### CGHC EPO Gold $2000 Deductible/20% -
Envision Network

<table>
<thead>
<tr>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only² (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible (Runs Jan 1 – Dec 31)</td>
<td>$2,000 Single/$4,000 Family</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>20%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>$7,500 Single/$15,000 Family</td>
</tr>
</tbody>
</table>

### Office Visit
- Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic: $15 Copay¹¹
- Primary Care Provider (for non-preventive services)²: $30 Copay¹¹
- Mental/Behavioral Health: $30 Copay¹¹
- Chiropractic: $30 Copay¹¹
- Hearing Exam: $30 Copay¹¹
- Specialist³: $60 Copay¹¹

### Diagnostic Services¹
- Diagnostic Laboratory Test: Deductible/Coinsurance
- Diagnostic X-ray, Ultrasound and Other Radiology Service: Deductible/Coinsurance
- Imaging (MRI, MRA, PET and CT Service only): PA

### Mental/Behavioral Health & Subsistance 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
- 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: $100 Copay
- Ambulance (ground and air): Deductible/Coinsurance

### Hospital Services⁴
- Outpatient Surgery & Ambulatory Surgical Center - Facility Fee: PA
- Outpatient (non-Surgical) – Facility Fee: PA
- Outpatient Surgical - Physician Services: PA
- Outpatient - All Other Services³: Deductible/Coinsurance
- Inpatient – Facility Fee: PA
- Inpatient - Physician and Surgical Services: PA
- Inpatient - Rehabilitation (limited to 60 days/year): PA

### Maternity Services
- Prenatal Care: Deductible/Coinsurance
- Delivery and Inpatient Services: PA*

### Preventive Services
- Preventive Services¹: 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 (1 exam/year): Not Covered

### Miscellaneous Services
- Accidental Dental Services: Deductible/Coinsurance
- Allergy Testing: Deductible/Coinsurance
- 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
**PA = Prior Authorization**

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network Benefits Only¹ (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services (up to 60 visits/year)</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Hospice Services/End of Life Services</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Outpatient Chemotherapy</td>
<td>PA</td>
</tr>
<tr>
<td>Outpatient Radiation Therapy</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Post-Cochlear Implant Aural Therapy (up to 30 visits/year)</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Preventive Dental Services</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)</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>Not Covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility (up to 30 days per stay)</td>
<td>PA</td>
</tr>
<tr>
<td>Specified Oral Surgical Procedures¹</td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

### 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 ³ (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                                      | $15 Copay                      |
| Tier 2 - Preferred Drugs¹                                              | $40 Copay                      |
| Tier 2 - Preferred Insulin Copay                                       | $15 Copay                      |
| Tier 3 - Non-Preferred Drugs¹                                           | $80 Copay                      |
| Tier 4 - Specialty Drugs                                               | PA                              |

### Supplies & Equipment

| Durable Medical Equipment                                             | PA                                  |
| Prosthetic Devices                                                     | Deductible/Coinsurance              |
| Diabetic Equipment                                                     | PA                                  |
| 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)).

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](http://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.

⁸Please refer to the Certificate of Coverage to determine what oral surgery procedures are covered.

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

¹⁰When 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.

¹¹Copay is applied per provider, per date of service.