COMMON GROUND
HEALTHCARE COOPERATIVE

Envision Aurora Bellin PPO - Bronze 7000-100

PA = Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)*
Calendar Year Deductible (Runs Jan 1 – Dec 31)	$7000 single/$14000 family	$14000 single/$28000 family
Coinsurance (applies only to certain services)	0%	30%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)	$7000 single/$14000 family	$28000 single/$56000 family
Office Visits		
Primary Care Provider Visit (to treat an illness or injury)[1]	$35 for first 3 visits, then Ded/Coins	Deductible/Coinsurance
Aurora Quick Care or Bellin Fast Care	$35 for first 3 visits, then Ded/Coins	Not Offered
Obstetrics/Gynecology Visit	$35 for first 3 visits, then Ded/Coins	Deductible/Coinsurance
Specialist Visit	Deductible /Coinsurance	Deductible/Coinsurance
Chiropractic Visit	$35 for first 3 visits, then Ded/Coins	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	$35 for first 3 visits, then Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services	Deductible/Coinsurance	Deductible/Coinsurance
Transitional **PA**	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** (non-emergency only)	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)	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (including manipulation therapy and limited to 20 visits each)	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits/yr)	Deductible/Coinsurance	Deductible/Coinsurance
Post-Cochlear Implant Aural Therapy (up to 30 visits/yr)	Deductible/Coinsurance	Deductible/Coinsurance
Cognitive Rehabilitation Therapy (up to 20 visits/yr)	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders **PA** (in-home treatment only)	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)	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ) **PA**	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[6] **PA**	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.	NA Tier 1 — Ded/Coins Tier 2 — Ded/Coins Tier 3 — Ded/Coins **Preventive** - $0 (see formulary for details)	NA Tier 1 — Ded/Coins Tier 2 — Ded/Coins Tier 3 — Ded/Coins **Preventive** – $0 (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 we do not contract with out-of-network providers, we have a maximum allowed amount that we will pay toward out-of-network care. If the doctor's charge is higher than our maximum allowed amount, the doctor (or facility) could decide to bill you for the difference, called "balance billing."

[1]The copay applies to the first 3 visits to either a behavioral health and/or primary care provider combined (not per provider type). 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 Certificate of Coverage to determine what oral surgeries procedures are covered.

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