<table>
<thead>
<tr>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible (Runs Jan 1 – Dec 31)</td>
<td>$5,100 Single/$10,200 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>$5,100 Single/$10,200 Family</td>
</tr>
</tbody>
</table>

**Office Visit**
- Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic: Deductible/Coinsurance
- Primary Care Provider (For non-preventive services): Deductible/Coinsurance
- Mental/Behavioral Health: Deductible/Coinsurance
- Chiropractic: Deductible/Coinsurance
- Hearing Exam: Deductible/Coinsurance
- Specialist: Deductible/Coinsurance

**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): Deductible/Coinsurance

**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 Deductible/Coinsurance
- 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: Deductible/Coinsurance
- Ambulance (ground and air): Deductible/Coinsurance

**Hospital Services**
- 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 Services: 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 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
<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>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Preventive Dental Services</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Rehabilitative Services</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>(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.

- **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**
  - Deductible/Coinsurance
- **Tier 2 - Preferred Drugs\(^8\)**
  - Deductible/Coinsurance
  - **Tier 2 - Preferred Insulin Copay**
    - $15 Copay
- **Tier 3 - Non-Preferred Drugs\(^8\)**
  - Deductible/Coinsurance
- **Tier 4 - Specialty Drugs**
  - PA
  - Deductible/Coinsurance

### Supplies & Equipment

<table>
<thead>
<tr>
<th>Service</th>
<th>PA</th>
<th>Deductible/Coinsurance</th>
</tr>
</thead>
<tbody>
<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>

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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)).

\(^1\)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 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.