<table>
<thead>
<tr>
<th>PA = Prior Authorization</th>
<th>In Network Benefits Only (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>50%</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (includes deductible, coinsurance, copays)</td>
<td>$8,700 single/$17,400 family</td>
</tr>
</tbody>
</table>

### Office Visits
- **Primary Care Provider Visit (to treat an illness or injury)**
  - $15 Copay
- **Aurora Quick Care or Bellin/ThedaCare Fast Care**
  - $20 Copay
- **Obstetrics/Gynecology Visit**
  - $15 Copay
- **Specialist Visit**
  - $200 Copay
- **Chiropractic Visit**
  - $15 Copay
- **Hearing Exam**
  - $15 Copay

### Diagnostic Services
- **Diagnostic Laboratory Tests**
  - $50 Copay
- **Diagnostic X-rays**
  - $50 Copay
- **Imaging (MRI, MRA, PET and CT Services only)**
  - PA $1,000 Copay

### Mental/Behavioral Health & Substance Abuse
- **Outpatient - Office / Physician Visit**
  - $15 Copay
- **Outpatient - Facility Fee**
  - $200 Copay
- **Outpatient - All Other Services**
  - Deductible/Coinsurance
- **Transitional**
  - Deductible/Coinsurance
- **Inpatient – Including Residential**
  - PA $1,500 Copay Per Day

### Emergency Services
- **Emergency Room** (copay waived if admitted)
  - $1,800 Copay
- **Physician Services**
  - Deductible/Coinsurance
- **Urgent Care**
  - $200 Copay
- **Ambulance (ground and air)**
  - Deductible/Coinsurance

### Hospital Services
- **Outpatient Surgical Facility/Ambulatory Surgical Care Centers**
  - PA $200 Copay
- **Outpatient Surgical Services**
  - PA $200 Copay
- **Inpatient Hospital Services**
  - PA $1,500 Copay Per Day
- **Inpatient Physician and Surgical Services**
  - PA Deductible/Coinsurance
- **Inpatient Rehabilitation (limited to 60 days/year)**
  - PA $1,500 Copay Per Day

### Maternity Services
- **Prenatal Care**
  - Deductible/Coinsurance
- **Delivery and Inpatient Services**
  - PA* Deductible/Coinsurance

### Preventive Services
- **Preventive Services**
  - Preventive Services - ACA Required
    - Covered in Full
  - Preventive Services - Not ACA Required
    - Deductible/Coinsurance

### 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**  (1 exam/year)
  - Covered in Full

### Other Services
- **Transplants**
  - PA Deductible/Coinsurance
- **Habilitation Services**
  - (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)
  - $200 Copay
- **Rehabilitative Services**
  - (Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)
  - $200 Copay
- **Cardiac/Pulmonary Rehabilitation (up to 36 visits/year)**
  - Deductible/Coinsurance
- **Post-Cochlear Implant Aural Therapy (up to 30 visits/year)**
  - Deductible/Coinsurance
- **Cognitive Rehabilitation Therapy (up to 20 visits/year)**
  - $200 Copay

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*CGHC Solutions Bronze $0 Deductible (Allergy Testing+ Vision Exam)*

2022 Schedule of Benefits

87416WI0050023

Solutions Bronze 0Ded_ALGY Testg+ Vision Exam

CGHC.PB.1001b-2021
<table>
<thead>
<tr>
<th>Service Description</th>
<th>PA</th>
<th>Deductible/Coincurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism Spectrum Disorders</td>
<td></td>
<td>Deductible/Coincurrence</td>
</tr>
<tr>
<td>Skilled Nursing Facility (up to 30 days per stay)</td>
<td>PA</td>
<td>$1,500 Copay Per Day</td>
</tr>
<tr>
<td>Outpatient Chemotherapy</td>
<td></td>
<td>Deductible/Coincurrence</td>
</tr>
<tr>
<td>Outpatient Radiation Therapy</td>
<td></td>
<td>Deductible/Coincurrence</td>
</tr>
<tr>
<td>Hospice Services/End of Life Services</td>
<td></td>
<td>Deductible/Coincurrence</td>
</tr>
<tr>
<td>Home Health Services (up to 60 visits/year)</td>
<td></td>
<td>Deductible/Coincurrence</td>
</tr>
<tr>
<td>Non-Surgical Treatment for Temporomandibular Joint (TMI)</td>
<td>PA</td>
<td>Deductible/Coincurrence</td>
</tr>
<tr>
<td>Specified Oral Surgical Procedures 5</td>
<td>PA</td>
<td>Deductible/Coincurrence</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>Accidental Dental Services</td>
<td></td>
<td>Deductible/Coincurrence</td>
</tr>
<tr>
<td>Preventive Dental Services for Adults 5</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Preventive Dental Services for Children 5</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td></td>
<td>Deductible/Coincurrence</td>
</tr>
</tbody>
</table>

**Prescription Drugs**

Separate Rx Deductible $3,000 single/$6,000 family

See formulary to determine tier and if medication is preventative. Diabetic test strips are included. Drugs are available in Retail setting (30-day supply) at coinsurance or 1 copay or using Mail Order 6 (90-day supply) at coinsurance or 2 copays

<table>
<thead>
<tr>
<th>Tier</th>
<th>Coverage</th>
<th>Deductible/Coincurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM</td>
<td>Preventative Drugs (30-day supply)</td>
<td>$0 (See formulary for details)</td>
</tr>
<tr>
<td>1</td>
<td>Generic Drugs</td>
<td>Deductible Then Covered in Full</td>
</tr>
<tr>
<td>2</td>
<td>Preferred Brand Drugs</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>3</td>
<td>Non-Preferred Brand Drugs</td>
<td>$125 Copay</td>
</tr>
<tr>
<td>4</td>
<td>Specialty Drugs</td>
<td>Deductible/50% Coinsurance</td>
</tr>
</tbody>
</table>

**Supplies & Equipment**

<table>
<thead>
<tr>
<th>Supply</th>
<th>PA</th>
<th>Deductible/Coincurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
<td>Deductible/Coincurrence</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td></td>
<td>Deductible/Coincurrence</td>
</tr>
<tr>
<td>Diabetic Equipment</td>
<td></td>
<td>Deductible/Coincurrence</td>
</tr>
<tr>
<td>Hearing Aids and Cochlear Implants</td>
<td>PA</td>
<td>Deductible/Coincurrence</td>
</tr>
</tbody>
</table>

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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 regarding Common Ground Healthcare Cooperative Benefits, please call us at 1-877-514-CGHC (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.

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1Primary Care Provider may include general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics. 
2Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.
3The 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/members/preventivecare for a complete listing.
4Examples of transplants for which benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea when medically necessary and not experimental.
5Please refer to the Certificate of Coverage to determine what oral surgeries procedures are covered.
6Only certain Prescription Drug products are available through mail order.
7No 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.
8Refraction and dilation are not included in the adult eye exam.
9Preventive 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), sealants (up to age 14 on permanent molars only)

87416WI0050023 2022 Schedule of Benefits
Solutions Bronze 0Ded_ALGY Test+ Vision Exam CGHC.PB.1001b-2021