COMMON GROUND
HEALTHCARE COOPERATIVE

CGHC Bronze Standard $7500 - Envision Network

PA = Prior Authorization		In Network Benefits Only[1] (You Pay)
Calendar Year Deductible (Runs Jan 1 – Dec 31)		$7,500 Single/$15,000 Family
Coinsurance (applies only to certain services)		50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$9,400 Single/$18,800 Family
Office Visit		
Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic		$30 Copay[13]
Primary Care Provider (For non-Preventive services)[2]		$50 Copay[13]
Mental/Behavioral Health		$50 Copay[13]
Chiropractic		$50 Copay[13]
Hearing Exam		$50 Copay[13]
Specialist[3]		$100 Copay[13]
Diagnostic Services[4]		
Diagnostic Laboratory Test		Deductible/Coinsurance
Diagnostic X-ray, Ultrasound and Other Radiology Service		Deductible/Coinsurance
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[5]		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[6] (copay waived if admitted)		Deductible/Coinsurance
Physician Services rendered in an Emergency Room		Deductible/Coinsurance
Emergency Room – All Other Services[5]		Deductible/Coinsurance
Urgent Care[4]		$75 Copay
Ambulance (ground and air)		Deductible/Coinsurance
Hospital Services[4]		
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[5]		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[7]		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[8] (1 exam/year)		Not Covered
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)		$50 Copay Per Therapy
Habilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)		$50 Copay Per Therapy Type Per Day

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Home Health Services (up to 60 visits/year)		Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance
Outpatient Chemotherapy	**PA**	Deductible/Coinsurance
Outpatient Radiation Therapy		Deductible/Coinsurance
Post-Cochlear Implant Aural Therapy (up to 30 visits/year)		Deductible/Coinsurance
Preventive Dental Services[9]		Not Covered
Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)		$50 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[10]	**PA**	Deductible/Coinsurance
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)
Tier CM - Oral Chemotherapy Drugs		Deductible Then Covered in Full
Tier 1 - Typically Generic Drugs		$25 Copay
Tier 2 - Preferred Drugs[12]		$50 Copay after Deductible
Tier 3 - Non-Preferred Drugs[12]		$100 Copay after Deductible
Tier 4 - Specialty Drugs	**PA**	$500 Copay after Deductible
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)		Deductible/Coinsurance

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

[4]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.

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

[6]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.

[7]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.

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

[9]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).

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

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

[12]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.

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