COMMON GROUND
HEALTHCARE COOPERATIVE

CGHC EPO Plus HSA Bronze $7000 Deductible/0%

	PA = Prior Authorization	In Network Benefits Only[7] (You Pay)
Calendar Year Deductible (Runs Jan 1 – Dec 31)		$7,000 single/$14,000 family
Coinsurance (applies only to certain services)		0%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$7,000 single/$14,000 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
Obstetrics/Gynecology Visit		Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance
Diagnostic Services[8]		
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 / Physician Visit		Deductible/Coinsurance
Outpatient - Facility Fee		Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance
Transitional		Deductible/Coinsurance
Inpatient – Including Residential	**PA**	Deductible/Coinsurance
Emergency Services		
Emergency Room[2] (copay waived if admitted)		Deductible/Coinsurance
Physician Services		Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance
Ambulance (ground and air)		Deductible/Coinsurance
Hospital Services		
Outpatient/Ambulatory Surgical Facility Fee	**PA**	Deductible/Coinsurance
Outpatient Surgical Services	**PA**	Deductible/Coinsurance
Inpatient Hospital Facility Fee	**PA**	Deductible/Coinsurance
Inpatient Physician and Surgical 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 or Contacts (1 pair per year)		Deductible/Coinsurance
Routine Vision Exam for Adults[9] (1 exam/year)		Not Covered
Other Services		
Transplants[4]	**PA**	Deductible/Coinsurance
Habilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)		Deductible/Coinsurance
Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)		Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits/year)		Deductible/Coinsurance
Post-Cochlear Implant Aural Therapy (up to 30 visits/year)		Deductible/Coinsurance

Cognitive Rehabilitation Therapy (up to 20 visits/year)		Deductible/Coinsurance
Autism Spectrum Disorders		Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per stay)	**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/year)		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
Preventive Dental Services for Adults[10]		Not Covered
Preventive Dental Services for Children[10]		Not Covered
Allergy Testing		Deductible/Coinsurance
Prescription Drugs		
Separate Rx Deductible		Does Not Apply; Under Medical Deductible.
See formulary to determine tier and if medication is preventative. Diabetic test strips are included. Drugs are available in Retail setting (30-day supply) at coinsurance or 1 copay or using Mail Order[6] (90-day supply) at coinsurance or 2 copays		
Preventative Drugs (30-day supply)		$0 (See formulary for details)
Tier CM - Oral Chemotherapy Drugs		Deductible Then Covered in Full
Tier 1 - Generic Drugs		Deductible/Coinsurance
Tier 2 - Preferred Brand Drugs		Deductible/Coinsurance
Tier 3 - Non-Preferred Brand Drugs		Deductible/Coinsurance
Tier 4 - Specialty Drugs	**PA**	Deductible/Coinsurance
Supplies & Equipment		
Durable Medical Equipment	**PA**	Deductible/Coinsurance
Prosthetic Devices	**PA**	Deductible/Coinsurance
Diabetic Equipment	**PA**	Deductible/Coinsurance
Hearing Aids and Cochlear Implants (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 1-877-514-2442.

PA indicates Prior Authorization is required for these services. Call 1-877-825-9293 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. (*PA required when inpatient stay extends beyond the standard 48 hours (vaginal) to 96 hours (cesarean)).

When working with a health insurance broker, the broker is compensated $20 per member per month.

[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 https://commongroundhealthcare.org/coverage-details 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.

[8]When receiving covered services at an office or hospital visit, member may be subject to copay charges for both the facility and the service rendered.

[9]Refraction and dilation are not included in the adult eye exam.

[10]Preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), sealants (up to age 14 on permanent molars only)