COMMON GROUND
HEALTHCARE COOPERATIVE

CGHC Gold $0 Ded - Envision Network (Vision Exam)

PA = Prior Authorization		In Network Benefits Only[1] (You Pay)
Calendar Year Deductible (Runs Jan 1 – Dec 31)		$0 Single/$0 Family
Coinsurance (applies only to certain services)		20%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$8,500 Single/$17,000 Family
Office Visit		
Retail Based Clinic (such as Fast Care or Quick Care)		$25 Copay[13]
Primary Care Provider (For non-Preventive services)[2]		$35 Copay[13]
Mental/Behavioral Health		$35 Copay[13]
Chiropractic[3]		$35 Copay[13]
Hearing Exam		$35 Copay[13]
Specialist[4]		$75 Copay[13]
Diagnostic Services[5]		
Diagnostic Laboratory Test		$50 Copay Per Test
Diagnostic X-ray, Ultrasound and Other Radiology Service		$60 Copay Per Service
Imaging (MRI, MRA, PET and CT Service only)	**PA**	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse		
Outpatient - Facility Fee		Deductible/Coinsurance
Outpatient - All Other Services[6]		Deductible/Coinsurance
Transitional Care Services (room/board at transitional care facility is not covered)		Deductible/Coinsurance
Inpatient – Facility Fee (Including Residential)	**PA**	Deductible/Coinsurance
Inpatient – Physician Services		Deductible/Coinsurance
Emergency Services		
Emergency Room Facility Fee[7] (copay waived if admitted)		$500 Copay
Physician Services rendered in an Emergency Room		Deductible/Coinsurance
Emergency Room – All Other Services[6]		Deductible/Coinsurance
Urgent Care[5]		$75 Copay
Ambulance[8] (ground and air)		Deductible/Coinsurance
Hospital Services[5]		
Outpatient Surgery & Ambulatory Surgical Center - Facility Fee	**PA**	Deductible/Coinsurance
Outpatient (non-Surgical) – Facility Fee	**PA**	Deductible/Coinsurance
Outpatient Surgical - Physician Services	**PA**	Deductible/Coinsurance
Outpatient - All Other Services[6]		Deductible/Coinsurance
Inpatient - Facility Fee	**PA**	Deductible/Coinsurance
Inpatient - Physician and Surgical Services	**PA**	Deductible/Coinsurance
Inpatient - Rehabilitation (limited to 60 days/year)	**PA**	Deductible/Coinsurance
Maternity Services		
Prenatal Care		Deductible/Coinsurance
Delivery and Inpatient Services	**PA***	Deductible/Coinsurance
Preventive Services		
Preventive Services[9]		Covered in Full
Vision Services		
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[10] (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)	**PA**	Deductible/Coinsurance
Cognitive Rehabilitation Therapy (up to 20 visits/year)	**PA**	$70 Copay Per Therapy
Habilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)	**PA**	$70 Copay Per Therapy Type Per Day

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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	$70 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	Deductible/Coinsurance
Specified Oral Surgical Procedures[11]	PA	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment		
Tier 4 - Oral Chemotherapy Drugs	PA	Deductible/Coinsurance
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 [12] (90-day supply) at coinsurance or 2 copays.		
Preventive Drugs (30-day supply)		$0 (See formulary for details)
Tier 1 - Typically Generic Drugs		$20 Copay
Tier 2 - Preferred Drugs Tier 2 - Preferred Insulin Copay		$55 Copay $15 Copay
Tier 3 - Non-Preferred Drugs		Deductible/30% 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)	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.

[1]**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.

[2]**Primary Care Provider** may include general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[3]**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.

[4]**Specialists are all provider types** other than those defined elsewhere in this Schedule of Benefits.

[5]**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.

[6]**All Other Services** are defined as services not elsewhere listed in this schedule of benefits.

[7]**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.

[8]**Ground Ambulance** does require prior authorization for any non-emergency transports.

[9]**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 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.

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

[11]Please refer to the Certificate of Coverage to determine what **oral surgery procedures** are covered.

[12]**Only certain Prescription Drug products are available through mail order**.

[13]**Copay is applied per provider, per date of service.**