### CGHC Silver $150 CSR 94% - Envision Network (Vision Exam)

<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>$150 Single/$300 Family</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>10%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>$2,500 Single/$5,000 Family</td>
</tr>
</tbody>
</table>

#### Office Visit

- **Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic**
  - $0 Copay

- **Primary Care Provider (For non-Preventive services)**
  - $0 Copay

- **Mental/Behavioral Health**
  - $0 Copay

- **Chiropractic**
  - $0 Copay

- **Hearing Exam**
  - $0 Copay

- **Specialist**
  - $10 Copay

#### 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

- **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

- **Inpatient – Physician Services**
  - Deductible/Coinsurance

#### Emergency Services

- **Emergency Room Facility Fee**
  - (copay waived if admitted)

- **Physician Services rendered in an Emergency Room**
  - Deductible/Coinsurance

- **Emergency Room – All Other Services**
  - Deductible/Coinsurance

- **Urgent Care**
  - $30 Copay

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

#### Hospital Services³

- **Outpatient Surgery & Ambulatory Surgical Center - Facility Fee**
  - PA

- **Outpatient (non-Surgical) – Facility Fee**
  - PA

- **Outpatient Surgical - Physician Services**
  - PA

- **Outpatient - All Other Services**
  - 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 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)**
  - Covered in Full

- **Routine Vision Exam for Adults¹ (1 exam/year)**
  - Covered in Full

#### 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
<table>
<thead>
<tr>
<th>Service</th>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only (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 Services¹</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 Procedures¹</td>
<td></td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Prescription Drugs, Supplies &amp; Equipment</td>
<td></td>
<td>Does Not Apply; Under Medical Deductible.</td>
</tr>
<tr>
<td>Separate Rx Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Drugs (30-day supply)</td>
<td>$0 (See formulary for details)</td>
<td></td>
</tr>
<tr>
<td>Tier CM - Oral Chemotherapy Drugs</td>
<td>Deductible Then Covered in Full</td>
<td></td>
</tr>
<tr>
<td>Tier 1 - Typically Generic Drugs</td>
<td>$0 Copay</td>
<td></td>
</tr>
<tr>
<td>Tier 2 - Preferred Drugs¹²</td>
<td>$25 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 Drugs¹²</td>
<td>Deductible/Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Tier 4 - Specialty Drugs</td>
<td>PA</td>
<td>Deductible/30% Coinsurance</td>
</tr>
<tr>
<td>Supplies &amp; Equipment</td>
<td></td>
<td></td>
</tr>
<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></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)).

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

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.

²The 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.

³If you purchased a plan that includes routine vision exams for adults, refraction and dilation are not included in the adult eye exam.

¹²If 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).

¹³Please refer to the Certificate of Coverage to determine what oral surgery procedures are covered.

¹⁴Only certain Prescription Drug products are available through mail order.

¹⁵When 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.

¹ Sixty-Six (66) visits per year for routine dental care for children under age 13.

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