



HEALTHCARE COOPERATIVE

Empower PPO - HSA Bronze 5800-90

	PA = Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)*
Calendar Year Deductible (Runs Jan 1 – Dec 31)		\$5800 single/\$11600 family	\$11600 single/\$23200 family
Coinsurance (applies only to certain services)		10%	40%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		\$6500 single/\$13000 family	\$13000 single/\$26000 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 Offered
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	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."

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.

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.

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.

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.