



HEALTHCARE COOPERATIVE

Silver 5200-80 LCS

| PA = Prior Authorization | In Network (You Pay) | Out-of-Network (You Pay) |
|--|------------------------------|-------------------------------|
| Calendar Year Deductible (Runs Jan 1 – Dec 31) | \$5200 single/\$10400 family | \$15600 single/\$31210 family |
| Coinsurance (applies only to certain services) | 20% | 50% |
| Maximum Out-of-Pocket (includes deductible, coinsurance, copays) | \$7150 single/\$14300 family | \$21450 single/\$42900 family |
| Office Visits | | |
| Primary Care Provider Visit (to treat an illness or injury) ¹ | \$50 Copay | Deductible/Coinsurance |
| Aurora Quick Care or Bellin Fast Care | \$15 Copay | Not Applicable |
| Obstetrics/Gynecology Visit | \$50 Copay | Deductible/Coinsurance |
| Specialist Visit | \$80 Copay | Deductible/Coinsurance |
| Chiropractic Visit | \$50 Copay | Deductible/Coinsurance |
| Hearing Exam | \$50 Copay | 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 | \$50 Copay | 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) | \$300 After Ded | 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 |

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| 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: 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. | | \$3500 Rx Deductible Tier 1 — \$10 (Before/After Rx Ded) Tier 2 — \$50 (After Rx Ded) Tier 3 — \$75 (After Rx Ded) Preventive - \$0 (see formulary for details) | \$3500 Rx Deductible Tier 1 — \$10 (Before/After Rx Ded) Tier 2 — \$50 (After Rx Ded) Tier 3 — \$75 (After Rx Ded) Preventive – \$0 (see formulary for details) |
| Specialty Drugs | PA | Rx Deductible/Coinsurance | Rx 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).

Member will not be responsible for out-of-pocket amounts if member utilizes an Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization or through referral under contract health services, pursuant to 45 CFR 156.420(b)(2). These benefits have been identified as Essential Health Benefits but this does not mean all services under these categories will be subject to limited 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.

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.

¹Primary Care Provider includes 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.

³ Prior Authorization is only required for non-emergent ground and air ambulance.

⁴The 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.

⁵Examples 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.

⁶Please 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 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 [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-514-2442.

Laotian

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ນຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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.