COMMON GROUND
HEALTHCARE COOPERATIVE

Bronze HSA 7000/100

PA = Prior Authorization	In Network Benefits Only[7] (You Pay)
Calendar Year Deductible (Runs Jan 1 – Dec 31)	$7,000 single/$14,000 family
Coinsurance (applies only to certain services)	0%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)	$7,000 single/$14,000 family
Office Visits	
Primary Care Provider Visit (to treat an illness or injury)[1]	Deductible/Coinsurance
Aurora Quick Care or Bellin/ThedaCare Fast Care	Deductible/Coinsurance
Virtuwell	$49 Copay
Obstetrics/Gynecology Visit	Deductible/Coinsurance
Specialist Visit	Deductible/Coinsurance
Chiropractic Visit	Deductible/Coinsurance
Hearing Exam	Deductible/Coinsurance
Diagnostic Services	
Diagnostic Laboratory Tests	Deductible/Coinsurance
Diagnostic X-rays	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only) **PA**	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse	
Outpatient - Office	Deductible/Coinsurance
Outpatient - All Other Services	Deductible/Coinsurance
Transitional	Deductible/Coinsurance
Inpatient – Including Residential **PA**	Deductible/Coinsurance
Emergency Services	
Emergency Room[2] (waived if admitted)	Deductible/Coinsurance
Physician Services	Deductible/Coinsurance
Urgent Care	Deductible/Coinsurance
Ambulance (ground and air)	Deductible/Coinsurance
Hospital Services	
Outpatient Surgical/Ambulatory Surgical Care Centers **PA**	Deductible/Coinsurance
Inpatient Hospital 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[3] – ACA Required	Covered in Full
Preventive Services – Not ACA Required	Deductible/Coinsurance
Vision Services	
Children's Vision Exam (1 exam per year)	Covered in Full
Children's Eye Glasses (1 pair per year)	Deductible/Coinsurance

Other Services	
Transplants[4] **PA**	Deductible/Coinsurance
Habilitation Services (up to 20 visits/yr)	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (limited to 20 visits each)	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits/yr)	Deductible/Coinsurance
Post-Cochlear Implant Aural Therapy (up to 30 visits/yr)	Deductible/Coinsurance
Cognitive Rehabilitation Therapy (up to 20 visits/yr)	Deductible/Coinsurance
Autism Spectrum Disorders	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per stay) **PA**	Deductible/Coinsurance
Outpatient Chemotherapy	Deductible/Coinsurance
Outpatient Radiation Therapy	Deductible/Coinsurance
Hospice Services/End of Life Services	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ) **PA**	Deductible/Coinsurance
Specified Oral Surgical Procedures[5] **PA**	Deductible/Coinsurance
Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin)	Not Covered
Accidental Dental Services	Deductible/Coinsurance
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	 Tier 1 — Deductible/Coinsurance Tier 2 — Deductible/Coinsurance Tier 3 — Deductible/Coinsurance **Preventive** - $0 (see formulary for details)
Specialty Drugs **PA**	Deductible/Coinsurance
Oral Chemotherapy Drugs	Deductible Then Covered in Full
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years) **PA if over $1,000**	Deductible/Coinsurance
Prosthetic Devices **PA**	Deductible/Coinsurance
Diabetic Equipment and Supplies	Deductible/Coinsurance
Hearing Aids and Cochlear Implants (Limited to 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 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 1-877-825-9293 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.