Drugs  |    | Deductible/Coinsurance                    |
| Tier 4 - Specialty Drugs  | PA | Deductible/30% 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)