



**CGHC Copay Gold \$0 Ded LCS -  
Envision Network**

PA = Prior Authorization	In Network Benefits Only <sup>1</sup> (You Pay)
Calendar Year Deductible (Runs Jan 1 – Dec 31)	\$0 Single/\$0 Family
Coinsurance (applies only to certain services)	20%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)	\$8,500 Single/\$17,000 Family
<b>Office Visit</b>	
Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic	\$25 Copay <sup>13</sup>
Primary Care Provider (For non-Preventive services) <sup>2</sup>	\$35 Copay <sup>13</sup>
Mental/Behavioral Health	\$35 Copay <sup>13</sup>
Chiropractic	\$35 Copay <sup>13</sup>
Hearing Exam	\$35 Copay <sup>13</sup>
Specialist <sup>3</sup>	\$75 Copay <sup>13</sup>
<b>Diagnostic Services<sup>4</sup></b>	
Diagnostic Laboratory Test	\$50 Copay Per Test
Diagnostic X-ray, Ultrasound and Other Radiology Service	\$60 Copay Per Service
Imaging (MRI, MRA, PET and CT Service only) PA	Deductible/Coinsurance
<b>Mental/Behavioral Health &amp; Substance Abuse</b>	
Outpatient - Facility Fee	Deductible/Coinsurance
Outpatient - All Other Services <sup>5</sup>	Deductible/Coinsurance
Transitional Care Services (room/board at transitional care facility is not covered)	Deductible/Coinsurance
Inpatient – Facility Fee (Including Residential) PA	Deductible/Coinsurance
Inpatient – Physician Services	Deductible/Coinsurance
<b>Emergency Services</b>	
Emergency Room Facility Fee <sup>6</sup> (copay waived if admitted)	\$500 Copay
Physician Services rendered in an Emergency Room	Deductible/Coinsurance
Emergency Room – All Other Services <sup>5</sup>	Deductible/Coinsurance
Urgent Care <sup>4</sup>	\$75 Copay
Ambulance (ground and air)	Deductible/Coinsurance
<b>Hospital Services<sup>4</sup></b>	
Outpatient Surgery & Ambulatory Surgical Center - Facility Fee PA	Deductible/Coinsurance
Outpatient (non-Surgical) – Facility Fee PA	Deductible/Coinsurance
Outpatient Surgical - Physician Services PA	Deductible/Coinsurance
Outpatient - All Other Services <sup>5</sup>	Deductible/Coinsurance
Inpatient - Facility Fee PA	Deductible/Coinsurance
Inpatient - Physician and Surgical Services PA	Deductible/Coinsurance
Inpatient - Rehabilitation (limited to 60 days/year) PA	Deductible/Coinsurance
<b>Maternity Services</b>	
Prenatal Care	Deductible/Coinsurance
Delivery and Inpatient Services PA*	Deductible/Coinsurance
<b>Preventive Services</b>	
Preventive Services <sup>7</sup>	Covered in Full
<b>Vision Services</b>	
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 <sup>8</sup> (1 exam/year)	Not Covered
<b>Miscellaneous Services</b>	
Accidental Dental Services	Deductible/Coinsurance
Allergy Testing	Not Covered
Anesthesia Services (any place of service)	Deductible/Coinsurance
Autism Spectrum Disorder Treatment	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits/year)	Deductible/Coinsurance
Cognitive Rehabilitation Therapy (up to 20 visits/year)	\$70 Copay Per Therapy
Habilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)	\$70 Copay Per Therapy Type Per Day

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Home Health Services (up to 60 visits/year)	Deductible/Coinsurance
Hospice Services/End of Life Services	Deductible/Coinsurance
Outpatient Chemotherapy <span style="float: right;">PA</span>	Deductible/Coinsurance
Outpatient Radiation Therapy	Deductible/Coinsurance
Post-Cochlear Implant Aural Therapy (up to 30 visits/year)	Deductible/Coinsurance
Preventive Dental Services <sup>9</sup>	Not Covered
Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)	\$70 Copay Per Therapy Type Per Day
Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin)	Not Covered
Skilled Nursing Facility (up to 30 days per stay) <span style="float: right;">PA</span>	Deductible/Coinsurance
Specified Oral Surgical Procedures <sup>10</sup> <span style="float: right;">PA</span>	Deductible/Coinsurance
<b>Prescription Drugs, Supplies &amp; Equipment</b>	
Separate Rx Deductible	Does Not Apply; Under Medical Deductible.
<i>See formulary to determine tier and if medication is preventive. Diabetic test strips are included. Drugs are available in Retail setting (30-day supply) at coinsurance or 1 copay or using Mail Order<sup>11</sup> (90-day supply) at coinsurance or 2 copays.</i>	
Preventive Drugs (30-day supply)	\$0 (See formulary for details)
Tier CM - Oral Chemotherapy Drugs	Deductible Then Covered in Full
Tier 1 - Typically Generic Drugs	\$20 Copay
Tier 2 - Preferred Drugs <sup>12</sup>	\$55 Copay
Tier 2 - Preferred Insulin Copay	\$15 Copay
Tier 3 - Non-Preferred Drugs <sup>12</sup>	Deductible/30% Coinsurance
Tier 4 - Specialty Drugs <span style="float: right;">PA</span>	Deductible/30% Coinsurance
<b>Supplies &amp; Equipment</b>	
Durable Medical Equipment <span style="float: right;">PA</span>	Deductible/Coinsurance
Prosthetic Devices <span style="float: right;">PA</span>	Deductible/Coinsurance
Diabetic Equipment <span style="float: right;">PA</span>	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 about Common Ground Healthcare Cooperative Benefits, call 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.

<sup>1</sup>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.

<sup>2</sup>Primary Care Provider may include general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

<sup>3</sup>Specialists are all provider types other than those defined elsewhere in this Schedule of Benefits.

<sup>4</sup>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.

<sup>5</sup>All Other Services are defined as services not elsewhere listed in this schedule of benefits.

<sup>6</sup>Copay applies to the facility ER charge. All other charges rendered as part of your ER visit are subject to their applicable additional copayment or deductible/coinsurance as specified in this schedule of benefits.

<sup>7</sup>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/coverage-details](http://www.commongroundhealthcare.org/coverage-details) for a complete listing. During a preventive care visit, you may receive services that aren't required to be covered at no cost to you under the ACA. Those services may require a copay, or the charges may apply towards your deductible and/or coinsurance.

<sup>8</sup>If you purchased a plan that includes routine vision exams for adults, refraction and dilation are not included in the adult eye exam.

<sup>9</sup>If you purchased a plan that includes dental coverage, 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), and sealants (up to age 14 on permanent molars only).

<sup>10</sup>Please refer to the Certificate of Coverage to determine what oral surgery procedures are covered.

<sup>11</sup>Only certain Prescription Drug products are available through mail order.

<sup>12</sup>When a brand is dispensed and a generic is available, you may be responsible to pay the difference in cost between the brand and generic in addition to the brand drug cost share (copay, deductible and/or coinsurance). The difference in cost will not apply towards your deductible and/or maximum out-of-pocket.

<sup>13</sup>Copay is applied per provider, per date of service.