**CGHC EPO Gold $2000 Deductible/20% - Rise Network**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>In Network Benefits Only</th>
<th>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>
<td></td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>$7,500 Single/$15,000 Family</td>
<td></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): $30 Copay¹¹
- Mental/Behavioral Health: $30 Copay¹¹
- Chiropractic: $30 Copay¹¹
- Hearing Exam: $30 Copay¹¹
- Specialist: $60 Copay¹¹

**Diagnostic Services**

- 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 & Substance Abuse**

- Outpatient - Facility Fee: Deductible/Coinsurance
- Outpatient - All Other Services: 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 Fee (copay waived if admitted): Deductible/Coinsurance
- Physician Services rendered in an Emergency Room: Deductible/Coinsurance
- Emergency Room – All Other Services: Deductible/Coinsurance
- Urgent Care: $100 Copay
- Ambulance (ground and air): Deductible/Coinsurance

**Hospital Services**

- Outpatient Surgery & Ambulatory Surgical Center - Facility Fee: PA
- Outpatient (non-Surgical) – Facility Fee: PA
- Outpatient Surgical - Physician Services: PA
- Outpatient - All Other Services: 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 Services: 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

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¹¹ These copays do not apply to Preventive Services.
<table>
<thead>
<tr>
<th>Service</th>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only(^1) (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services (up to 60 visits/year)</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Hospice Services/End of Life Services</td>
<td></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></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Post-Cochlear Implant Aural Therapy (up to 30 visits/year)</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Preventive Dental Services</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)</td>
<td></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></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 Procedures(^8)</td>
<td>PA</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\(^9\) (90-day supply) at coinsurance or 2 copays.

| Tier 1: Typically Generic Drugs                                      |                       | $15 Copay                             |
| Tier 2: Preferred Drugs\(^10\)                                       |                       | $40 Copay                             |
| Tier 2: Preferred Insulin Copay                                       |                       | $15 Copay                             |
| Tier 3: Non-Preferred Drugs\(^10\)                                   |                       | $80 Copay                             |
| Tier 4: Specialty Drugs                                              | PA                     | Deductible/Coinsurance                |

**Supplies & Equipment**

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

Hearing Aids and Cochlear Implants (One aid per ear every 36 months)  

\(^1\)No 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. 

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

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

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

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

\(^6\)Copay 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. 

\(^7\)The 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. 

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

\(^9\)Only certain Prescription Drug products are available through mail order. 

\(^10\)When 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. 

\(^1\)Copay is applied per provider, per date of service.