



HEALTHCARE COOPERATIVE

Gold HSA 3000/100

| PA = Prior Authorization | In Network Benefits Only ⁷ (You Pay) |
|--|--|
| Calendar Year Deductible (Runs Jan 1 – Dec 31) | \$3,000 single/\$6,000 family |
| Coinsurance (applies only to certain services) | 0% |
| Maximum Out-of-Pocket (includes deductible, coinsurance, copays) | \$3,000 single/\$6,000 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 Insulin Discount (30 day supply) 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 2 Insulin Discount \$15 Copay 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.

¹Primary Care Provider may include 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.

³The 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.

⁴Examples 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.

⁵Please 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.

⁷No 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.