

Envision Aurora Bellin ThedaCare CHHS PPO - Bronze 7900-100

	PA = Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)*
Calendar Year Deductible (Runs Jan 1 – Dec 31)		\$7900 single/\$15800 family	\$15800 single/\$31600 family
Coinsurance (applies only to certain services)		0%	30%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		\$7900 single/\$15800 family	\$31600 single/\$63200 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury) ¹		\$35 for first 3 visits, then Deductible/Coinsurance	Deductible/Coinsurance
Aurora Quick Care or Bellin/ThedaCare Fast Care		\$35 for first 3 visits, then Deductible/Coinsurance	Not Offered
Obstetrics/Gynecology Visit		\$35 for first 3 visits, then Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible /Coinsurance	Deductible/Coinsurance
Chiropractic Visit		\$35 for first 3 visits, then Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		\$35 for first 3 visits, then Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	PA	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		\$35 for first 3 visits, then Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional	PA	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient – Including Residential	PA	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room ² (waived if admitted)		Deductible/Coinsurance	Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)		Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	PA	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	PA	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Rehabilitation (limited to 60 days/year)	PA	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	PA	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Services ⁴ – ACA Required		Covered in Full	Deductible/Coinsurance
Preventive Services – Not ACA Required		Deductible/Coinsurance	Deductible/Coinsurance

Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Other Services			
Transplants ⁵	PA	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services (up to 20 visits/yr)		Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (including manipulation therapy and limited to 20 visits each)		Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits/yr)		Deductible/Coinsurance	Deductible/Coinsurance
Post-Cochlear Implant Aural Therapy (up to 30 visits/yr)		Deductible/Coinsurance	Deductible/Coinsurance
Cognitive Rehabilitation Therapy (up to 20 visits/yr)		Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders		Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	PA	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy		Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)		Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	PA	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures ⁶	PA	Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin)		Not Covered	Not Covered
Accidental Dental Services		Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: Retail (30 day supply) Includes diabetic test strip Mail Order ⁷ (2 Copays per 90 day supply) Includes diabetic test strip Preventive (30 day supply) Medications defined in our formulary as preventive.		NA Tier 1 — Deductible/Coinsurance Tier 2 — Deductible/Coinsurance Tier 3 — Deductible/Coinsurance Preventive - \$0 (see formulary for details)	NA Tier 1 — Not Covered Tier 2 — Not Covered Tier 3 — Not Covered Preventive – Not Covered (see formulary for details)
Specialty Drugs	PA	Deductible/Coinsurance	Not Covered
Oral Chemotherapy Drugs		Deductible then 100%	Deductible then 100%
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	PA	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices	PA if over \$1,000	Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	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 regarding Common Ground Healthcare Cooperative Benefits, please call us at 1-877-514-CGHC (2442).

PA indicates Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit.

*If we do not contract with out-of-network providers, we have a maximum allowed amount that we will pay toward out-of-network care. If the doctor's charge is higher than our maximum allowed amount, the doctor (or facility) could decide to bill you for the difference, called "balance billing."

¹Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

²Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

⁴ 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/members/preventivecare for a complete listing.

⁵ Examples of transplants for which benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea when medically necessary and not experimental.

⁶ Please refer to the Certificate of Coverage to determine what oral surgeries procedures are covered.

⁷ Only certain Prescription Drug products are available through mail order.