**CGHC Silver $0 CSR 94% - Envision Network**

<table>
<thead>
<tr>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only¹ (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible (Runs Jan 1 – Dec 31)</td>
<td>$0 Single/$0 Family</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>15%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>$3,150 Single/$6,300 Family</td>
</tr>
</tbody>
</table>

### Office Visit
- Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic: $0 Copay¹³
- Primary Care Provider (For non-Preventive services)²: $5 Copay¹³
- Mental/Behavioral Health: $5 Copay¹³
- Chiropractic: $5 Copay¹³
- Hearing Exam: $5 Copay¹³
- Specialist: $25 Copay¹³

### 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): PA Deductible/Coinsurance

### Mental/Behavioral Health & Substance Abuse
- Outpatient - Facility Fee: Deductible/Coinsurance
- Outpatient - All Other Services²: 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): $55 Copay
- Physician Services rendered in an Emergency Room: Deductible/Coinsurance
- Emergency Room – All Other Services²: Deductible/Coinsurance
- Urgent Care: 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 Services²: 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* Covered in Full

### 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 Adults⁷ (1 exam per year): Not Covered

### Miscellaneous Services
- Accidental Dental Services: Deductible/Coinsurance
- Allergy Testing: Not Covered
- 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 You Pay
² Includes Mental Health & Substance Abuse
³ Not covered if admitted
⁴ Does not include emergency room
⁵ Does not include hospital services
⁶ Not covered in an emergency room
⁷ Not covered in hospital

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*CGHC PB.2050-2023-07*
### Prescription Drugs, Supplies & Equipment

<table>
<thead>
<tr>
<th>Description</th>
<th>PA</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 Services⁷</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 Procedures¹⁰</td>
<td>PA</td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

### Supplies & Equipment

<table>
<thead>
<tr>
<th>Description</th>
<th>PA</th>
<th>In Network Benefits Only¹ (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td></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></td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

¹See 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 ¹¹ (90-day supply) at coinsurance or 2 copays.

²Tier CM - Oral Chemotherapy Drugs

³Tier 1 - Typically Generic Drugs

⁴Tier 2 - Preferred Drugs⁷

⁵Tier 2 - Preferred Insulin Copay

⁶Tier 3 - Non-Preferred Drugs¹²

⁷Tier 3 - Non-Preferred Drugs¹²

⁸Tier 4 - Specialty Drugs

⁹Separate Rx Deductible

¹⁰Does Not Apply; Under Medical Deductible.

¹¹This 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.

¹²PA = Prior Authorization

When working with a health insurance broker, the broker is compensated $20 per member per month.

¹³Copay 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.

¹⁴This 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)).

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.

¹Copay 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.

¹ªThe 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.

¹²If you purchased a plan that includes routine vision exams for adults, refraction and dilation are not included in the adult eye exam.

¹³If you purchased a plan that includes dental coverage, preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), and sealants (up to age 14 on permanent molars only).

¹⁴Please refer to the Certificate of Coverage to determine what oral surgery procedures are covered.

¹⁵Only certain Prescription Drug products are available through mail order.

¹⁶When 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.

¹⁷Copay is applied per provider, per date of service.