**CGHC Bronze $9450 ($35 PCP Copay) - Envision Network**

<table>
<thead>
<tr>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only¹ (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible (Runs Jan 1 – Dec 31)</td>
<td>$9,450 Single/$18,900 Family</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>0%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>$9,450 Single/$18,900 Family</td>
</tr>
</tbody>
</table>

**Office Visit**
- Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic
  - $25 Copay¹³
- Primary Care Provider (For non-Preventive services)²
  - $35 Copay¹³
- Mental/Behavioral Health
  - $35 Copay¹³
- Chiropractic
  - $35 Copay¹³
- Hearing Exam
  - $35 Copay¹³
- Specialist³
  - Deductible/Coinsurance

**Diagnostic Services⁴**
- 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 Services⁵
  - 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 Fee⁶ (copay waived if admitted)
  - Deductible/Coinsurance
- Physician Services rendered in an Emergency Room
  - Deductible/Coinsurance
- Emergency Room – All Other Services⁷
  - Deductible/Coinsurance
- Urgent Care⁸
  - Deductible/Coinsurance
- Ambulance (ground and air)
  - Deductible/Coinsurance

**Hospital Services⁹**
- 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 Services⁵
  - 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 Services¹⁰
  - 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 Adults¹¹ (1 exam per year)
  - Not Covered

**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
<table>
<thead>
<tr>
<th>Service Description</th>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only¹ (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services (up to 60 visits/year)</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Hospice Services/End of Life Services</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Outpatient Chemotherapy</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Outpatient Radiation Therapy</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Post-Cochlear Implant Aural Therapy (up to 30 visits/year)</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Preventive Dental Services²</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin)</td>
<td>PA</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility (up to 30 days per stay)</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Specified Oral Surgical Procedures¹</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Prescription Drugs, Supplies &amp; Equipment</td>
<td></td>
<td>Does Not Apply; Under Medical Deductible.</td>
</tr>
<tr>
<td>Preventive Drugs (30-day supply)</td>
<td></td>
<td>$0 (See formulary for details)</td>
</tr>
<tr>
<td>Tier CM - Oral Chemotherapy Drugs</td>
<td>PA</td>
<td>Deductible Then Covered in Full</td>
</tr>
<tr>
<td>Tier 1 - Typically Generic Drugs</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Tier 2 - Preferred Drugs¹</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Drugs</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Tier 4 - Specialty Drugs</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Supplies &amp; Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Diabetic Equipment</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Hearing Aids and Cochlear Implants (One aid per ear every 36 months)</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

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.

¹No 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.

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

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

₄When receiving covered services at an office or hospital visit, member may be subject to copay charges for both the facility and the service rendered.

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

₆Copay 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.

₇The 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.

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

₉If 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).

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

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

¹²When 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.

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