



**CGHC Copay Silver \$0 Ded CSR 73% -
Envision Network**

| | 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) | | 30% |
| Maximum Out-of-Pocket (includes deductible, coinsurance, copays) | | \$7,215 single/\$14,430 family |
| Office Visits | | |
| Primary Care Provider Visit (to treat an illness or injury) ¹ | | \$50 Copay |
| Aurora Quick Care or Bellin/ThedaCare Fast Care | | \$30 Copay |
| Obstetrics/Gynecology Visit | | \$50 Copay |
| Specialist Visit | | \$120 Copay |
| Chiropractic Visit | | \$50 Copay |
| Hearing Exam | | \$50 Copay |
| Diagnostic Services⁸ | | |
| Diagnostic Laboratory Tests | | \$50 Copay |
| Diagnostic X-rays | | \$50 Copay |
| Imaging (MRI, MRA, PET and CT Services only) | PA | \$500 Copay |
| Mental/Behavioral Health & Substance Abuse | | |
| Outpatient - Office / Physician Visit | | \$50 Copay |
| Outpatient - Facility Fee | | \$500 Copay |
| Outpatient - All Other Services | | Deductible/Coinsurance |
| Transitional | | Deductible/Coinsurance |
| Inpatient – Including Residential | PA | \$1,250 Copay Per Day |
| Emergency Services | | |
| Emergency Room ² (copay waived if admitted) | | \$1,150 Copay |
| Physician Services | | Deductible/Coinsurance |
| Urgent Care | | \$75 Copay |
| Ambulance (ground and air) | | Deductible/Coinsurance |
| Hospital Services | | |
| Outpatient/Ambulatory Surgical Facility Fee | PA | \$500 Copay |
| Outpatient Surgical Services | PA | \$75 Copay |
| Inpatient Hospital Facility Fee | PA | \$1,250 Copay Per Day |
| Inpatient Physician and Surgical Services | PA | Deductible/Coinsurance |
| Inpatient Rehabilitation (limited to 60 days/year) | PA | \$1,250 Copay Per Day |
| 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) | | \$75 Copay |
| Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year) | | \$75 Copay |
| 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) | | \$75 Copay |
| Autism Spectrum Disorders | | Deductible/Coinsurance |
| Skilled Nursing Facility (up to 30 days per stay) | PA | \$1,250 Copay Per Day |
| 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 | | Not Covered |
| Prescription Drugs | | |
| Separate Rx Deductible | | \$500 single/\$1,000 family |
| <i>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 Order⁶ (90-day supply) at coinsurance or 2 copays</i> | | |
| Preventative Drugs (30-day supply) | | \$0 (See formulary for details) |
| Tier CM - Oral Chemotherapy Drugs | | Deductible Then Covered in Full |
| Tier 1 - Generic Drugs | | \$15 Copay |
| Tier 2 - Preferred Brand Drugs | | \$55 Copay |
| Tier 2 - Preferred Insulin Copay | | \$15 Copay |
| 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.

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 <https://commongroundhealthcare.org/coverage-details> 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.

⁶Only 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.

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

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

¹⁰Preventive 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)