COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 6500-75 NCS

PA = Prior Authorization	In Network Benefits Only[7] (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 Visits	
Primary Care Provider Visit (to treat an illness or injury)[1]	Covered in Full
Aurora Quick Care or Bellin/ThedaCare Fast Care	Covered in Full
Virtuwell	Covered in Full
Obstetrics/Gynecology Visit	Covered in Full
Specialist Visit	Covered in Full
Chiropractic Visit	Covered in Full
Hearing Exam	Covered in Full
Diagnostic Services	
Diagnostic Laboratory Tests	Covered in Full
Diagnostic X-rays	Covered in Full
Imaging (MRI, MRA, PET and CT Services only) **PA**	Covered in Full
Mental/Behavioral Health & Substance Abuse	
Outpatient - Office	Covered in Full
Outpatient - All Other Services	Covered in Full
Transitional	Covered in Full
Inpatient – Including Residential **PA**	Covered in Full
Emergency Services	
Emergency Room[2] (waived if admitted)	Covered in Full
Physician Services	Covered in Full
Urgent Care	Covered in Full
Ambulance (ground and air)	Covered in Full
Hospital Services	
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
Maternity Services	
Prenatal Care	Covered in Full
Delivery and Inpatient Services **PA**	Covered in Full
Preventive Services	
Preventive Services[3] – ACA Required	Covered in Full
Preventive Services – Not ACA Required	Covered in Full
Vision Services	
Children's Vision Exam (1 exam per year)	Covered in Full
Children's Eye Glasses (1 pair per year)	Covered in Full
Other Services	
Transplants[4] **PA**	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) **PA**	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) **PA**	Covered in Full
Specified Oral Surgical Procedures[5] **PA**	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
Prescription Drugs, Supplies & Equipment	
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strips **Mail Order**[6] (2 Copays per 90 day supply) Includes diabetic test strips **Preventive** (30 day supply) Medications defined in our formulary as preventive	NA Tier 1 — Covered in Full Tier 2 — Covered in Full Tier 3 — Covered in Full **Preventive** - $0 (see formulary for details)
Specialty Drugs **PA**	Covered in Full
Oral Chemotherapy Drugs	Covered in Full
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years) **PA if over $1,000**	Covered in Full
Prosthetic Devices **PA**	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.

[1]Primary Care Provider may include general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

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

[3] 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.

[4]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.

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

[7] 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.

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