



**CGHC Gold Standard \$1500 NCS -  
Envision Network**

| 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)  | 0%  |
| Maximum Out-of-Pocket (includes deductible, coinsurance, copays)  | \$0 Single/\$0 Family                           |
| <b>Office Visit</b>   |   |
| Retail Based Clinic (such as Fast Care or Quick Care)   | \$0 Copay <sup>13</sup>                         |
| Primary Care Provider (For non-Preventive services) <sup>2</sup>  | \$0 Copay <sup>13</sup>                         |
| Mental/Behavioral Health  | \$0 Copay <sup>13</sup>                         |
| Chiropractic <sup>3</sup>   | \$0 Copay <sup>13</sup>                         |
| Hearing Exam  | \$0 Copay <sup>13</sup>                         |
| Specialist <sup>4</sup>   | \$0 Copay <sup>13</sup>                         |
| <b>Diagnostic Services<sup>5</sup></b>  |   |
| Diagnostic Laboratory Test  | \$0 Copay Per Test                              |
| Diagnostic X-ray, Ultrasound and Other Radiology Service  | \$0 Copay Per Service                           |
| Imaging (MRI, MRA, PET and CT Service only) PA  | \$0 Copay Per Service                           |
| <b>Mental/Behavioral Health &amp; Substance Abuse</b>   |   |
| Outpatient - Facility Fee   | \$0 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   | \$0 Copay                                       |
| Inpatient – Physician Services  | Deductible/Coinsurance                          |
| <b>Emergency Services</b>   |   |
| Emergency Room Facility Fee <sup>7</sup> (copay waived if admitted)                                     | \$0 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>  | \$0 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                                       | \$0 Copay                                       |
| Outpatient (non-Surgical) – Facility Fee PA   | \$0 Copay                                       |
| Outpatient Surgical - Physician Services PA   | \$0 Copay Per Service                           |
| Outpatient - All Other Services <sup>6</sup>  | Deductible/Coinsurance                          |
| Inpatient - Facility Fee PA   | \$0 Copay                                       |
| Inpatient - Physician and Surgical Services PA  | Deductible/Coinsurance                          |
| Inpatient - Rehabilitation (limited to 60 days/year) PA   | \$0 Copay                                       |
| <b>Maternity Services</b>   |   |
| Prenatal Care   | Deductible/Coinsurance                          |
| Delivery and Inpatient Services PA*   | \$0 Copay                                       |
| <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)  | Not Covered                                     |
| <b>Miscellaneous Services</b>   |   |
| 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  | \$0 Copay Per Therapy                           |
| Habilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year) PA | \$0 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                       | \$0 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                       | \$0 Copay                                       |
| Specified Oral Surgical Procedures <sup>11</sup>  | PA                       | Deductible/Coinsurance                          |
| <b>Prescription Drugs, Supplies &amp; Equipment</b>   |                          |   |
| Tier 4 - Oral Chemotherapy Drugs  | PA                       | Deductible/Coinsurance                          |
| Separate Rx Deductible  |                          | Does Not Apply; Under Medical Deductible.       |
| <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  |                          | \$0 Copay                                       |
| Tier 2 - Preferred Drugs  |                          | \$0 Copay                                       |
| Tier 3 - Non-Preferred Drugs  |                          | \$0 Copay                                       |
| Tier 4 - Specialty Drugs  | PA                       | \$0 Copay                                       |
| <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.**