



## Silver 4000-75 NCS

	PA = Prior Authorization	In Network Benefits Only <sup>7</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 Visits</b>		
Primary Care Provider Visit (to treat an illness or injury) <sup>1</sup>		
		Covered in Full
Aurora Quick Care or Bellin/ThedaCare Fast Care		
		Covered in Full
Obstetrics/Gynecology Visit		
		Covered in Full
Specialist Visit		
		Covered in Full
Chiropractic Visit		
		Covered in Full
Hearing Exam		
		Covered in Full
<b>Diagnostic Services</b>		
Diagnostic Laboratory Tests		
		Covered in Full
Diagnostic X-rays		
		Covered in Full
Imaging (MRI, MRA, PET and CT Services only) PA		
		Covered in Full
<b>Mental/Behavioral Health &amp; Substance Abuse</b>		
Outpatient - Office		
		Covered in Full
Outpatient - All Other Services		
		Covered in Full
Transitional		
		Covered in Full
Inpatient – Including Residential PA		
		Covered in Full
<b>Emergency Services</b>		
Emergency Room <sup>2</sup> (waived if admitted)		
		Covered in Full
Physician Services		
		Covered in Full
Urgent Care		
		Covered in Full
Ambulance (ground and air)		
		Covered in Full
<b>Hospital Services</b>		
Outpatient Surgical/Ambulatory Surgical Care Centers PA		
		Covered in Full
Inpatient Hospital Services PA		
		Covered in Full
Inpatient Rehabilitation (limited to 60 days/year) PA		
		Covered in Full
<b>Maternity Services</b>		
Prenatal Care		
		Covered in Full
Delivery and Inpatient Services PA		
		Covered in Full
<b>Preventive Services</b>		
Preventive Services <sup>3</sup> – ACA Required		
		Covered in Full
Preventive Services – Not ACA Required		
		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)		
		Covered in Full

<b>Other Services</b>		
Transplants <sup>4</sup>	<b>PA</b>	Covered in Full
Habilitation Services (up to 20 visits/yr)		Covered in Full
Physical, Speech & Occupational Therapy (limited to 20 visits each)		Covered in Full
Cardiac/Pulmonary Rehabilitation (up to 36 visits/yr)		Covered in Full
Post-Cochlear Implant Aural Therapy (up to 30 visits/yr)		Covered in Full
Cognitive Rehabilitation Therapy (up to 20 visits/yr)		Covered in Full
Autism Spectrum Disorders		Covered in Full
Skilled Nursing Facility (up to 30 days per year)	<b>PA</b>	Covered in Full
Outpatient Chemotherapy		Covered in Full
Outpatient Radiation Therapy		Covered in Full
Hospice Services/End of Life Services		Covered in Full
Home Health Services (up to 60 visits per year)		Covered in Full
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	<b>PA</b>	Covered in Full
Specified Oral Surgical Procedures <sup>5</sup>	<b>PA</b>	Covered in Full
Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin)		Not Covered
Accidental Dental Services		Covered in Full
<b>Prescription Drugs, Supplies &amp; Equipment</b>		
Prescription Medicines:		
<b>Retail</b> (30 day supply) Includes diabetic test strips		Tier 1 — Covered in Full Tier 2 — Covered in Full Tier 3 — Covered in Full
<b>Mail Order</b> <sup>6</sup> (2 Copays per 90 day supply) Includes diabetic test strips		
<b>Preventive</b> (30 day supply) Medications defined in our formulary as preventive		<b>Preventive - \$0</b> (see formulary for details)
Specialty Drugs	<b>PA</b>	Deductible/30% Coinsurance
Oral Chemotherapy Drugs		Deductible then 100%
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	<b>PA if over \$1,000</b>	Covered in Full
Prosthetic Devices	<b>PA</b>	Covered in Full
Diabetic Equipment and Supplies		Covered in Full
Hearing Aids and Cochlear Implants (Limited to one aid per ear every 36 months)		Covered in Full

*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).*

*Co-payments, deductibles, or coinsurance will not apply under this plan when receiving essential health benefits through an in-network provider or when getting care from an Indian Health Service or tribal program.*

**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.

<sup>1</sup>Primary Care Provider may include general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

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

<sup>3</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/members/preventivecare](http://www.commongroundhealthcare.org/members/preventivecare) for a complete listing.

<sup>4</sup>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.

<sup>5</sup>Please refer to the Certificate of Coverage to determine what oral surgeries procedures are covered.<sup>6</sup> Only certain Prescription Drug products are available through mail order.

<sup>7</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.