### CGHC Silver $700 CSR 87% - Envision Network (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>$700 Single/$1,400 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>$3,000 Single/$6,000 Family</td>
</tr>
</tbody>
</table>

### Office Visit
- **Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic**
  - $10 Copay\(^{13}\)
- **Primary Care Provider (for non-Preventive services)**
  - $20 Copay\(^{13}\)
- **Mental/Behavioral Health**
  - $20 Copay\(^{13}\)
- **Chiropractic**
  - $20 Copay\(^{13}\)
- **Hearing Exam**
  - $20 Copay\(^{13}\)
- **Specialist**
  - $40 Copay\(^{13}\)

### Diagnostic Services\(^{4}\)
- **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**\(^{6}\) (copay waived if admitted)
  - Deductible/Coinsurance
- **Physician Services rendered in an Emergency Room**
  - Deductible/Coinsurance
- **Emergency Room – All Other Services**
  - Deductible/Coinsurance
- **Urgent Care**
  - $60 Copay
- **Ambulance (ground and air)**
  - Deductible/Coinsurance

### Hospital Services\(^{4}\)
- **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\(^{7}\)**
  - 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**\(^{7}\) (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
### Network Benefits Only

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network Benefits Only (You Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services (up to 60 visits/year)</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Hospice Services/End of Life Services</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Outpatient Chemotherapy</td>
<td>PA</td>
</tr>
<tr>
<td>Outpatient Radiation Therapy</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Post-Cochlear Implant Aural Therapy (up to 30 visits/year)</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Preventive Dental Services&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Rehabilitative Services (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)</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>Not Covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility (up to 30 days per stay)</td>
<td>PA</td>
</tr>
<tr>
<td>Specified Oral Surgical Procedures&lt;sup&gt;10&lt;/sup&gt;</td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>

### Prescription Drugs, Supplies & Equipment

- See 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<sup>11</sup> (90-day supply) at coinsurance or 2 copays.

<table>
<thead>
<tr>
<th>Tier Name</th>
<th>Cost Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Drugs (30-day supply)</td>
<td>$0 (See formulary for details)</td>
</tr>
<tr>
<td>Tier CM - Oral Chemotherapy Drugs</td>
<td>Deductible Then Covered in Full</td>
</tr>
<tr>
<td>Tier 1 - Typically Generic Drugs</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>Tier 2 - Preferred Drugs&lt;sup&gt;12&lt;/sup&gt;</td>
<td>$50 Copay</td>
</tr>
<tr>
<td>Tier 2 - Preferred Insulin Copay</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Tier 3 - Non-Preferred Drugs&lt;sup&gt;12&lt;/sup&gt;</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Tier 4 - Specialty Drugs</td>
<td>Deductible/30% Coinsurance</td>
</tr>
</tbody>
</table>

### Supplies & Equipment

- See formulary to determine 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 = Prior Authorization

- No 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.

- Primary Care Provider may include general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

- Specialties are all provider types other than those defined elsewhere in this Schedule of Benefits.

- 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.

- Copay 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.

- The 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.

- If 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).

- Please refer to the Certificate of Coverage to determine what oral surgical procedures are covered.

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

- When 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.

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