# CGHC EPO Gold $800 Deductible/20% - Envision Network

<table>
<thead>
<tr>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only(^2) (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible (Runs Jan 1 – Dec 31)</td>
<td>$800 Single/$1,600 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>$8,350 Single/$16,700 Family</td>
</tr>
</tbody>
</table>

### Office Visit
- Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic: $15 Copay
- Primary Care Provider (For non-Preventive services): $35 Copay
- Mental/Behavioral Health: $35 Copay
- Chiropractic: $35 Copay
- Hearing Exam: $35 Copay
- Specialist: $70 Copay

### Diagnostic Services\(^2\)
- 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\(^2\): 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\(^6\) (copay waived if admitted): $300 Copay
- Physician Services rendered in an Emergency Room: Deductible/Coinsurance
- Emergency Room – All Other Services\(^2\): Deductible/Coinsurance
- Urgent Care\(^2\): $100 Copay
- Ambulance (ground and air): Deductible/Coinsurance

### Hospital Services\(^4\)
- Outpatient Surgery & Ambulatory Surgical Center - Facility Fee: PA
- Outpatient (non-Surgical) – Facility Fee: PA
- Outpatient Surgical - Physician Services: PA
- Outpatient - All Other Services\(^2\): 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\(^1\): 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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\(^1\) Preventive services covered in full include:
- Prenatal Care
- Breast Cancer Screening
- Colon Cancer Screening
- Child Health Screening
- Adult Health Screening
- Cancer Early Detection
- Vision Screening
- Tobacco Cessation Counseling
- General Wellness

\(^2\) In Network Benefits Only

\(^3\) Not Covered

\(^4\) Per calendar year

\(^5\) Per calendar year

\(^6\) Copay waived if admitted
<table>
<thead>
<tr>
<th>Service</th>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only¹ (You Pay)</th>
</tr>
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<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>Not Covered</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 Procedures²</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
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</table>

**Prescription Drugs, Supplies & Equipment**

Separate Rx 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 Order³ (90-day supply) at coinsurance or 2 copays.

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<tr>
<th>Service</th>
<th>Deductible Then Covered in Full</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Drugs (30-day supply)</td>
<td>$0 (See formulary for details)</td>
</tr>
<tr>
<td>Tier CM - Oral Chemotherapy Drugs</td>
<td>Deductible Then Covered in Full</td>
</tr>
<tr>
<td>Tier 1 - Typically Generic Drugs</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Tier 2 - Preferred Drugs¹</td>
<td>$40 Copay</td>
</tr>
<tr>
<td>Tier 2 - Preferred Insulin Copay</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Drugs¹</td>
<td>$80 Copay</td>
</tr>
<tr>
<td>Tier 4 - Specialty Drugs</td>
<td>PA</td>
</tr>
</tbody>
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<tr>
<th>Supplies &amp; Equipment</th>
<th>Deductible/Coinsurance</th>
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<tr>
<td>Durable Medical Equipment</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>PA</td>
</tr>
<tr>
<td>Diabetic Equipment</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Hearing Aids and Cochlear Implants (One aid per ear every 36 months)</td>
<td>Deductible/Coinsurance</td>
</tr>
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</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)).

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.

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

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

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.

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

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.

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 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.

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

Only certain Prescription Drug products are available through mail order.

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.

Copay is applied per provider, per date of service.