



HEALTHCARE COOPERATIVE

HSA Bronze 6750-100

	PA = Prior Authorization	In Network Benefits Only ⁷ (You Pay)
Calendar Year Deductible (Runs Jan 1 – Dec 31)		\$6750 single/\$13500 family
Coinsurance (applies only to certain services)		0%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		\$6750 single/\$13500 family
Office Visits		
Primary Care Provider Visit (to treat an illness or injury) ¹		Deductible/Coinsurance
Aurora Quick Care or Bellin/ThedaCare Fast Care		Deductible/Coinsurance
Virtuwell		Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance
Specialist Visit		Deductible /Coinsurance
Chiropractic Visit		Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance
Diagnostic Services		
Diagnostic Laboratory Tests		Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	PA	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse		
Outpatient - Office		Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance
Transitional		Deductible/Coinsurance
Inpatient – Including Residential	PA	Deductible/Coinsurance
Emergency Services		
Emergency Room ² (waived if admitted)		Deductible/Coinsurance
Physician Services		Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance
Ambulance (ground and air)		Deductible/Coinsurance
Hospital Services		
Outpatient Surgical/Ambulatory Surgical Care Centers	PA	Deductible/Coinsurance
Inpatient Hospital Services	PA	Deductible/Coinsurance
Inpatient Rehabilitation (limited to 60 days/year)	PA	Deductible/Coinsurance
Maternity Services		
Prenatal Care		Deductible/Coinsurance
Delivery and Inpatient Services	PA	Deductible/Coinsurance
Preventive Services		
Preventive Services ³ - ACA Required		Covered in Full
Preventive Services - Not ACA Required		Deductible/Coinsurance
Vision Services		
Children's Vision Exam (1 exam per year)		Covered in Full
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance
Other Services		
Transplants ⁴	PA	Deductible/Coinsurance

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

¹Primary Care Provider may include 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.

³The 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.

⁴Examples 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.

⁵Please 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.

⁷No 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.