# Silver HSA 3000/80
# 1900/80 CSR

| PA = Prior Authorization | In Network (You Pay) | Out-of-Network (You Pay) |
|---|---|---|
| Calendar Year Deductible (Runs Jan 1 – Dec 31) | $1900 single/$3800 family | $5700 single/$11400 family |
| Coinsurance (applies only to certain services) | 20% | 50% |
| Maximum Out-of-Pocket (includes deductible, coinsurance, copays) | $5000 single/$10000 family | $15000 single/$30000 family |
| **Office Visits** | | |
| Primary Care Provider Visit (to treat an illness or injury)[1] | Deductible/Coinsurance | Deductible/Coinsurance |
| Aurora Quick Care or Bellin Fast Care | Deductible/Coinsurance | Not Applicable |
| Obstetrics/Gynecology Visit | Deductible/Coinsurance | Deductible/Coinsurance |
| Specialist Visit | Deductible /Coinsurance | Deductible/Coinsurance |
| Chiropractic Visit | Deductible/Coinsurance | Deductible/Coinsurance |
| Hearing Exam | Deductible/Coinsurance | Deductible/Coinsurance |
| **Diagnostic Services** | | |
| Diagnostic Laboratory Tests | Deductible/Coinsurance | Deductible/Coinsurance |
| Diagnostic X-rays | Deductible/Coinsurance | Deductible/Coinsurance |
| Imaging (MRI, MRA, PET and CT Services only) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| **Mental/Behavioral Health & Substance Abuse** | | |
| Outpatient - Office | Deductible/Coinsurance | Deductible/Coinsurance |
| Outpatient - All Other Services | Deductible/Coinsurance | Deductible/Coinsurance |
| Transitional | Deductible/Coinsurance | Deductible/Coinsurance |
| Inpatient – Including Residential **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| **Emergency Services** | | |
| Emergency Room[2] (waived if admitted) | Deductible/Coinsurance | Deductible/Coinsurance |
| Physician Services | Deductible/Coinsurance | Deductible/Coinsurance |
| Urgent Care | Deductible/Coinsurance | Deductible/Coinsurance |
| Ambulance (ground and air)[3] **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| **Hospital Services** | | |
| Outpatient Surgical/Ambulatory Surgical Care Centers **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Inpatient Hospital Services **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Inpatient Rehabilitation (limited to 60 days/year) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| **Maternity Services** | | |
| Prenatal Care | Deductible/Coinsurance | Deductible/Coinsurance |
| Delivery and Inpatient Services **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| **Preventive Services** | | |
| Preventive Services[4] – ACA Required | Covered in Full | Deductible/Coinsurance |
| Preventive Services – Not ACA Required | Deductible/Coinsurance | Deductible/Coinsurance |
| **Vision Services** | | |
| Children's Vision Exam (1 exam per year) | Covered in Full | Deductible/Coinsurance |
| Children's Eye Glasses (1 pair per year) | Deductible/Coinsurance | Deductible/Coinsurance |
| **Other Services** | | |
| Transplants[5] **PA** | Deductible/Coinsurance | Deductible/Coinsurance |

| | | |
|---|---|---|
| Habilitation Services (up to 20 visits/yr) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Physical, Speech & Occupational Therapy (limited to 20 visits each) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Cardiac/Pulmonary Rehabilitation (up to 36 visits/yr) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Post-Cochlear Implant Aural Therapy (up to 30 visits/yr) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Cognitive Rehabilitation Therapy (up to 20 visits/yr) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Autism Spectrum Disorders **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Skilled Nursing Facility (up to 30 days per year) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Outpatient Chemotherapy **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Outpatient Radiation Therapy **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Hospice Services/End of Life Services | Deductible/Coinsurance | Deductible/Coinsurance |
| Home Health Services (up to 60 visits per year) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Non-Surgical Treatment for Temporomandibular Joint (TMJ) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Specified Oral Surgical Procedures[6] | Deductible/Coinsurance | Deductible/Coinsurance |
| Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin) | Not Covered | Not Covered |
| Accidental Dental Services **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| **Prescription Drugs, Supplies & Equipment** | | |
| Prescription Medicines:<br>**Retail** (30 day supply)<br>Includes diabetic test strip<br>**Mail Order**[7] (2 Copays per 90 day supply)<br>Includes diabetic test strip<br>**Preventive** (30 day supply) Medications defined in our formulary as preventive. | Tier 1 — Deductible/Coinsurance<br>Tier 2 — Deductible/Coinsurance<br>Tier 3 — Deductible/Coinsurance<br><br>**Preventive** - $0<br>(see formulary for details) | Tier 1 — Deductible/Coinsurance<br>Tier 2 — Deductible/Coinsurance<br>Tier 3 — Deductible/Coinsurance<br><br>**Preventive** – $0<br>(see formulary for details) |
| Specialty Drugs **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Oral Chemotherapy Drugs **PA** | Deductible then 100% | Deductible then 100% |
| Durable Medical Equipment (Limited to a single purchase per DME type per 3 years) **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Prosthetic Devices **PA** | Deductible/Coinsurance | Deductible/Coinsurance |
| Diabetic Equipment and Supplies | Deductible/Coinsurance | Deductible/Coinsurance |
| Hearing Aids and Cochlear Implants (Limited to one aid per ear every 36 months) | Deductible/Coinsurance | 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 1-877-779-7598 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 required if the item is over $1000.

[* If you have more than one covered person under your policy, the family deductible must be satisfied before coinsurance will apply. In addition, the Family Out-of-Pocket must be met before the Plan will pay services in full.]

[1]Primary Care Provider includes 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] Prior Authorization is only required for non-emergent ground and air ambulance.

[4] 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.

[5]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.

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

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

*Common Ground Healthcare Cooperative (CGHC) is required by law to include the following information with any significant document we provide you:*

**Notice of Nondiscrimination and Availability of Language Assistance Services**
CGHC complies with applicable Federal civil rights laws and does not discriminate. This means that we do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CGHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please call 877-514-2442.

If you believe that CGHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting:

| | |
|---|---|
| Civil Rights Coordinator: | Wayne Creggett |
| Telephone Number: | 414-269-4684 |
| TTY: | 844-472-2442 |
| Mailing Address: | 120 Bishop's Way, Suite 150<br>Brookfield, WI 53005-6271 |
| Fax Number: | 262-754-9690 |
| Email Address: | civilrights@commongroundhealthcare.org |

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance, Wayne Creggett, Civil Rights Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

## Foreign Language Assistance

**Spanish**
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-514-2442.

**Hmong**
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-514-2442.

**Chinese**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-514-2442。

**German**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-514-2442.

**Arabic**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-514-2442

**Russian**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-514-2442.

**Korean**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-514-2442 번으로 전화해 주십시오.

**Vietnamese**
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-514-2442.

**Pennsylvania Dutch**
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-514-2442.

**Laotian**
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-514-2442..

**French**
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-514-2442.

**Polish**
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-514-2442.

**Hindi**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-514-2442. पर कॉल करें।

**Albanian**
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-514-2442.

**Tagalog**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-514-2442.