



**CGHC Silver Standard \$5000 NCS -
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) | | 0% |
| Maximum Out-of-Pocket (includes deductible, coinsurance, copays) | | \$0 Single/\$0 Family |
| Office Visit | | |
| Retail Based Clinic (such as Fast Care or Quick Care) | | \$0 Copay ¹³ |
| Primary Care Provider (For non-Preventive services) ² | | \$0 Copay ¹³ |
| Mental/Behavioral Health | | \$0 Copay ¹³ |
| Chiropractic ³ | | \$0 Copay ¹³ |
| Hearing Exam | | \$0 Copay ¹³ |
| Specialist ⁴ | | \$0 Copay ¹³ |
| Diagnostic Services⁵ | | |
| 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 |
| Mental/Behavioral Health & Substance Abuse | | |
| Outpatient - Facility Fee | | \$0 Copay |
| 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 | \$0 Copay |
| Inpatient – Physician Services | | Deductible/Coinsurance |
| Emergency Services | | |
| Emergency Room Facility Fee ⁷ (copay waived if admitted) | | \$0 Copay |
| Physician Services rendered in an Emergency Room | | Deductible/Coinsurance |
| Emergency Room – All Other Services ⁶ | | Deductible/Coinsurance |
| Urgent Care ⁵ | | \$0 Copay |
| Ambulance ⁸ (ground and air) | | Deductible/Coinsurance |
| Hospital Services⁵ | | |
| 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 ⁶ | | 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 |
| Maternity Services | | |
| Prenatal Care | | Deductible/Coinsurance |
| Delivery and Inpatient Services | PA* | \$0 Copay |
| 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 | \$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 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. |
| <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 Order¹² (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 |
| 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.

¹¹Please 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.**