

## EXCLUSIONS AND LIMITATIONS

We want you to understand what is not included in our plan. Below is a brief summary of services that are not covered by this plan. 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](http://www.commongroundhealthcare.org) or by calling 877.514.2442.

### The following services are not covered under your plan:

#### 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 adjustment (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
- 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

#### REPRODUCTION (Cont.)

- 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, disability, or sex. For more information, visit: [www.CommonGroundHealthcare/LegalPrivacy](http://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.

# 2020 EMPLOYER BENEFIT PLAN DESIGNS

## COMMON GROUND HEALTHCARE COOPERATIVE

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[www.CommonGroundHealthcare.org](http://www.CommonGroundHealthcare.org)



## HEALTHCARE COOPERATIVE

### 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.



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# 2020 EMPLOYER BENEFIT PLAN DESIGNS

Common Ground Healthcare Cooperative is proud to partner with [Aurora Healthcare](#), [Bellin Health System](#), [ThedaCare](#), [Door County Medical Centers](#), [Children's Hospital and Health System](#), [St. Joseph Hospital - Milwaukee](#), and the [First Health Travel Network](#).

## SMALL GROUP PLANS

### ENVISION PPO

	Calendar Year Deductible				Out-Of-Pocket Maximum				Coinsurance (You Pay)		Provider Visits			Aurora Quick-Care/ Bellin FastCare	In- & Out-Of-Network Member Copay/ Coinsurance	In-Network	Virtuwell	Prescription Drugs				
	In-Network		Out-Of-Network		In-Network		Out-Of-Network		In-Network		Out-Of-Network		Emergency <sup>2</sup>					Preventive <sup>3</sup>	Tier 1	Tier 2	Tier 3	Specialty
	Single	Family	Single	Family	Single	Family	Single	Family	In-Network	Out-Of-Network	PCP <sup>1</sup>	Specialist										
<b>Gold 800/80</b> Envision 87416WI0020015	\$800	\$1,600	\$1,600	\$3,200	\$8,150	\$16,300	\$16,300	\$32,600	20%	50%	\$35	\$60	\$50	\$15	\$300	\$0	10/\$0	\$10	\$45	\$75	<b>D/C<sup>4</sup></b>	
<b>Gold 1000/80</b> Envision 87416WI0020016	\$1,000	\$2,000	\$2,000	\$4,000	\$8,150	\$16,300	\$16,300	\$32,600	20%	50%	\$35	\$60	\$50	\$15	\$300	\$0	10/\$0	\$10	\$45	\$75	D/C	
<b>Silver 4000/80</b> Envision 87416WI0020053	\$4,000	\$8,000	\$8,000	\$16,000	\$8,150	\$16,300	\$16,300	\$32,600	20%	50%	\$45	\$80	\$50	\$15	D/C	\$0	10/\$0	\$25	\$50	\$75	D/C	
<b>Silver HSA 4200/100</b> Envision 87416WI0020035	\$4,200	\$8,400	\$8,400	\$16,800	\$4,200	\$8,400	\$16,800	\$33,600	0%	30%	D/C	D/C	D/C	D/C	D/C	\$0	\$49	D/C	D/C	D/C	D/C	
<b>Silver 3600/80/Copay 40</b> Envision 87416WI0020017	\$3,600	\$7,200	\$7,200	\$14,400	\$8,150	\$16,300	\$16,300	\$32,600	20%	50%	\$40	\$75	\$50	\$15	D/C	\$0	10/\$0	\$25	\$65	D/C	D/C	
<b>Silver 2500/80</b> Envision 87416WI0020019	\$2,500	\$5,000	\$5,000	\$10,000	\$8,150	\$16,300	\$16,300	\$32,600	20%	50%	D/C	D/C	D/C	D/C	D/C	\$0	10/\$0	D/C	D/C	D/C	D/C	
<b>Bronze 8150/100</b> Envision 87416WI0020021	\$8,150	\$16,300	\$16,300	\$32,600	\$8,150	\$16,300	\$32,600	\$65,200	0%	30%	\$35	D/C	D/C	\$15	D/C	\$0	10/\$0	D/C	D/C	D/C	D/C	
<b>Bronze HSA 6750/100</b> Envision 87416WI0020036	\$6,750	\$13,500	\$13,500	\$27,000	\$6,750	\$13,500	\$27,000	\$54,000	0%	30%	D/C	D/C	D/C	D/C	D/C	\$0	\$49	D/C	D/C	D/C	D/C	

**ENVISION:** CGHC is proud to partner with [Aurora Healthcare System](#), [Bellin Health System](#), [ThedaCare](#), [Door County Medical Center](#), [Children's Hospital and Health System](#) and [St. Joseph Hospital - Milwaukee](#) 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.

<sup>1</sup> **PCP** = Primary Care Provider (includes general pediatrics, internal medicine, OB/GYN, family practice, general medicine, chiropractor and geriatrics) **Urgent** = Urgent Care Services **Emergency** (ER) = Emergency Room Care Services

<sup>2</sup> **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.

<sup>3</sup> **Preventive care** - Cost sharing will apply to preventive care received out-of-network.

<sup>4</sup> **D/C** refers to Deductible/Coinsurance.

**Our Deductibles, Explained:** All plans have a 12 month deductible. All deductibles, coinsurance, and copayments accumulate toward the out-of-pocket maximum. In-network and out-of-network deductibles and out-of-pocket maximums must be satisfied separately. 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.

