# CGHC EPO Plus Gold $2000 Deductible/20%

<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>$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 Copay

- **Primary Care Provider (For non-Preventive services)**
  - $30 Copay

- **Mental/Behavioral Health**
  - $30 Copay

- **Chiropractic**
  - $30 Copay

- **Hearing Exam**
  - $30 Copay

- **Specialist**
  - $60 Copay

## 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
  - 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**
  - $100 Copay

## 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

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*87416WI00040040*

2024 Schedule of Benefits
CGHC.PB.2049-2023-07
<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>PA</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</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></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 Procedures⁸</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

**Prescription Drugs, Supplies & Equipment**

<table>
<thead>
<tr>
<th>Service</th>
<th>Separate Rx Deductible</th>
<th>Does Not Apply; Under Medical Deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Drugs (30-day supply)</td>
<td>$0 (See formulary for details)</td>
<td>Deductible Then Covered in Full</td>
</tr>
<tr>
<td>Tier CM - Oral Chemotherapy Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 - Typically Generic Drugs</td>
<td>$15 Copay</td>
<td></td>
</tr>
<tr>
<td>Tier 2 - Preferred Drugs¹⁰</td>
<td>$40 Copay</td>
<td></td>
</tr>
<tr>
<td>Tier 2 - Preferred Insulin Copay</td>
<td>$15 Copay</td>
<td></td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Drugs¹⁰</td>
<td>$80 Copay</td>
<td></td>
</tr>
<tr>
<td>Tier 4 - Specialty Drugs</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

**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>

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.