COMMON GROUND
HEALTHCARE COOPERATIVE

# CGHC Gold $1800 LCS - Envision Network (Vision Exam)

| PA = Prior Authorization | | In Network Benefits Only[1] (You Pay) |
|---|---|---|
| Calendar Year Deductible (Runs Jan 1 – Dec 31) | | $1,800 Single/$3,600 Family |
| Coinsurance (applies only to certain services) | | 20% |
| Maximum Out-of-Pocket (includes deductible, coinsurance, copays) | | $6,600 Single/$13,200 Family |
| **Office Visit** | | |
| Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic | | $15 Copay[13] |
| Primary Care Provider (For non-Preventive services)[2] | | $25 Copay[13] |
| Mental/Behavioral Health | | $25 Copay[13] |
| Chiropractic | | $25 Copay[13] |
| Hearing Exam | | $25 Copay[13] |
| Specialist[3] | | $50 Copay[13] |
| **Diagnostic Services[4]** | | |
| Diagnostic Laboratory Test | | Deductible/Coinsurance |
| Diagnostic X-ray, Ultrasound and Other Radiology Service | | Deductible/Coinsurance |
| Imaging (MRI, MRA, PET and CT Service only) | **PA** | Deductible/Coinsurance |
| **Mental/Behavioral Health & Substance Abuse** | | |
| Outpatient - Facility Fee | | Deductible/Coinsurance |
| Outpatient - All Other Services[5] | | 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 |
| **Emergency Services** | | |
| Emergency Room Facility Fee[6] (copay waived if admitted) | | $300 Copay |
| Physician Services rendered in an Emergency Room | | Deductible/Coinsurance |
| Emergency Room – All Other Services[5] | | Deductible/Coinsurance |
| Urgent Care[4] | | $75 Copay |
| Ambulance (ground and air) | | Deductible/Coinsurance |
| **Hospital Services[4]** | | |
| 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[5] | | 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 |
| **Maternity Services** | | |
| Prenatal Care | | Deductible/Coinsurance |
| Delivery and Inpatient Services | **PA*** | Deductible/Coinsurance |
| **Preventive Services** | | |
| Preventive Services[7] | | Covered in Full |
| **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[8] (1 exam/year) | | Covered in Full |
| **Miscellaneous Services** | | |
| 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) | | Deductible/Coinsurance |
| Habilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year) | | Deductible/Coinsurance |

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| Home Health Services (up to 60 visits/year) | | Deductible/Coinsurance |
| Hospice Services/End of Life Services | | Deductible/Coinsurance |
| Outpatient Chemotherapy | **PA** | Deductible/Coinsurance |
| Outpatient Radiation Therapy | | Deductible/Coinsurance |
| Post-Cochlear Implant Aural Therapy (up to 30 visits/year) | | Deductible/Coinsurance |
| Preventive Dental Services[9] | | Not Covered |
| Rehabilitative Services<br>(Physical, Speech, Occupational Therapy - 20 visits per therapy type per year) | | Deductible/Coinsurance |
| 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) | **PA** | Deductible/Coinsurance |
| Specified Oral Surgical Procedures[10] | **PA** | Deductible/Coinsurance |
| **Prescription Drugs, Supplies & Equipment** | | |
| Separate Rx Deductible | | Does Not Apply; Under Medical Deductible. |
| *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 [11] (90-day supply) at coinsurance or 2 copays.* | | |
| 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 | | $10 Copay |
| Tier 2 - Preferred Drugs[12] | | $50 Copay |
| Tier 2 - Preferred Insulin Copay | | $15 Copay |
| Tier 3 - Non-Preferred Drugs[12] | | $100 Copay after Deductible |
| Tier 4 - Specialty Drugs | **PA** | Deductible/30% 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 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.

[1]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.

[2]Primary Care Provider may include general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[3]Specialists are all provider types other than those defined elsewhere in this Schedule of Benefits.

[4]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.

[5]All Other Services are defined as services not elsewhere listed in this schedule of benefits.

[6]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.

[7]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 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.

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

[9]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).

[10]Please refer to the Certificate of Coverage to determine what oral surgery procedures are covered.

[11]Only certain Prescription Drug products are available through mail order.

[12]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.

[13]Copay is applied per provider, per date of service.