EXCLUSIONS AND LIMITATIONS

We want you to understand what is not included in CGHC plans. Below is a summary of services that are not covered, but please know it is not a full list. A full listing of exclusions and limitations, including additional details, can be found in the Certificate of Coverage, which is available online at www.commongroundhealthcare.org or by calling 877.514.2442.

The following services are not covered under your plan:

OUT-OF-NETWORK SERVICES
- Out-of-network services, except for emergency and urgent care, and when there is a referral approved by CGHC
- Urgent Care Services received by a Non-Network Provider located in the CGHC Service Area
- Out-of-network follow-up care for emergency and urgent services

DENTAL
- Pediatric dental care mandated by the Affordable Care Act
- Dental care unless related to trauma

DEVICES, APPLIANCES PROSTHETICS/ MEDICAL SUPPLIES, EQUIPMENT
- See Certificate of Coverage for a full list of those that are not covered

FOOT CARE
- Routine foot care, including the cutting or removal of corns and calluses, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet (some exceptions)
- Hygienic and preventive maintenance foot care (some exceptions), such as treatment of flat feet; shoes; shoe orthotics; shoe inserts; and arch supports

MATERNITY SERVICES
- Elective abortions excluded except when performed to save the life/ health of the mother and in instances of rape or incest
- Birthing classes; Home or intentional out of Hospital deliveries

MENTAL HEALTH AND SUBSTANCE USE DISORDERS
- Services performed for certain non-classified conditions or adustment (v-code) conditions as identified by the American Psychiatric Assn.
- Treatments for the primary diagnoses of sleep, sexual dysfunction, feeding, or neurological disorders; or those with a known physical basis
- Tuition for or services that are school-based for children and adolescents
- Learning, motor skills and primary communication disorders
- Room and Board at Transitional Care facilities

NUTRITION
- Enteral feedings, even if the sole source of nutrition
- Infant formula and donor breast milk

PERSONAL CARE, COMFORT OR CONVENIENCE
- Please see Certificate of Coverage for a complete list.

PHYSICAL APPEARANCE
- Cosmetic Procedures, such as skin abrasion procedures and botox; liposuction; treatment for spider veins; hair removal or replacement; skin tags and other benign skin lesions
- Treatment of benign abnormal breast enlargement in males
- Weight loss programs even when under medical supervision
- Wigs for hair loss or any other reason

PROCEDURES AND TREATMENTS (NOT A FULL LIST- SEE CERTIFICATE)
- Excision or elimination of hanging skin on any part of the body
- Medical and surgical treatment of excessive sweating (hyperhidrosis) or snoring
- Gender reassignment operations and related services
- Oral surgery, upper and lower jawbone surgery, orthognathic surgery, and jaw alignment
- Surgical and non-surgical treatment of obesity

REPRODUCTION
- Health services and associated expenses for infertility treatments, including assisted reproductive technology and in vitro fertilization
- Surrogate parenting, donor eggs, donor sperm and host uterus
- Storage and retrieval of all reproductive materials
- The reversal of voluntary sterilization and related procedures

SERVICES PROVIDED UNDER ANOTHER PLAN
- Health services for which other coverage is required by Federal, state or local law through other arrangements
- Health services while on active military duty or for treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you

TRAVEL
- Health services provided in a foreign country, unless required as Emergency Health Services
- Travel or transportation expenses, even when prescribed

TYPES OF CARE/PROVIDERS
- Services performed by a Provider who is a family member by birth or marriage or at your same residence
- Multi-disciplinary pain management programs provided on an inpatient basis for acute pain
- Custodial Care or maintenance care or therapy, domiciliary care, or Private Duty Nursing
- Respite care (some exceptions), rest cures, services of personal care attendants, or work hardening

VISION AND HEARING
- Routine visions expenses, eyeglasses and contact lenses, implantable lenses used to correct a refractive error, adult eye exams without eye disease, surgery that is intended to allow you to see better without glasses or other vision correction
- Bone anchored hearing aids (some exceptions)

OTHER EXCLUSIONS (NOT A FULL LIST- SEE CERTIFICATE)
- Health services and supplies that do not meet the definition of a Covered Health Service, including those that are not medically necessary or experimental, investigational or alternative
- Health services for which you have no legal responsibility to pay, for which a charge would not ordinarily be made in the absence of coverage under this Policy, or for which a Provider, pharmaceutical manufacturer or similar entity pays any portion of the charge
- Health services for which billing is not received by us within 15 months of the date of service
- Coverage for Prescription Drug Products for the amount dispensed which exceeds the supply limit; or is dispensed outside the US
- Charges for non-listed drugs or compounded medications
- Over-the-counter drugs, including vitamins (some exceptions)
- New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by us
- Prescription Drug Products administered in a Physician's office or other outpatient setting that can be safely and effectively delivered in the home setting, either orally or by self-injection
- Charges for drugs used to treat quality of life or lifestyle concerns including but not limited to: weight; growth; morbid obesity; sexual function; pigmentation; phobias; aging; memory; daytime drowsiness, dry mouth; cognitive enhancement; or hyperhidrosis

Common Ground Healthcare Cooperative complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disabillity, or sex. For more information, visit: www.CommonGroundHealthcare/LegalPrivacy
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-514-2442.
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-514-2442.

CGHC.SB.1001-2019

2020 INDIVIDUAL BENEFIT PLAN DESIGNS

COMMON GROUND HEALTHCARE COOPERATIVE
120 Bishop's Way, Suite 150, Brookfield, WI 53005
877.450.8497
www.CommonGroundHealthcare.org

PEOPLE. NOT PROFIT.

Common Ground Healthcare Cooperative believes its members deserve honesty, compassion and exemplary service from their health insurer. We are committed to changing the health insurance experience through open dialogue, powerful advocacy and the delivery of trusted and understandable information.

Facebook.com/CommonGroundHealthcare

Twitter.com/CGHealthcare

2020 INDIVIDUAL EPO BENEFIT PLAN DESIGNS

COMMON GROUND HEALTHCARE COOPERATIVE

Common Ground Healthcare Cooperative is proud to partner with **Aurora Healthcare System**, **Bellin Health System**, **ThedaCare, Door County Medical Centers**, **Children's Hospital and Health System, and St. Joseph Hospital - Milwaukee** to offer the Envision EPO Integrated Care Network.

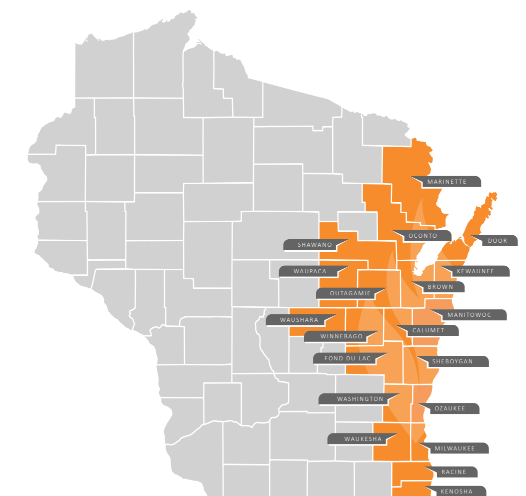
INDIVIDUAL PLANS

ENVISION EPO

	Calendar Year Deductible In-Network Only		Out-Of-Pocket Maximum In-Network Only		Coinsurance In-Network	Provider Visits Copay/Coinsurance In-Network Only				Aurora QuickCare/ Bellin FastCare	In-Network Only	Virtuwell	Prescription Drugs			
	Single	Family	Single	Family	You Pay	PCP[1]	Specialist	Urgent Care	Emergency[2]	Select Locations	Preventative		Tier 1	Tier 2	Tier 3	Specialty
Envision Gold 2000/80 87416WI0030020	$2,000	$4,000	$8,150	$16,300	20%	$40	$60	$75	$300	$15	$0	10/$0	$10	$50	Ded; then $100	Ded; then 30%
Envision Silver 4000/75 87416WI0030021	$4,000	$8,000	$8,150	$16,300	25%	$50	$80	$100	Ded/Coins	$20	$0	10/$0	$20	Ded; then $75	Ded/Coins	Ded; then 30%
Envision Silver 3000/75/Copay 40 87416WI0030022	$3,000	$6,000	$8,150	$16,300	25%	$40	$80	$100	Ded/Coins	$20	$0	10/$0	$25	Ded; then $75	Ded/Coins	Ded; then 30%
Envision Silver 6500/75 w Rx Ded[3] 87416WI0030047	$6,500	$13,000	$8,150	$16,300	25%	$60	$100	Ded/Coins	Ded/Coins	$20	$0	10/$0	$10	$100	Ded/Coins	Ded; then 40%
Envision Bronze 8150/100 87416WI0030027	$8,150	$16,300	$8,150	$16,300	0%	$35	Ded/Coins	Ded/Coins	Ded/Coins	$20	$0	10/$0	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Envision Bronze HSA 6750/100 87416WI0030031	$6,750	$13,500	$6,750	$13,500	0%	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	$0	$49	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Envision Catastrophic 8150/100[4] 87416WI0030026	$8,150	$16,300	$8,150	$16,300	0%	$0	Ded/Coins	Ded/Coins	Ded/Coins	$0	$0	10/$0	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins

Important Note: All CGHC individual plans are EPO plans. Out-of-network care is not covered without a referral and authorization by CGHC. Benefits will apply to necessary emergency care in any ER and urgent care received outside of our service region. Referrals to in-network specialists are not required. PCP selections are not required.

CGHC is proud to partner with Aurora Healthcare System, Bellin Health System, ThedaCare, Door County Medical Center, St. Joseph Hospital- Milwaukee, and Children's Hospital and Health System to offer the Envision Integrated Care Network. An integrated care model is one where a patient's health care is coordinated among various types of providers (such as primary care doctors, specialists, hospitals and others) to achieve better outcomes and patient satisfaction.



[1] **PCP** = Primary Care Provider includes general pediatrics, internal medicine, OB/GYN, family practice, general medicine, chiropractor and geriatrics.

[2] **Emergency** (ER) = Emergency Room Care Services. Services that meet the definition of emergency are paid at the in-network rate even when care is delivered in a non-network ER. Because we do not have a contract with out-of-network ER facilities, we cannot prevent these facilities from billing our members for the balance of the charge. The copay applies to the facility charge only. All other charges related to ER visit are subject to deductible/coinsurance.

[3] **Silver 6500/75 plan** has a separate prescription drug deductible of $4,500.

[4] **Catastrophic plan** applies only to persons under age 30 or those with a hardship exemption from the federal Marketplace (healthcare.gov)

Our Deductibles, Explained: All plans have a January 1 to December 31 deductible. All deductibles, coinsurance, and copayments accumulate toward the out-of-pocket maximum. All plans described on this page have embedded deductibles for family coverage. This means that if you are enrolled in 2-person or family coverage, an individual family member only has to satisfy the single person deductible before the plan begins to make payment for covered services for that family member.