



**CGHC Bronze \$0 Ded / \$2250 Rx Ded -  
Envision Network (Vision Exam + Allergy Test)**

	PA = Prior Authorization	In Network Benefits Only <sup>1</sup> (You Pay)
Calendar Year Deductible (Runs Jan 1 – Dec 31)		\$0 Single/\$0 Family
Coinsurance (applies only to certain services)		50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		\$9,200 Single/\$18,400 Family
<b>Office Visit</b>		
Retail Based Clinic (such as Fast Care or Quick Care)		\$30 Copay <sup>13</sup>
Primary Care Provider (For non-Preventive services) <sup>2</sup>		\$40 Copay <sup>13</sup>
Mental/Behavioral Health		\$40 Copay <sup>13</sup>
Chiropractic <sup>3</sup>		\$40 Copay <sup>13</sup>
Hearing Exam		\$40 Copay <sup>13</sup>
Specialist <sup>4</sup>		\$100 Copay <sup>13</sup>
<b>Diagnostic Services<sup>5</sup></b>		
Diagnostic Laboratory Test		\$75 Copay Per Test
Diagnostic X-ray, Ultrasound and Other Radiology Service		\$150 Copay Per Service
Imaging (MRI, MRA, PET and CT Service only)	PA	\$1,075 Copay Per Service
<b>Mental/Behavioral Health &amp; Substance Abuse</b>		
Outpatient - Facility Fee		\$200 Copay
Outpatient - All Other Services <sup>6</sup>		Deductible/Coinsurance
Transitional Care Services (room/board at transitional care facility is not covered)		Deductible/Coinsurance
Inpatient – Facility Fee (Including Residential)	PA	\$1,500 Copay Per Day
Inpatient – Physician Services		Deductible/Coinsurance
<b>Emergency Services</b>		
Emergency Room Facility Fee <sup>7</sup> (copay waived if admitted)		\$1,850 Copay
Physician Services rendered in an Emergency Room		Deductible/Coinsurance
Emergency Room – All Other Services <sup>6</sup>		Deductible/Coinsurance
Urgent Care <sup>5</sup>		\$200 Copay
Ambulance <sup>8</sup> (ground and air)		Deductible/Coinsurance
<b>Hospital Services<sup>5</sup></b>		
Outpatient Surgery & Ambulatory Surgical Center - Facility Fee	PA	\$200 Copay
Outpatient (non-Surgical) – Facility Fee	PA	\$200 Copay
Outpatient Surgical - Physician Services	PA	\$200 Copay Per Service
Outpatient - All Other Services <sup>6</sup>		Deductible/Coinsurance
Inpatient - Facility Fee	PA	\$1,500 Copay Per Day
Inpatient - Physician and Surgical Services	PA	Deductible/Coinsurance
Inpatient - Rehabilitation (limited to 60 days/year)	PA	\$1,500 Copay Per Day
<b>Maternity Services</b>		
Prenatal Care		Deductible/Coinsurance
Delivery and Inpatient Services	PA*	\$1,500 Copay Per Day
<b>Preventive Services</b>		
Preventive Services <sup>9</sup>		Covered in Full
<b>Vision Services</b>		
Children's Vision Exam (1 exam per year)		Covered in Full
Children's Eye Glasses (1 pair per year) or Contacts (1 year supply)		Deductible/Coinsurance
Routine Vision Exam for Adults <sup>10</sup> (1 exam/year)		Covered in Full
<b>Miscellaneous Services</b>		
Accidental Dental Services		Deductible/Coinsurance
Allergy Testing		Deductible/Coinsurance
Anesthesia Services (any place of service)		Deductible/Coinsurance
Autism Spectrum Disorder Treatment		Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits/year)	PA	Deductible/Coinsurance
Cognitive Rehabilitation Therapy (up to 20 visits/year)	PA	\$100 Copay Per Therapy
Habilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)	PA	\$100 Copay Per Therapy Type Per Day

	PA = Prior Authorization	In Network Benefits Only <sup>1</sup> (You Pay)
Home Health Services (up to 60 visits/year)	PA	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance
Outpatient Chemotherapy	PA	Deductible/Coinsurance
Outpatient Radiation Therapy	PA	Deductible/Coinsurance
Post-Cochlear Implant Aural Therapy (up to 30 visits/year)		Deductible/Coinsurance
Preventive Dental Services		Not Covered
Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)	PA	\$100 Copay Per Therapy Type Per Day
Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin)		Not Covered
Skilled Nursing Facility (up to 30 days per stay)	PA	\$1,500 Copay Per Day
Specified Oral Surgical Procedures <sup>11</sup>	PA	Deductible/Coinsurance
<b>Prescription Drugs, Supplies &amp; Equipment</b>		
Tier 4 - Oral Chemotherapy Drugs	PA	Medical Deductible/Coinsurance
Separate Rx Deductible		\$2,250 Single/\$4,500 Family
<i>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<sup>12</sup> (90-day supply) at coinsurance or 2 copays.</i>		
Preventive Drugs (30-day supply)		\$0 (See formulary for details)
Tier 1 - Typically Generic Drugs		\$35 Copay
Tier 2 - Preferred Drugs		\$140 Copay
Tier 3 - Non-Preferred Drugs		Rx Deductible/Coinsurance
Tier 4 - Specialty Drugs	PA	Rx 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)	PA	Deductible/Coinsurance

**This Schedule of Benefits does not replace the legal contract or Certificate** which identifies all covered services, additional details, benefit 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 your Common Ground Healthcare Cooperative Benefits, call 1-877-514-2442.

**PA indicates Prior Authorization** is required for these services. Call 1-877-514-2442 for any Prior Authorization. Failure to obtain Prior Authorization when required may 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>**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>2</sup>**Primary Care Provider** may include general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

<sup>3</sup>**Chiropractic** maintenance therapy is not covered, refer to Certificate of Coverage for further details. Modality will be subject to an additional copay or will apply towards your deductible and/or coinsurance.

<sup>4</sup>**Specialists are all provider types** other than those defined elsewhere in this Schedule of Benefits.

<sup>5</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>6</sup>**All Other Services** are defined as services not elsewhere listed in this schedule of benefits.

<sup>7</sup>**Copay 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.

<sup>8</sup>**Ground Ambulance** does require prior authorization for any non-emergency transports.

<sup>9</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 [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.

<sup>10</sup>**If you purchased a plan that includes routine vision exams for adults**, refraction and dilation are not included in the adult eye exam.

<sup>11</sup>Please refer to the Certificate of Coverage to determine what **oral surgery procedures** are covered.

<sup>12</sup>**Only certain Prescription Drug products are available through mail order.**

<sup>13</sup>**Copay is applied per provider, per date of service.**