COMMON GROUND
HEALTHCARE COOPERATIVE

# HSA Silver 3500-75 NCS

| PA = Prior Authorization | In Network Benefits Only[7] (You Pay) |
|---|---|
| Calendar Year Deductible (Runs Jan 1 – Dec 31) | $0 single/$0 family |
| Coinsurance (applies only to certain services) | 0% |
| Maximum Out-of-Pocket (includes deductible, coinsurance, copays) | $0 single/$0 family |
| **Office Visits** | |
| Primary Care Provider Visit (to treat an illness or injury)[1] | Covered in Full |
| Aurora Quick Care or Bellin/ThedaCare Fast Care | Covered in Full |
| Obstetrics/Gynecology Visit | Covered in Full |
| Specialist Visit | Covered in Full |
| Chiropractic Visit | Covered in Full |
| Hearing Exam | Covered in Full |
| **Diagnostic Services** | |
| Diagnostic Laboratory Tests | Covered in Full |
| Diagnostic X-rays | Covered in Full |
| Imaging (MRI, MRA, PET and CT Services only) **PA** | Covered in Full |
| **Mental/Behavioral Health & Substance Abuse** | |
| Outpatient - Office | Covered in Full |
| Outpatient - All Other Services | Covered in Full |
| Transitional | Covered in Full |
| Inpatient – Including Residential **PA** | Covered in Full |
| **Emergency Services** | |
| Emergency Room[2] (waived if admitted) | Covered in Full |
| Physician Services | Covered in Full |
| Urgent Care | Covered in Full |
| Ambulance (ground and air) | Covered in Full |
| **Hospital Services** | |
| Outpatient Surgical/Ambulatory Surgical Care Centers **PA** | Covered in Full |
| Inpatient Hospital Services **PA** | Covered in Full |
| Inpatient Rehabilitation (limited to 60 days/year) **PA** | Covered in Full |
| **Maternity Services** | |
| Prenatal Care | Covered in Full |
| Delivery and Inpatient Services **PA** | Covered in Full |
| **Preventive Services** | |
| Preventive Services[3] – ACA Required | Covered in Full |
| Preventive Services – Not ACA Required | Covered in Full |
| **Vision Services** | |
| Children's Vision Exam (1 exam per year) | Covered in Full |
| Children's Eye Glasses (1 pair per year) | Covered in Full |

| Other Services | |
|---|---|
| Transplants[4] **PA** | Covered in Full |
| Habilitation Services (up to 20 visits/yr) | Covered in Full |
| Physical, Speech & Occupational Therapy (limited to 20 visits each) | Covered in Full |
| Cardiac/Pulmonary Rehabilitation (up to 36 visits/yr) | Covered in Full |
| Post-Cochlear Implant Aural Therapy (up to 30 visits/yr) | Covered in Full |
| Cognitive Rehabilitation Therapy (up to 20 visits/yr) | Covered in Full |
| Autism Spectrum Disorders | Covered in Full |
| Skilled Nursing Facility (up to 30 days per year) **PA** | Covered in Full |
| Outpatient Chemotherapy | Covered in Full |
| Outpatient Radiation Therapy | Covered in Full |
| Hospice Services/End of Life Services | Covered in Full |
| Home Health Services (up to 60 visits per year) | Covered in Full |
| Non-Surgical Treatment for Temporomandibular Joint (TMJ) **PA** | Covered in Full |
| Specified Oral Surgical Procedures[5] **PA** | Covered in Full |
| Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin) | Not Covered |
| Accidental Dental Services | Covered in Full |
| **Prescription Drugs, Supplies & Equipment** | |
| Prescription Medicines:<br>**Retail** (30 day supply)<br>Includes diabetic test strips<br>**Mail Order**[6] (2 Copays per 90 day supply)<br>Includes diabetic test strips<br>**Preventive** (30 day supply) Medications defined in our formulary as preventive | <br>Tier 1 — Covered in Full<br>Tier 2 — Covered in Full<br>Tier 3 — Covered in Full<br><br>**Preventive** - $0<br>(see formulary for details) |
| Specialty Drugs **PA** | Deductible/30% Coinsurance |
| Oral Chemotherapy Drugs | Deductible then 100% |
| Durable Medical Equipment (Limited to a single purchase per DME type per 3 years) **PA if over $1,000** | Covered in Full |
| Prosthetic Devices **PA** | Covered in Full |
| Diabetic Equipment and Supplies | Covered in Full |
| Hearing Aids and Cochlear Implants (Limited to one aid per ear every 36 months) | Covered in Full |

***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).***
***Co-payments, deductibles, or coinsurance will not apply under this plan when receiving essential health benefits through an in-network provider or when getting care from an Indian Health Service or tribal program.***

**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.

[1]Primary Care Provider may include 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] 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.

[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 when medically necessary and not experimental.

[5]Please refer to the Certificate of Coverage to determine what oral surgeries procedures are covered.[6] Only certain Prescription Drug products are available through mail order.

[7] No payment will be made for out-of-network care except for emergency care, urgent care outside of our service area or when there is no in-network provider that can perform covered services and written approval is obtained as outlined in our certificate of coverage.