



**CGHC EPO Silver \$4000 Deductible/20% -  
Rise Network**

| PA = Prior Authorization  | In Network Benefits Only <sup>1</sup> (You Pay) |
|---|---|
| Calendar Year Deductible (Runs Jan 1 – Dec 31)  | \$4,000 Single/\$8,000 Family                   |
| Coinsurance (applies only to certain services)  | 20%   |
| Maximum Out-of-Pocket (includes deductible, coinsurance, copays)  | \$8,500 Single/\$17,000 Family                  |
| <b>Office Visit</b>   |   |
| Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic                            | \$15 Copay <sup>11</sup>                        |
| Primary Care Provider (For non-Preventive services) <sup>2</sup>  | \$40 Copay <sup>11</sup>                        |
| Mental/Behavioral Health  | \$40 Copay <sup>11</sup>                        |
| Chiropractic  | \$40 Copay <sup>11</sup>                        |
| Hearing Exam  | \$40 Copay <sup>11</sup>                        |
| Specialist <sup>3</sup>   | \$80 Copay <sup>11</sup>                        |
| <b>Diagnostic Services<sup>4</sup></b>  |   |
| 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                          |
| <b>Mental/Behavioral Health &amp; Substance Abuse</b>   |   |
| Outpatient - Facility Fee   | Deductible/Coinsurance                          |
| Outpatient - All Other Services <sup>5</sup>  | 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                          |
| <b>Emergency Services</b>   |   |
| Emergency Room Facility Fee <sup>6</sup> (copay waived if admitted)                                     | Deductible/Coinsurance                          |
| Physician Services rendered in an Emergency Room  | Deductible/Coinsurance                          |
| Emergency Room – All Other Services <sup>5</sup>  | Deductible/Coinsurance                          |
| Urgent Care <sup>4</sup>  | \$150 Copay                                     |
| Ambulance (ground and air)  | Deductible/Coinsurance                          |
| <b>Hospital Services<sup>4</sup></b>  |   |
| 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 <sup>5</sup>  | 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                          |
| <b>Maternity Services</b>   |   |
| Prenatal Care   | Deductible/Coinsurance                          |
| Delivery and Inpatient Services PA*   | Deductible/Coinsurance                          |
| <b>Preventive Services</b>  |   |
| Preventive Services <sup>7</sup>  | Covered in Full                                 |
| <b>Vision Services</b>  |   |
| 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                                     |
| <b>Miscellaneous Services</b>   |   |
| 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<br>(Physical, Speech, Occupational Therapy - 20 visits per therapy type per year) | Deductible/Coinsurance                          |

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|--|--------------------------|---|
| Home Health Services (up to 60 visits/year)  |                          | Deductible/Coinsurance                          |
| Hospice Services/End of Life Services  |                          | Deductible/Coinsurance                          |
| Outpatient Chemotherapy  | PA                       | Deductible/Coinsurance                          |
| Outpatient Radiation Therapy   |                          | Deductible/Coinsurance                          |
| Post-Cochlear Implant Aural Therapy (up to 30 visits/year)   |                          | Deductible/Coinsurance                          |
| Preventive Dental Services   |                          | Not Covered                                     |
| Rehabilitative Services<br>(Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)  |                          | Deductible/Coinsurance                          |
| Routine Dental Care (Pediatric dental coverage or a stand-alone dental services product can be purchased separately in Wisconsin)  |                          | Not Covered                                     |
| Skilled Nursing Facility (up to 30 days per stay)  | PA                       | Deductible/Coinsurance                          |
| Specified Oral Surgical Procedures <sup>8</sup>  | PA                       | Deductible/Coinsurance                          |
| <b>Prescription Drugs, Supplies &amp; Equipment</b>  |                          |   |
| Separate Rx Deductible   |                          | Does Not Apply; Under Medical Deductible.       |
| <i>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>9</sup> (90-day supply) at coinsurance or 2 copays.</i> |                          |   |
| Preventive Drugs (30-day supply)   |                          | \$0 (See formulary for details)                 |
| Tier CM - Oral Chemotherapy Drugs  |                          | Deductible Then Covered in Full                 |
| Tier 1 - Typically Generic Drugs   |                          | \$30 Copay                                      |
| Tier 2 - Preferred Drugs <sup>10</sup>   |                          | \$50 Copay                                      |
| Tier 2 - Preferred Insulin Copay   |                          | \$15 Copay                                      |
| Tier 3 - Non-Preferred Drugs <sup>10</sup>   |                          | \$90 Copay                                      |
| Tier 4 - Specialty Drugs   | PA                       | Deductible/Coinsurance                          |
| <b>Supplies &amp; Equipment</b>  |                          |   |
| Durable Medical Equipment  | PA                       | Deductible/Coinsurance                          |
| Prosthetic Devices   | PA                       | Deductible/Coinsurance                          |
| Diabetic Equipment   | PA                       | Deductible/Coinsurance                          |
| Hearing Aids and Cochlear Implants (One aid per ear every 36 months)   |                          | Deductible/Coinsurance                          |

***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)).

<sup>1</sup>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.

<sup>2</sup>Primary Care Provider may include general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

<sup>3</sup>Specialists are all provider types other than those defined elsewhere in this Schedule of Benefits.

<sup>4</sup>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.

<sup>5</sup>All Other Services are defined as services not elsewhere listed in this schedule of benefits.

<sup>6</sup>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.

<sup>7</sup>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.

<sup>8</sup>Please refer to the Certificate of Coverage to determine what oral surgery procedures are covered.

<sup>9</sup>Only certain Prescription Drug products are available through mail order.

<sup>10</sup>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.

<sup>11</sup>Copay is applied per provider, per date of service.