COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 1800/80 NCS

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		None	None
Coinsurance (applies only to certain services)		0%	0%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		None	None
Office Visits			
*Primary Care Provider Visit (to treat an illness or injury)[1]		Covered in Full	Covered in Full
*Obstetrics/Gynecology Visit		Covered in Full	Covered in Full
*Specialist Visit		Covered in Full	Covered in Full
*Chiropractic Visit		Covered in Full	Covered in Full
*Hearing Exam		Covered in Full	Covered in Full
Diagnostic Services			
*Diagnostic Laboratory Tests		Covered in Full	Covered in Full
*Diagnostic X-rays		Covered in Full	Covered in Full
*Imaging (MRI, MRA, PET and CT Services only)	✓	Covered in Full	Covered in Full
Allergy Testing		Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
*Outpatient - Office		Covered in Full	Covered in Full
*Outpatient - All Other Services		Covered in Full	Covered in Full
*Transitional		Covered in Full	Covered in Full
*Inpatient	✓	Covered in Full	Covered in Full
Emergency Services			
*Emergency Room		Covered in Full	Covered in Full
*Physician Services		Covered in Full	Covered in Full
*Urgent Care		Covered in Full	Covered in Full
*Ambulance (ground and air)[2]	✓	Covered in Full	Covered in Full
Hospital Services			
*Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Covered in Full	Covered in Full
Reconstructive Surgery	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Inpatient Hospital Services	✓	Covered in Full	Covered in Full
Maternity Services			
*Prenatal Care		Covered in Full	Covered in Full
*Delivery and Inpatient Services	✓	Covered in Full	Covered in Full
Preventive Services			
*Preventive Service[3]		Covered in Full	No Coverage
Vision Services			
*Children's Vision Exam (1 exam per year)		Covered in Full	Covered in Full
*Children's Eye Glasses (1 pair per year)		Covered in Full	Covered in Full
*Adult Vision Exam (1 exam per 2 years)		Covered in Full	Covered in Full

Other Services			
*Transplants[4]	✓	Covered in Full	Covered in Full
Clinical Trials	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Habilitation Services	✓	Covered in Full	Covered in Full
*Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Covered in Full	Covered in Full
*Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Covered in Full	Covered in Full
*Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Skilled Nursing Facility (up to 30 days per year)	✓	Covered in Full	Covered in Full
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Hospice Services/End of Life Services		Covered in Full	Covered in Full
*Home Health Services (up to 60 visits per year)	✓	Covered in Full	Covered in Full
Diabetes Education		Deductible/Coinsurance	Deductible/Coinsurance
Dialysis	✓	Deductible/Coinsurance	Deductible/Coinsurance
Infusion Therapy		Deductible/Coinsurance	Deductible/Coinsurance
*Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Covered in Full	Covered in Full
Specified Oral Surgical Procedures[5]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[6]		Please see below. [6]	
*Accidental Dental Services	✓	Covered in Full	Covered in Full
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.		Covered in Full **Preventive** - Covered in Full (see formulary for details)	Covered in Full **Preventive** - Covered in Full (see formulary for details)
*Specialty Drugs	✓	Covered in Full	Covered in Full
*Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Covered in Full	Covered in Full
*Prosthetic Devices		Covered in Full	Covered in Full
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
*Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Covered in Full	Covered in Full
*Hearing Aids for Members under Age 18. (Limited to one aid per ear every 36 months)		Covered in Full	Covered in Full
*Cochlear Implants for Members under Age 18		Deductible/Coinsurance	Deductible/Coinsurance

This is a Schedule of Benefits only and 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 Member Certificate and any amendments to your Benefit Plan. If you have questions regarding Common Ground Healthcare Cooperative Benefits, please call Customer Service at 1-877-514-CGHC (2442).

✓ 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. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

*These benefits have been identified as Essential Health Benefits but this does not mean all services under these categories will be subject to no cost sharing. In addition, all services must meet all other requirements for coverage. Members should call Customer Service to determine the benefits provided under the plan.

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

[2] Prior Authorization is only required for non-emergent ground and air ambulance.

[3] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[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.

[5] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[6] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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