# CGHC Silver $4050 CSR 73% - Envision Network (Dental/Vision Exam)

**Calendar Year Deductible (Runs Jan 1 – Dec 31)** | **In Network Benefits Only**
---|---
$4,050 Single/$8,100 Family | **(You Pay)**

**Coinsurance (applies only to certain services)** | **30%**

**Maximum Out-of-Pocket (includes deductible, coinsurance, copays)** | **$7,550 Single/$15,100 Family**

## Office Visit
- Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic | $30 Copay¹³
- Primary Care Provider (for non-preventive services) | $40 Copay¹³
- Mental/Behavioral Health | $40 Copay¹³
- Chiropractic | $40 Copay¹³
- Hearing Exam | $40 Copay¹³
- Specialist | $75 Copay¹³

## Diagnostic Services
- Diagnostic Laboratory Test | Deductible/Coinsurance
- Diagnostic X-ray, ultrasound and other radiology service | Deductible/Coinsurance
- Imaging (MRI, MRA, PET and CT service only) | PA

## Mental/Behavioral Health & Substance Abuse
- Outpatient - Facility Fee | Deductible/Coinsurance
- Outpatient - All Other Services | Deductible/Coinsurance
- Transitional Care Services (room/board at transitional care facility is not covered) | Deductible/Coinsurance
- Inpatient – Facility Fee (including residential) | PA
- Inpatient – Physician Services | Deductible/Coinsurance

## Emergency Services
- Emergency Room Facility Fee (copay waived if admitted) | Deductible/Coinsurance
- Physician Services rendered in an Emergency Room | Deductible/Coinsurance
- Emergency Room – All Other Services | Deductible/Coinsurance
- Urgent Care | Deductible/Coinsurance
- Ambulance (ground and air) | Deductible/Coinsurance

## Hospital Services
- Outpatient Surgery & Ambulatory Surgical Center - Facility Fee | PA
- Outpatient (non-surgical) – Facility Fee | PA
- Outpatient Surgical - Physician Services | PA
- Outpatient - All Other Services | Deductible/Coinsurance
- Inpatient – Facility Fee | PA
- Inpatient - Physician and Surgical Services | PA
- Inpatient - Rehabilitation (limited to 60 days/year) | PA

## Maternity Services
- Prenatal Care | Deductible/Coinsurance
- Delivery and Inpatient Services | PA* Covered in Full

## Preventive Services
- Preventive Services | Covered in Full

## Vision Services
- 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 (1 exam/year) | Covered in Full

## Miscellaneous Services
- Accidental Dental Services | Deductible/Coinsurance
- Allergy Testing | Not Covered
- Anesthesia Services (any place of service) | Deductible/Coinsurance
- Autism Spectrum Disorder Treatment | Deductible/Coinsurance
- Cardiac/Pulmonary Rehabilitation (up to 36 visits/year) | Deductible/Coinsurance
- Cognitive Rehabilitation Therapy (up to 20 visits/year) | Deductible/Coinsurance
- Habilitative Services (physical, speech, occupational therapy - 20 visits per therapy type per year) | Deductible/Coinsurance
### Prescription Drugs, Supplies & Equipment

<table>
<thead>
<tr>
<th>Description</th>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only[^1] (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services (up to 60 visits/year)</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Hospice Services/End of Life Services</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Outpatient Chemotherapy</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Outpatient Radiation Therapy</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Post-Cochlear Implant Aural Therapy (up to 30 visits/year)</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Preventive Dental Services[^2]</td>
<td></td>
<td>Covered in Full</td>
</tr>
<tr>
<td>Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin)</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility (up to 30 days per stay)</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Specified Oral Surgical Procedures[^10]</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

[^1]: PA = Prior Authorization

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**Prescription Drugs, Supplies & Equipment**

Separate Rx Deductible: Does Not Apply; Under Medical Deductible.

See formulary to determine tier and if medication is preventive. Diabetic test strips are included. Drugs are available in Retail setting (30-day supply) at coinsurance or 1 copay or using Mail Order[^11] (90-day supply) at coinsurance or 2 copays.

**Preventive Drugs (30-day supply)**: $0 (See formulary for details)

<table>
<thead>
<tr>
<th>Tier CM - Oral Chemotherapy Drugs</th>
<th>Tier 1 - Typically Generic Drugs</th>
<th>Tier 1 - Preferred Drugs[^7]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible/Then Covered in Full</td>
<td>$10 Copay</td>
<td>$90 Copay</td>
</tr>
</tbody>
</table>

**Tier 2 - Preferred Insulin Copay**

<table>
<thead>
<tr>
<th>Tier 2 - Preferred Insulin Copay</th>
<th>Tier 4 - Specialty Drugs</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15 Copay</td>
<td>Deductible/Coinsurance</td>
<td>PA</td>
</tr>
</tbody>
</table>

**Supplies & Equipment**

<table>
<thead>
<tr>
<th>Supplies &amp; Equipment</th>
<th>PA</th>
<th>Deductible/Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Diabetic Equipment</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Hearing Aids and Cochlear Implants (One aid per ear every 36 months)</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

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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 about Common Ground Healthcare Cooperative Benefits, call 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.

[^1]: ¹Copay applies to the facility ER charge. All other charges rendered as part of your ER visit are subject to their applicable additional copayment or deductible/coinsurance as specified in this schedule of benefits.

[^2]: 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.

[^3]: All Other Services are defined as services not elsewhere listed in this schedule of benefits.

[^4]: ¹¹Copay applies to the facility ER charge. All other charges rendered as part of your ER visit are subject to their applicable additional copayment or deductible/coinsurance as specified in this schedule of benefits.

[^5]: 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 [www.commongroundhealthcare.org/coverage-details](http://www.commongroundhealthcare.org/coverage-details) for a complete listing. During a preventive care visit, you may receive services that aren’t required to be covered at no cost to you under the ACA. Those services may require a copay, or the charges may apply towards your deductible and/or coinsurance.

[^6]: If you purchased a plan that includes routine vision exams for adults, refraction and dilation are not included in the adult eye exam.

[^7]: If you purchased a plan that includes dental coverage, 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), and sealants (up to age 14 on permanent molars only).

[^8]: ¹²Please refer to the Certificate of Coverage to determine what oral surgical procedures are covered.

[^9]: Only certain Prescription Drug products are available through mail order.

[^10]: When a brand is dispensed and a generic is available, you may be responsible to pay the difference in cost between the brand and generic in addition to the brand drug cost share (copay, deductible and/or coinsurance). The difference in cost will not apply towards your deductible and/or maximum out-of-pocket.

[^11]: Copay is applied per provider, per date of service.