### CGHC Silver $600 CSR 87% - Envision Network (Dental/Vision Exam)

<table>
<thead>
<tr>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only (^1) (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible (Runs Jan 1 – Dec 31)</td>
<td>$600 Single/$1,200 Family</td>
</tr>
<tr>
<td>Coinsurance (applies only to certain services)</td>
<td>25%</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: $20 Copay\(^9\)
- Primary Care Provider (For non-Preventive services): $30 Copay\(^9\)
- Mental/Behavioral Health: $30 Copay\(^9\)
- Chiropractic: $30 Copay\(^9\)
- Hearing Exam: $30 Copay\(^9\)
- Specialist\(^2\): $70 Copay\(^9\)

**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\(^5\): Deductible/Coinsurance
- Transitional Care Services (room/board at transitional care facility is not covered): Deductible/Coinsurance
- Inpatient – Facility Fee (Including Residential): Deductible/Coinsurance
- Inpatient – Physician Services: Deductible/Coinsurance

**Emergency Services**

- Emergency Room Facility Fee\(^6\) (copay waived if admitted): $100 Copay
- Physician Services rendered in an Emergency Room: Deductible/Coinsurance
- Emergency Room – All Other Services\(^7\): Deductible/Coinsurance
- Urgent Care\(^8\): Deductible/Coinsurance
- Ambulance (ground and air): Deductible/Coinsurance

**Hospital Services**

- Outpatient Surgery & Ambulatory Surgical Center - Facility Fee: PA
- Outpatient (non-Surgical) – Facility Fee: PA
- Outpatient Surgical - Physician Services: PA
- Outpatient - All Other Services\(^5\): 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* (1 exam/year)

**Preventive Services**

- Preventive Services\(^7\): 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\(^5\) (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
### Prescription Drugs, Supplies & Equipment

<table>
<thead>
<tr>
<th>Category</th>
<th>Deductible/Coinsurance</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>$0 (See formulary for details)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier CM - Oral Chemotherapy Drugs</td>
<td>Deductible Then Covered in Full</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 - Typically Generic Drugs</td>
<td>$5 Copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2 - Preferred Drugs¹²</td>
<td>$50 Copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2 - Preferred Insulin Copay</td>
<td>$15 Copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Drugs¹³</td>
<td>Deductible/20% Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 4 - Specialty Drugs</td>
<td>Deductible/40% Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplies &amp; Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Deductible/Coinsurance</td>
<td>PA</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>Deductible/Coinsurance</td>
<td>PA</td>
<td></td>
</tr>
<tr>
<td>Diabetic Equipment</td>
<td>Deductible/Coinsurance</td>
<td>PA</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids and Cochlear Implants (One aid per ear every 36 months)</td>
<td>Deductible/Coinsurance</td>
<td></td>
<td></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 1: Typically Generic Drugs.

*³Tier 2: Preferred Drugs.

*⁴Tier 3: Non-Preferred Drugs.

*⁵Tier 4: Specialty Drugs.

*¹¹Therapeutic Classes: Preparations of Diabetic Insulin.

*¹²The 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.

*¹³If you purchased a plan that includes routine vision exams for adults, refraction and dilation are not included in the adult eye exam. If 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).

*¹⁴Covered in Full

*¹⁵Not Covered

*¹⁶Does Not Apply; Under Medical Deductible.

*¹⁷Copay 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.

*¹⁸Specialists are all provider types other than those defined elsewhere in this Schedule of Benefits.

*¹⁹When receiving covered services at an office or hospital visit, member may be subject to copay charges for both the facility and the service rendered.

*²⁰All Other Services are defined as services not elsewhere listed in this schedule of benefits.

*²¹Copay 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.

*²²When 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.

*²³Copay is applied per provider, per date of service.

---

**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. (⁴PA 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.  

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.

⁸If you purchased a plan that includes routine vision exams for adults, refraction and dilation are not included in the adult eye exam. If 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).

⁹Please refer to the Certificate of Coverage to determine what oral surgery procedures are covered.

¹⁰Only certain Prescription Drug products are available through mail order.

¹¹When 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.

¹²Copay is applied per provider, per date of service.