### CGHC EPO Plus Bronze $5500 Deductible/30%

<table>
<thead>
<tr>
<th>PA</th>
<th>In Network Benefits Only² (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible (Runs Jan 1 – Dec 31)</td>
<td>$5,500 Single/$11,000 Family</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>30%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>$8,250 Single/$16,500 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**
  - $75 Copay¹¹
- **Mental/Behavioral Health**
  - $75 Copay¹¹
- **Chiropractic**
  - $75 Copay¹¹
- **Hearing Exam**
  - $75 Copay¹¹
- **Specialist²**
  - $150 Copay¹¹

**Diagnostic Services²**
- **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 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 Services⁶**
  - Deductible/Coinsurance
- **Urgent Care⁶**
  - Deductible/Coinsurance
- **Ambulance (ground and air)**
  - Deductible/Coinsurance

**Hospital Services⁴**
- **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 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
<table>
<thead>
<tr>
<th>Service</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></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>
</tbody>
</table>
| Rehabilitative Services  
(Physical, Speech, Occupational Therapy - 20 visits per therapy type per year) |                          | Deductible/Coinsurance              |
| Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin) |                          | Not Covered                         |
| Skilled Nursing Facility (up to 30 days per stay)                    | PA                       | Deductible/Coinsurance              |
| Specified Oral Surgical Procedures                                   | PA                       | Deductible/Coinsurance              |

**Prescription Drugs, Supplies & Equipment**

<table>
<thead>
<tr>
<th>Description</th>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only¹ (You Pay)</th>
</tr>
</thead>
<tbody>
<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></td>
<td>Deductible Then Covered in Full</td>
</tr>
<tr>
<td>Tier 1 - Typically Generic Drugs</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Tier 2 - Preferred Drugs¹⁰</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Drugs¹⁰</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Tier 4 - Specialty Drugs</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supplies &amp; Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
</tr>
<tr>
<td>Diabetic Equipment</td>
</tr>
<tr>
<td>Hearing Aids and Cochlear Implants (One aid per ear every 36 months)</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)).

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.