COMMON GROUND
HEALTHCARE COOPERATIVE

Bronze HSA 5650/90

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible[1]		$5,650 self only/ $11,300 family[1]	$11,300 self only/ $22,600 family[1]
Coinsurance (applies only to certain services)		10%	40%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$6,500 self only / $13,000 family[1]	$13,000 self only / $26,000 family[1]
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[2]		Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room[3] (waived if admitted)		Deductible/Coinsurance	Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/ Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[5]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[6]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[7]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[8]		Please see below.[8]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[9] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years); Prior Authorization if costs>$1000	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

This is a Schedule of Benefits only and 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 Member Certificate and any amendments to your Benefit Plan. If you have questions regarding Common Ground Healthcare Cooperative Benefits, please call Customer Service at 1-877-514-CGHC (2442).

✓ 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. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1] The deductible and out-of-pocket maximum in this plan are embedded. This means that if one family member meets the self-only deductible or self-only out-of-pocket maximum, the deductible and out-of-pocket maximum are satisfied for that family member.

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

[3] Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance. Any copay, coinsurance and deductible amounts paid for Out-of-Network emergency services will be applied to the Out-of-Network Maximum Out-of-Pocket.

[4] Prior Authorization is only required for non-emergent ground and air ambulance.

[5] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[6] 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.

[7] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[8] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

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