

## CGHC Gold \$1800 -Envision Network (Vision Exam)

Coinsurance (applies only to certain services)     20%       Maximum Out-of-Pocket (includes deductible, coinsurance, copays)     \$6,600 Single/S13,200 Family       Aurora Quick Care or Bellin/TheddCare Fast Care or Other Retail Based Clinic     \$15 Copay <sup>18</sup> Primary Care Provider (For non-Preventive services) <sup>2</sup> \$25 Copay <sup>18</sup> Mental/Behavioral Health     \$25 Copay <sup>18</sup> Mental/Behavioral Health     \$25 Copay <sup>18</sup> Chiropractic     \$25 Copay <sup>18</sup> Specialist <sup>2</sup> \$25 Copay <sup>18</sup> Diagnostic Laboratory Test     Deductible/Coinsurance       Diagnostic Laboratory Test     Deductible/Coinsurance       Outpatient - Facility Fee     Deductible/Coinsurance       Outpatient - Facility Fee (condy Noard at transitional care facility is not covered)     Deductible/Coinsurance       Inpatient - Physician Services     Deductible/Coinsurance       Imaging Care Services (room/board at transitional care facility is not covered)     Deductible/Coinsurance       Inpatient - Physician Services     Deductible/Coinsurance       Imaging Care Services (room/board at transitional care facility is not covered)     Deductible/Coinsurance       Inpatient - Physician Services     Deductible/Coinsurance <td< th=""><th></th><th>PA = Prior Authorization</th><th>In Network Benefits Only<sup>1</sup> (You Pay)</th></td<>		PA = Prior Authorization	In Network Benefits Only <sup>1</sup> (You Pay)
Absimum Dut of Pocket (Includes deductible, coinsurance, copays) S6,600 Single/S13,200 Family Office Viti Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic S15 Copay <sup>10</sup> S25 Copay <sup>10</sup> S25 Copay <sup>10</sup> S25 Copay <sup>10</sup> Hearing Exam S25 Copay <sup>10</sup> Bignostic Laboratory Test Diagnostic Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic S25 Copay <sup>10</sup> S25 Copay <sup>10</sup> Hearing Exam S25 Copay <sup>10</sup> Diagnostic Services <sup>1</sup> Diagnostic Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic S25 Copay <sup>10</sup> Hearing Exam S25 Copay <sup>10</sup> Diagnostic Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic S25 Copay <sup>10</sup> Diagnostic Services <sup>1</sup> Diagnostic Services <sup>1</sup> Diagnostic Services <sup>1</sup> Diagnostic Charon or Based Clinic Service or Deductible/Coinsurance Diagnostic Mark PET and TService only PA Deductible/Coinsurance Cutpatient - Facility Fee Deductible/Coinsurance Cutpatient - Facility Fee Deductible/Coinsurance Doutpatient - Facility Fee Deductible/Coinsurance Cutpatient - Physician Services <sup>1</sup> Deductible/Coinsurance Emergency Room Facility Fee <sup>10</sup> Deductible/Coinsurance Cutpatient - Physician Services <sup>10</sup> Deductible/Coinsurance Emergency Room Facility Fee <sup>10</sup> Diagnostic Care Services (com/Noard at transitional care facility is not coverel) Deductible/Coinsurance Emergency Room Facility Fee <sup>10</sup> Deductible/Coinsurance Cutpatient - Physician Services <sup>10</sup> Deductible/Coinsurance Emergency Room Facility Fee <sup>10</sup> Deductible/Coinsurance Cutpatient - Physician Services <sup>10</sup> Deductible/Coinsurance Deductible/Coinsurance Cutpatient Services <sup>10</sup> Deductible/Coinsurance Ded	Calendar Year Deductible (Runs Jan 1 – Dec 31)		\$1,800 Single/\$3,600 Family
Office Visit     Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic     \$15 Copay <sup>13</sup> Aurora Quick Care Provider (for non-Preventive services) <sup>2</sup> \$25 Copay <sup>13</sup> Menta/Behavioral Heath     \$25 Copay <sup>13</sup> Chriopractic     \$25 Copay <sup>13</sup> Hearing Exam     \$25 Copay <sup>13</sup> Specialist <sup>1</sup> \$36 Copay <sup>13</sup> Diagnostic Services <sup>1</sup> \$26 Copay <sup>13</sup> Diagnostic Aurora     \$26 Copay <sup>13</sup> Specialist <sup>1</sup> \$36 Copay <sup>13</sup> Diagnostic Aurora     \$26 Copay <sup>13</sup> Diagnostic Services <sup>1</sup> Deductible/Coinsurance       Ibagnostic Aurora     Deductible/Coinsurance       Ibagnostic Aurora     Deductible/Coinsurance       Ibagnostic Aurora     Deductible/Coinsurance       Outpatient - All Other Services <sup>1</sup> Deductible/Coinsurance       Inpatient - Facility Fee (Including Residential)     PA       Deductible/Coinsurance     Inpatient - Physician Services       Image on Facility Fee <sup>1</sup> (copay waved if admitted)     PA       Deductible/Coinsurance     Emergency Soom Facility Fe <sup>2</sup> (copay waved if admitted)       Physician Services     PA       Deductible/Coinsurance     Emergency Room Facility Fee <sup>1</sup> (copay waved if admitted)       Physician Services     PA       Deductible/Coinsurance     Deductible/Coinsurance       Corate faca	Coinsurance (applies only to certain services)		20%
Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic     \$15 Copay <sup>10</sup> Primary Care Provider (For non-Preventive services) <sup>2</sup> \$25 Copay <sup>10</sup> Mental/Behaburgan Health     \$25 Copay <sup>10</sup> Mental/Behaburgan Health     \$25 Copay <sup>10</sup> Specialist     \$26 Copay <sup>10</sup> Mearing Exam     \$25 Copay <sup>10</sup> Diagnosti Caronica <sup>4</sup> \$26 Copay <sup>10</sup> Diagnosti Caronica <sup>4</sup> Deductible/Coinsurance       Diagnosti Caronica <sup>4</sup> Deductible/Coinsurance       Meana/Behaburgan     Pace Deductible/Coinsurance       Outpatient - Facility Fee     Deductible/Coinsurance       Outpatient - Facility Fee     Deductible/Coinsurance       Inpatient - Facility Fee     Deductible/Coinsurance       Inpatient - Facility Fee (nonulong Residentia)     PA       Deductible/Coinsurance     Deductible/Coinsurance       Inpatient - Facility Fee (notuber Services <sup>2</sup> Deductible/Coinsurance       Durgent Care <sup>6</sup> \$75 Copay	Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		\$6,600 Single/\$13,200 Family
Primary Care Provider (For non-Preventive services) <sup>2</sup> \$35 Copay <sup>10</sup> Mental/behavioral Health     \$35 Copay <sup>10</sup> Chriogractic     \$35 Copay <sup>10</sup> Chriogractic     \$35 Copay <sup>10</sup> Specialist <sup>1</sup> \$35 Copay <sup>10</sup> Diagnostic Area     \$35 Copay <sup>10</sup> Diagnostic Area     Deductible/Coinsurance       Dupatient - Facility Fee     Deductible/Coinsurance       Outpatient - Facility Fee     Deductible/Coinsurance       Diagnostic Area     Salo Copay       Preventees     Deductible/Coinsurance       Inpatient - Painty Fee (Including Residential)     PA       Deductible/Coinsurance     Deductible/Coinsurance       Inpatient - Facility Fee (Including Residential)     PA       Deductible/Coinsurance     Deductible/Coinsurance       Emergency Services     Deductible/Coinsurance       Emergency Services     PA       Deductible/Coinsurance     Deductible/Coinsurance       Emergency Room -All Other Services <sup>3</sup> Deductible/Coinsurance       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee	Office Visit		
Metal/kehavioral Health     \$25 Copay <sup>14</sup> Chiropractic     \$25 Copay <sup>16</sup> Hearing Exam     \$25 Copay <sup>16</sup> Specialst <sup>1</sup> \$50 Copay <sup>18</sup> Diagnostic convest     \$50 Copay <sup>18</sup> Diagnostic convest     Deductible/Coinsurance       Diagnostic convest     Deductible/Coinsurance       Diagnostic convest     Deductible/Coinsurance       Diagnostic convest     Deductible/Coinsurance       Dutpatient - Facility Fee     Deductible/Coinsurance       Outpatient - All Other Services <sup>1</sup> Deductible/Coinsurance       Transitional Care Services (room/board at transitional care facility is not covered)     Deductible/Coinsurance       Inpatient - Facility Fee (notume Residential)     PA     Deductible/Coinsurance       Impatient - Facility Fee (notume Residential)     PA     Deductible/Coinsurance       Impatient - Facility Fee (notume Residential)     PA     Deductible/Coinsurance       Impatient - Services rendered in an Emergency Room     Deductible/Coinsurance       Emergency Services     Beductible/Coinsurance     Bestication       Urgent Care <sup>4</sup> \$75 Copay     Ambulatory Surgical Center - Facility Fee     PA       Outpatient surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance	Aurora Quick Care or Bellin/ThedaCare Fast Care or Other Retail Based Clinic		\$15 Copay <sup>13</sup>
Metal/kehavioral Health     \$25 Copay <sup>14</sup> Chiropractic     \$25 Copay <sup>16</sup> Hearing Exam     \$25 Copay <sup>16</sup> Specialst <sup>1</sup> \$50 Copay <sup>18</sup> Diagnostic convest     \$50 Copay <sup>18</sup> Diagnostic convest     Deductible/Coinsurance       Diagnostic convest     Deductible/Coinsurance       Diagnostic convest     Deductible/Coinsurance       Diagnostic convest     Deductible/Coinsurance       Dutpatient - Facility Fee     Deductible/Coinsurance       Outpatient - All Other Services <sup>1</sup> Deductible/Coinsurance       Transitional Care Services (room/board at transitional care facility is not covered)     Deductible/Coinsurance       Inpatient - Facility Fee (notume Residential)     PA     Deductible/Coinsurance       Impatient - Facility Fee (notume Residential)     PA     Deductible/Coinsurance       Impatient - Facility Fee (notume Residential)     PA     Deductible/Coinsurance       Impatient - Services rendered in an Emergency Room     Deductible/Coinsurance       Emergency Services     Beductible/Coinsurance     Bestication       Urgent Care <sup>4</sup> \$75 Copay     Ambulatory Surgical Center - Facility Fee     PA       Outpatient surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance			\$25 Copay <sup>13</sup>
Hearing Exam     \$25 Coppy <sup>19</sup> Specialist <sup>2</sup> S35 Coppy <sup>19</sup> Diagnostic services <sup>1</sup> Deductible/Coinsurance       Diagnostic Laboratory Test     Deductible/Coinsurance       Imaging (MRI, MRA, PET and CT Service only)     PA     Deductible/Coinsurance       Outpatient - Facility Fee     Deductible/Coinsurance     Deductible/Coinsurance       Outpatient - Facility Fee     Deductible/Coinsurance     Deductible/Coinsurance       Impatient - Facility Fee (Including Residential)     PA     Deductible/Coinsurance       Impatient - Fhysician Services (coom/board at transitional care facility is not covered)     Deductible/Coinsurance       Impatient - Fhysician Services (coom/board at transitional care facility is not covered)     Deductible/Coinsurance       Emergency Room Facility Fee <sup>®</sup> (copay waived if admitted)     PA     Deductible/Coinsurance       Emergency Room Facility Fee <sup>®</sup> (copay waived if admitted)     \$300 Copay     Physician Services rendered in an Emergency Room       Emergency Room - All Other Services <sup>5</sup> Deductible/Coinsurance     Deductible/Coinsurance       Dotpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance       Dutpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance       Outpatient Surgical - Physician Services     PA     Deductible/Coinsurance       Outpatient Surgery & Ambulatory Surgical Center			\$25 Copay <sup>13</sup>
Hearing Exam     \$25 Coppy <sup>19</sup> Specialist <sup>2</sup> S35 Coppy <sup>19</sup> Diagnostic services <sup>1</sup> Deductible/Coinsurance       Diagnostic Laboratory Test     Deductible/Coinsurance       Imaging (MRI, MRA, PET and CT Service only)     PA     Deductible/Coinsurance       Outpatient - Facility Fee     Deductible/Coinsurance     Deductible/Coinsurance       Outpatient - Facility Fee     Deductible/Coinsurance     Deductible/Coinsurance       Impatient - Facility Fee (Including Residential)     PA     Deductible/Coinsurance       Impatient - Fhysician Services (coom/board at transitional care facility is not covered)     Deductible/Coinsurance       Impatient - Fhysician Services (coom/board at transitional care facility is not covered)     Deductible/Coinsurance       Emergency Room Facility Fee <sup>®</sup> (copay waived if admitted)     PA     Deductible/Coinsurance       Emergency Room Facility Fee <sup>®</sup> (copay waived if admitted)     \$300 Copay     Physician Services rendered in an Emergency Room       Emergency Room - All Other Services <sup>5</sup> Deductible/Coinsurance     Deductible/Coinsurance       Dotpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance       Dutpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance       Outpatient Surgical - Physician Services     PA     Deductible/Coinsurance       Outpatient Surgery & Ambulatory Surgical Center	Chiropractic		\$25 Copay <sup>13</sup>
Diagnostic Services <sup>4</sup> Diagnostic Aportory Test Diagnostic Aportory Test Diagnostic Aportory Test Diagnostic Aportany Test Deductible/Coinsurance Deductible/Coinsurance Mental/Behavioral Health & Substance Abuse Outpatient - Acility Fee Deductible/Coinsurance Deductible/Coinsurance Inpatient - Acility Fee Deductible/Coinsurance Inpatient - Another Services ' Deductible/Coinsurance Emergency Services Emergency Room Acility Fee (Including Residential) PA Deductible/Coinsurance Emergency Services Emergency Room Acility Fee <sup>(</sup> (copay waived if admitted) Farsitional Care Services (Composed at an Emergency Room Emergency Services Emergency Room Acility Fee <sup>(</sup> (copay waived if admitted) Sa00 Copay Physician Services rendered in an Emergency Room Emergency Room - All Other Services <sup>2</sup> Deductible/Coinsurance Emergency Room - All Other Services <sup>3</sup> Outpatient - Services and there are acility is not covered in the Sature of	Hearing Exam		\$25 Copay <sup>13</sup>
Diagnostic Services <sup>4</sup> Diagnostic Aportory Test Diagnostic Aportory Test Diagnostic Aportory Test Diagnostic Aportany Test Deductible/Coinsurance Deductible/Coinsurance Mental/Behavioral Health & Substance Abuse Outpatient - Acility Fee Deductible/Coinsurance Deductible/Coinsurance Inpatient - Acility Fee Deductible/Coinsurance Inpatient - Another Services ' Deductible/Coinsurance Emergency Services Emergency Room Acility Fee (Including Residential) PA Deductible/Coinsurance Emergency Services Emergency Room Acility Fee <sup>(</sup> (copay waived if admitted) Farsitional Care Services (Composed at an Emergency Room Emergency Services Emergency Room Acility Fee <sup>(</sup> (copay waived if admitted) Sa00 Copay Physician Services rendered in an Emergency Room Emergency Room - All Other Services <sup>2</sup> Deductible/Coinsurance Emergency Room - All Other Services <sup>3</sup> Outpatient - Services and there are acility is not covered in the Sature of			\$50 Copay <sup>13</sup>
Diagnostic X-ray, Ultrasound and Other Radiology Service         Deductible/Coinsurance           Imaging (MR, MRA, PET and CT Service only)         PA         Deductible/Coinsurance           Outpatient - Facility Fee         Deductible/Coinsurance         Deductible/Coinsurance           Outpatient - Facility Fee         Deductible/Coinsurance         Deductible/Coinsurance           Inpatient - Facility Fee (including Residential)         PA         Deductible/Coinsurance           Inpatient - Physician Services         Deductible/Coinsurance         Deductible/Coinsurance           Emergency Room Facility Fee (including Residential)         PA         Deductible/Coinsurance           Emergency Room - All Other Services <sup>5</sup> Deductible/Coinsurance         Deductible/Coinsurance           Urgent Care <sup>6</sup> \$75 Copay         Deductible/Coinsurance           Dutpatient surgery & Ambulatory Surgical Center - Facility Fee         PA         Deductible/Coinsurance           Outpatient (non-Surgical) - Facility Fee         PA         Deductible/Coinsurance           Outpatient + Facility Fee         PA         Deductible/Coinsurance           Outpatient + Noisician and Surgical Services         PA         Deductible/Coinsurance           Outpatient (non-Surgical) - Facility Fee         PA         Deductible/Coinsurance           Outpatient Surgical - Physician Services	Diagnostic Services <sup>4</sup>		
Imaging (MRI, MRA, PET and CT Service only)         PA         Deductible/Coinsurance           Wental/Behavioral Health & Substance Abuse         Utpatient - Facility Fee         Deductible/Coinsurance           Outpatient - Facility Fee         Deductible/Coinsurance         Deductible/Coinsurance           Inpatient - Physician Services         Deductible/Coinsurance         Deductible/Coinsurance           Emergency Services         Emergency Services         Deductible/Coinsurance           Emergency Services         Deductible/Coinsurance         Emergency Services           Emergency Room - All Other Services <sup>3</sup> Deductible/Coinsurance         Emergency Room - All Other Services <sup>3</sup> Urgent Care <sup>4</sup> \$75 Copay         Ambulance         \$75 Copay           Ambulance (ground and air)         Deductible/Coinsurance         Deductible/Coinsurance           Outpatient Surgical - Facility Fee         PA         Deductible/Coinsurance           Outpatient Surgical - Facility Fee         PA         Deductible/Coinsurance           Outpatient All Other Services <sup>3</sup> Deductible/Coinsurance         Deductible/Coinsurance           Outpatient Functional Surgical Services         PA         Deductible/Coinsurance           Dutpatient Facility Fee         PA         Deductible/Coinsurance           Outpatient All Other Services <sup>3</sup> Deductib	Diagnostic Laboratory Test		Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse         Deductible/Coinsurance           Outpatient - Facility Fee         Deductible/Coinsurance           Transitional Care Services (room/board at transitional care facility is not covered)         Deductible/Coinsurance           Inpatient - Physician Services         Deductible/Coinsurance           Inpatient - Physician Services         Deductible/Coinsurance           Emergency Services         Deductible/Coinsurance           Emergency Services         Deductible/Coinsurance           Emergency Room Facility Fee <sup>4</sup> (copay waived if admitted)         \$300 Copay           Physician Services rendered in an Emergency Room         Deductible/Coinsurance           Emergency Room - All Other Services <sup>2</sup> Deductible/Coinsurance           Mublance (ground nair)         Deductible/Coinsurance           Outpatient - Annous Togravy & Ambulatory Surgical Center - Facility Fee         PA           Outpatient - Annous Surgical - Physician Services         PA           Outpatient - Anil Other Services <sup>3</sup> Deductible/Coinsurance           Outpatient - All Other Services <sup>4</sup> PA           Outpatient - All Other Services <sup>3</sup> Deductible/Coinsurance           Inpatient - Physician Services         PA           Deductible/Coinsurance         Deductible/Coinsurance           Inpatient - Physician Services	Diagnostic X-ray, Ultrasound and Other Radiology Service		Deductible/Coinsurance
Outpatient - Facility Fee     Deductible/Coinsurance       Outpatient - All Other Services <sup>3</sup> Deductible/Coinsurance       Inpatient - Facility Fee (Including Residential)     PA     Deductible/Coinsurance       Inpatient - Facility Fee (Including Residential)     PA     Deductible/Coinsurance       Impatient - Physician Services     Deductible/Coinsurance     Deductible/Coinsurance       Emergency Room Facility Fee <sup>6</sup> (copay waived if admitted)     \$300 Copay     Deductible/Coinsurance       Urgent Care <sup>6</sup> \$300 Copay     Deductible/Coinsurance       Urgent Care <sup>6</sup> \$75 Copay     Deductible/Coinsurance       Mobulance (ground and air)     Deductible/Coinsurance     Deductible/Coinsurance       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance       Outpatient Surgical - Physician Services     PA     Deductible/Coinsurance       Outpatient - Facility Fee     PA     Deductible/Coinsurance       Inpatient - Facility Fee <t< td=""><td>Imaging (MRI, MRA, PET and CT Service only)</td><td>PA</td><td>Deductible/Coinsurance</td></t<>	Imaging (MRI, MRA, PET and CT Service only)	PA	Deductible/Coinsurance
Outpatient - All Other Services <sup>3</sup> Deductible/Coinsurance       Inpatient - Facility Fee (Including Residential)     PA     Deductible/Coinsurance       Inpatient - Physician Services     Deductible/Coinsurance     Deductible/Coinsurance       Emergency Services     Deductible/Coinsurance     S300 Copay       Physician Services rendered in an Emergency Room     Deductible/Coinsurance       Emergency Room - All Other Services <sup>5</sup> Deductible/Coinsurance       Urgent Care <sup>6</sup> S75 Copay       Ambulance (ground and air)     Deductible/Coinsurance       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA       Outpatient Surgical - Physician Services     PA       Deductible/Coinsurance     Outpatient Surgical - Physician Services       Dutpatient - Facility Fee     PA       Deductible/Coinsurance     Deductible/Coinsurance       Outpatient - Facility Fee     PA       Deductible/Coinsurance     Deductible/Coinsurance       Inpatient - Facility Fee     PA       Deductible/Coinsurance     Deductible/Coinsurance       Inpatient - Facility Fee     PA       Deductible/Coinsurance     Deductible/Coinsurance       Inpatient - Rehabilitation (limited to 60 days/year)<	Mental/Behavioral Health & Substance Abuse		
Transitional Care Services (room/board at transitional care facility is not covered)     Deductible/Coinsurance       Inpatient – Facility Fee (Including Residential)     PA     Deductible/Coinsurance       Impatient – Physician Services     Deductible/Coinsurance       Emergency Room Facility Fee <sup>6</sup> (copay waived if admitted)     S300 Copay       Physician Services rendered in an Emergency Room     Deductible/Coinsurance       Emergency Room – All Other Services <sup>5</sup> Deductible/Coinsurance       Urgent Care <sup>6</sup> S75 Copay       Ambulance (ground and air)     Deductible/Coinsurance       Bogstal Services     PA       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA       Outpatient Surgical - Physician Services     PA       Deductible/Coinsurance     Deductible/Coinsurance       Outpatient - All Other Services <sup>5</sup> Deductible/Coinsurance       Outpatient - Facility Fee     PA       Deductible/Coinsurance     Pace       Inpatient - All Other Services <sup>5</sup> Deductible/Coinsurance       Inpatient - Rehabilitation (Imited to 60 days/year)     PA       Deductible/Coinsurance     Deductible/Coinsurance       Inpatient - Services     PA*     Deductible/Coinsurance       Preventive Services     PA*     Deductible/Coinsurance       Prev	Outpatient - Facility Fee		Deductible/Coinsurance
Transitional Care Services (room/board at transitional care facility is not covered)     Deductible/Coinsurance       Inpatient – Facility Fee (Including Residential)     PA     Deductible/Coinsurance       Impatient – Physician Services     Deductible/Coinsurance       Emergency Room Facility Fee <sup>6</sup> (copay waived if admitted)     S300 Copay       Physician Services rendered in an Emergency Room     Deductible/Coinsurance       Emergency Room – All Other Services <sup>5</sup> Deductible/Coinsurance       Urgent Care <sup>6</sup> S75 Copay       Ambulance (ground and air)     Deductible/Coinsurance       Bogstal Services     PA       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA       Outpatient Surgical - Physician Services     PA       Deductible/Coinsurance     Deductible/Coinsurance       Outpatient - All Other Services <sup>5</sup> Deductible/Coinsurance       Outpatient - Facility Fee     PA       Deductible/Coinsurance     Pace       Inpatient - All Other Services <sup>5</sup> Deductible/Coinsurance       Inpatient - Rehabilitation (Imited to 60 days/year)     PA       Deductible/Coinsurance     Deductible/Coinsurance       Inpatient - Services     PA*     Deductible/Coinsurance       Preventive Services     PA*     Deductible/Coinsurance       Prev			·
Inpatient – Facility Fee (including Residential)       PA       Deductible/Coinsurance         Inpatient – Physician Services       Deductible/Coinsurance         Emergency Room Facility Fee <sup>6</sup> (copay waived if admitted)       \$300 Copay         Physician Services rendered in an Emergency Room       Deductible/Coinsurance         Emergency Room – All Other Services <sup>2</sup> Deductible/Coinsurance         Urgent Care <sup>6</sup> \$75 Copay         Ambulance (ground and air)       Deductible/Coinsurance         Hospital Services <sup>4</sup> Deductible/Coinsurance         Outpatient (non-Surgical) – Facility Fee       PA       Deductible/Coinsurance         Outpatient (non-Surgical) – Facility Fee       PA       Deductible/Coinsurance         Outpatient (non-Surgical) – Facility Fee       PA       Deductible/Coinsurance         Outpatient - All Other Services <sup>6</sup> Deductible/Coinsurance       Deductible/Coinsurance         Inpatient - Facility Fee       PA       Deductible/Coinsurance       Deductible/Coinsurance         Inpatient - Physician and Surgical Services       PA       Deductible/Coinsurance       Deductible/Coinsurance         Inpatient - Services       PA       Deductible/Coinsurance       Deductible/Coinsurance       Deductible/Coinsurance         Inpatient - Services       PA       Deductible/Coinsurance       Deductible/Coin		ility is not covered)	· ·
Inpatient – Physician Services         Deductible/Coinsurance           Emergency Services         3300 Copay           Emergency Room Facility Fee <sup>®</sup> (copay waived if admitted)         \$300 Copay           Physician Services rendered in an Emergency Room         Deductible/Coinsurance           Emergency Room – All Other Services <sup>3</sup> Deductible/Coinsurance           Urgent Care <sup>4</sup> \$75 Copay           Ambulance (ground and air)         Deductible/Coinsurance           Hospital Services <sup>4</sup> Outpatient Surgery & Ambulatory Surgical Center - Facility Fee         PA           Outpatient Consurgical - Physician Services         PA         Deductible/Coinsurance           Outpatient - All Other Services <sup>5</sup> Deductible/Coinsurance         Deductible/Coinsurance           Inpatient - Physician and Surgical Services         PA         Deductible/Coinsurance           Inpatient - All Other Services <sup>5</sup> Deductible/Coinsurance         Inpatient - Facility Fee         PA           Inpatient - Facility Fee         PA         Deductible/Coinsurance         Inpatient - Physician and Surgical Services         PA           Inpatient - All Other Services <sup>5</sup> Deductible/Coinsurance         Inpatient - Facility Fee         PA         Deductible/Coinsurance           Preventive Services         PA         Deductible/Coinsurance         Inpatient - Facilit			
Emergency Services Emergency Room Facility Fee <sup>6</sup> (copay waived if admitted) S300 Copay Physician Services rendered in an Emergency Room Physician Services rendered in an Emergency Room Urgent Care <sup>4</sup> Deductible/Coinsurance Urgent Care <sup>4</sup> S75 Copay Ambulance (ground and air) Bospital Services <sup>4</sup> Outpatient Surgery & Ambulatory Surgical Center - Facility Fee PA Deductible/Coinsurance Outpatient Surgery & Ambulatory Surgical Center - Facility Fee PA Deductible/Coinsurance Outpatient Surgery & Ambulatory Surgical Center - Facility Fee PA Deductible/Coinsurance Outpatient Surgery & Ambulatory Surgical Center - Facility Fee PA Deductible/Coinsurance Outpatient Surgery & Ambulatory Surgical Center - Facility Fee PA Deductible/Coinsurance Outpatient Surgical - Physician Services PA Deductible/Coinsurance Inpatient - Facility Fee PA Deductible/Coinsurance Inpatient - Facility Fee PA Deductible/Coinsurance Inpatient - Facility Fee PA Deductible/Coinsurance Delivery and Inpatient Services PA Deductible/Coinsurance Delivery and Inpatient Services PA* Deductible/Coinsurance Delivery and Inpatient Services Preventive Services Children's Vision Exam for Adults <sup>4</sup> (1 exam/year) Covered in Full Children's Services Accidental Dental Services Deductible/Coinsurance Deductible/Coinsurance Active Services Accidental Dental Services (any place of service) Accidental Dental Services (any place of service) Accidental Services (any place of service) Accidental Services Outpatient Accidental Services Outpatient Cardiac/Pulmonary Rehabilitation (up to 36 visits/year) Deductible/Coinsurance Habilitative Services Cognitive Rehabilitation (up to 20 visits/year) Deductible/Coinsurance Habilitative Services Cognitive Rehabilitation (Log 20 visits/year) Deductible/Coinsurance Deductible/Coinsurance Deductible/Coinsurance Cognitive Rehabilitation (Log 20 visits/year) De			·
Emergency Room Facility Fee <sup>6</sup> (copay waived if admitted)       \$300 Copay         Physician Services rendered in an Emergency Room       Deductible/Coinsurance         Emergency Room – All Other Services <sup>5</sup> Deductible/Coinsurance         Urgent Care <sup>4</sup> \$75 Copay         Ambulance (ground and air)       Deductible/Coinsurance         Hospital Services <sup>4</sup> Outpatient (non-Surgical) – Facility Fee         Outpatient (non-Surgical) – Facility Fee       PA         Dutpatient Surgery & Ambulatory Surgical Center - Facility Fee       PA         Dutpatient (non-Surgical) – Facility Fee       PA         Dutpatient (non-Surgical) – Facility Fee       PA         Dutpatient Surgical - Physician Services       PA         Deductible/Coinsurance       Deductible/Coinsurance         Inpatient - Facility Fee       PA         Deductible/Coinsurance       Inpatient - Facility Fee         PA       Deductible/Coinsurance         Inpatient - Rehabilitation (limited to 60 days/year)       PA         Delivery and Inpatient Services       PA*         Delivery and Inpatient Services       PA*         Delivery and Inpatient Services       Covered in Full         Children's Vision Exam for Adults <sup>8</sup> (1 exam/year)       Covered in Full         Vision Exam for Adults <sup>8</sup> (1 exam/year)       Covered	Emergency Services		
Physician Services rendered in an Emergency Room     Deductible/Coinsurance       Emergency Room – All Other Services <sup>5</sup> Deductible/Coinsurance       Urgent Care <sup>4</sup> \$75 Copay       Ambulance (ground and air)     Deductible/Coinsurance       Hospital Services <sup>4</sup> Deductible/Coinsurance       Outpatient Surgery & Ambulatory Surgical Center - Facility Fee     PA     Deductible/Coinsurance       Outpatient (non-Surgical) – Facility Fee     PA     Deductible/Coinsurance       Outpatient (non-Surgical) – Facility Fee     PA     Deductible/Coinsurance       Outpatient - All Other Services <sup>5</sup> Deductible/Coinsurance     Deductible/Coinsurance       Inpatient - All Other Services <sup>5</sup> Deductible/Coinsurance     Inpatient - Facility Fee       Inpatient - Rehabilitation (limited to 60 days/year)     PA     Deductible/Coinsurance       Inpatient - Rehabilitation (limited to 60 days/year)     PA     Deductible/Coinsurance       Maternity Services     PA     Deductible/Coinsurance       Preventive Services     PA*     Deductible/Coinsurance       Delivery and Inpatient Services     PA*     Deductible/Coinsurance       Vision Services     PA*     Deductible/Coinsurance       Preventive Services <sup>7</sup> Covered in Full     Covered in Full       Children's Vision Exam (1 exam per year)     Covered in Full       Children's Vision Exam for Adult			\$300 Copay
Emergency Room – All Other Services <sup>5</sup> Deductible/Coinsurance           Urgent Care <sup>4</sup> \$75 Copay           Ambulance (ground and air)         Deductible/Coinsurance           Hospital Services <sup>4</sup> Outpatient Surgery & Ambulatory Surgical Center - Facility Fee         PA           Outpatient Surgery & Ambulatory Surgical Center - Facility Fee         PA         Deductible/Coinsurance           Outpatient Surgical - Physician Services         PA         Deductible/Coinsurance           Outpatient Surgical - Physician Services         PA         Deductible/Coinsurance           Inpatient - Facility Fee         PA         Deductible/Coinsurance           Outpatient Surgical - Physician Services <sup>5</sup> Deductible/Coinsurance         Inpatient - Facility Fee           Inpatient - Facility Fee         PA         Deductible/Coinsurance         Inpatient - Facility Fee           Inpatient - Facility Fee         PA         Deductible/Coinsurance         Inpatient - Facility Fee         PA           Inpatient - Facility Fee         PA         Deductible/Coinsurance         Inpatient - Facility Fee         PA           Inpatient - Facility Fee         PA         Deductible/Coinsurance         Inpatient Services <sup>7</sup> Coinsurance           Vision Services         PA*         Deductible/Coinsurance         Deductible/Coinsurance			· ·
Urgent Care <sup>4</sup> \$75 CopayAmbulance (ground and air)Deductible/CoinsuranceHospital Services <sup>4</sup> Deductible/CoinsuranceOutpatient Surgery & Ambulatory Surgical Center - Facility FeePADeductible/CoinsuranceOutpatient fuon-Surgical) – Facility FeePADeductible/CoinsuranceOutpatient Surgical - Physician ServicesPADeductible/CoinsuranceOutpatient Surgical - Physician ServicesPADeductible/CoinsuranceInpatient - All Other Services <sup>5</sup> Deductible/CoinsuranceInpatient - All Other Services <sup>5</sup> Inpatient - Physician and Surgical ServicesPADeductible/CoinsuranceInpatient - Rehabilitation (limited to 60 days/year)PADeductible/CoinsuranceInpatient - Rehabilitation (limited to 60 days/year)PADeductible/CoinsurancePrenatal CareDeductible/CoinsurancePerventive ServicesPreventive ServicesPA*Deductible/CoinsurancePreventive ServicesCovered in FullVision ServicesChildren's Vision Exam (1 exam per year)Covered in FullChildren's Sty Glasses or Contacts (1 pair per year)Covered in FullMiscellaneous ServicesDeductible/CoinsuranceAllergy TestingNot CoveredAntental Services (any place of service)Deductible/CoinsuranceAllergy TestingNot CoveredAutism Spectrum Disorder TreatmentDeductible/CoinsuranceAutism Spectrum Disorder TreatmentDeductible/CoinsuranceCognitive Rehabilitation (up to 36 visits/year)Deductible/CoinsuranceAuti			·
Ambulance (ground and air)       Deductible/Coinsurance         Hospital Services <sup>4</sup> Utpatient Surgery & Ambulatory Surgical Center - Facility Fee       PA         Outpatient Surgical) – Facility Fee       PA       Deductible/Coinsurance         Outpatient 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         Inpatient - Facility Fee       PA       Deductible/Coinsurance         Inpatient - Facility Fee       PA       Deductible/Coinsurance         Inpatient - Rabilitation (limited to 60 days/year)       PA       Deductible/Coinsurance         Maternity Services       PA       Deductible/Coinsurance         Prenatal Care       Deductible/Coinsurance       Deductible/Coinsurance         Preventive Services       PA*       Deductible/Coinsurance         Preventive Services       Covered in Full       Vision Services         Children's Vision Exam (1 exam per year)       Covered in Full       Covered in Full         Vision Services       Deductible/Coinsurance       Deductible/Coinsurance         Routine Vision Exam for Adults <sup>8</sup> (1 exam/year)       Covered in Full       Mitscelaneous Services			
Hospital Services <sup>4</sup> Outpatient Surgery & Ambulatory Surgical Center - Facility Fee       PA       Deductible/Coinsurance         Outpatient (non-Surgical) – Facility Fee       PA       Deductible/Coinsurance         Outpatient (non-Surgical) – Physician Services       PA       Deductible/Coinsurance         Outpatient Surgical - Physician Services       PA       Deductible/Coinsurance         Outpatient - All Other Services <sup>5</sup> Deductible/Coinsurance       Deductible/Coinsurance         Inpatient - Facility Fee       PA       Deductible/Coinsurance         Inpatient - Rehabilitation (limited to 60 days/year)       PA       Deductible/Coinsurance         Maternity Services       Pa       Deductible/Coinsurance         Prenatal Care       Deductible/Coinsurance       Deductible/Coinsurance         Delivery and Inpatient Services       PA*       Deductible/Coinsurance         Preventive Services <sup>7</sup> Covered in Full       Coinsurance         Vision Exam (1 exam per year)       Deductible/Coinsurance       Deductible/Coinsurance         Children's Vision Exam (1 exam per year)       Covered in Full       Children's Eye Glasses or Contacts (1 pair per year)       Covered in Full         Children's Eye Glasses or Contacts (1 pair per year)       Covered in Full       Miscellaneous Services       Deductible/Coinsurance			
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 - All Other Services <sup>5</sup> Deductible/Coinsurance       Inpatient - Pacility Fee     PA     Deductible/Coinsurance       Inpatient - Richabilitation (limited to 60 days/year)     PA     Deductible/Coinsurance       Inpatient - Rehabilitation (limited to 60 days/year)     PA     Deductible/Coinsurance       Maternity Services     PA     Deductible/Coinsurance       Prenatal Care     Deductible/Coinsurance     Deductible/Coinsurance       Delivery and Inpatient Services <sup>7</sup> Deductible/Coinsurance     Preventive Services <sup>7</sup> Preventive Services <sup>7</sup> Covered in Full     Vision Services       Children's Vision Exam (1 exam per year)     Covered in Full     Covered in Full       Children's Sug Glasses or Contacts (1 pair per year)     Covered in Full     Miscellaneous Services       Accidental Dental Services     Deductible/Coinsurance     Deductible/Coinsurance       Accidental Dental Services     Deductible/Coinsurance     Accidental Dental Services       Accidental Dental Services (any place of service)     Deductible/Coinsurance </td <td></td> <td></td> <td></td>			
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       Maternity Services     PA     Deductible/Coinsurance       Prenatal Care     Deductible/Coinsurance       Delivery and Inpatient Services     PA*     Deductible/Coinsurance       Preventive Services <sup>7</sup> Covered in Full       Vision Services <sup>7</sup> Covered in Full       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 <sup>8</sup> (1 exam/year)     Covered in Full       Miscellaneous Services     Deductible/Coinsurance       Accidental Dental Services (any place of service)     Deductible/Coinsurance		e 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         Maternity Services       PA       Deductible/Coinsurance         Prenatal Care       Deductible/Coinsurance       Deductible/Coinsurance         Delivery and Inpatient Services       PA*       Deductible/Coinsurance         Preventive Services <sup>7</sup> Covered in Full       Vision Services         Children's Vision Exam (1 exam per year)       Covered in Full       Vision Services         Routine Vision Exam for Adults <sup>8</sup> (1 exam/year)       Covered in Full       Vision Services         Accidental Dental Services (any place of service)       Deductible/Coinsurance       Anesthesia Services (any place of service)         Allergy Testing       Not Covered       Anesthesia Services (any place of service)       Deductible/Coinsurance         Autism Spectrum Disorder Treatment       Deductible/Coinsurance       Corread in Full         Correadic/Pulmonary Rehabilitation (up to 36 visits/year)       Deductible/Coinsurance         Attism Spectrum Disorder Treatment       Deductible/Coinsurance         Correadic/Pulmonary Rehabilitati			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       PA       Deductible/Coinsurance         Delivery and Inpatient Services       PA*       Deductible/Coinsurance         Delivery and Inpatient Services       PA*       Deductible/Coinsurance         Preventive Services <sup>7</sup> Covered in Full         Vision Services       Covered in Full         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 <sup>8</sup> (1 exam/year)       Covered in Full         Miscellaneous 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	Outpatient Surgical - Physician Services	PA	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       PA       Deductible/Coinsurance         Delivery and Inpatient Services       PA*       Deductible/Coinsurance         Delivery and Inpatient Services       PA*       Deductible/Coinsurance         Preventive Services <sup>7</sup> Covered in Full         Vision Services       Covered in Full         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 <sup>8</sup> (1 exam/year)       Covered in Full         Miscellaneous 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	Outpatient - All Other Services <sup>5</sup>		Deductible/Coinsurance
Inpatient - Physician and Surgical Services PA Deductible/Coinsurance Inpatient - Rehabilitation (limited to 60 days/year) PA Deductible/Coinsurance Maternity Services Preventive Services Preventive Services Preventive Services' Children's Vision Exam (1 exam per year) Children's Eye Glasses or Contacts (1 pair per year) Covered in Full Children's Eye Glasses or Contacts (1 pair per year) Routine Vision Exam for Adults <sup>®</sup> (1 exam/year) Miscellaneous Services Accidental Dental Services Accidental Services Accidental Services Accidental Services Accidental Services Actives Acti		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 <sup>7</sup> 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 <sup>8</sup> (1 exam/year) Covered in Full Miscellaneous Services Accidental Dental Services Accidental Dental Services (any place of service) Deductible/Coinsurance Allergy Testing Not Covered Anesthesia Services (any place of service) Deductible/Coinsurance Cardiac/Pulmonary Rehabilitation (up to 36 visits/year) Deductible/Coinsurance Cagnitive Rehabilitation Therapy (up to 20 visits/year) Habilitative Services		PA	Deductible/Coinsurance
Maternity Services       Deductible/Coinsurance         Prenatal Care       Deductible/Coinsurance         Delivery and Inpatient Services       PA*         Preventive Services       Covered in Full         Vision Services       Covered in Full         Vision Services       Covered in Full         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 <sup>8</sup> (1 exam/year)       Covered in Full         Miscellaneous Services       Deductible/Coinsurance         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       Habilitative Services		PA	
Prenatal Care       Deductible/Coinsurance         Delivery and Inpatient Services       PA*       Deductible/Coinsurance         Preventive Services       Covered in Full         Vision Services       Covered in Full         Vision Services       Covered in Full         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 <sup>8</sup> (1 exam/year)       Covered in Full         Miscellaneous Services       Deductible/Coinsurance         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       Habilitative Services       Deductible/Coinsurance		I	·
Preventive Services       Covered in Full         Vision Services       Covered in Full         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 <sup>8</sup> (1 exam/year)       Covered in Full         Miscellaneous Services       Covered         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       Deductible/Coinsurance	-		Deductible/Coinsurance
Preventive Services <sup>7</sup> Covered in Full         Vision Services       Covered in Full         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 <sup>8</sup> (1 exam/year)       Covered in Full         Miscellaneous Services       Covered in Full         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       Identification for the period of the	Delivery and Inpatient Services	PA*	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 <sup>8</sup> (1 exam/year)       Covered in Full         Miscellaneous Services       Covered in Full         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       Habilitative Services	Preventive Services		· · · · · · · · · · · · · · · · · · ·
Children's Vision Exam (1 exam per year)Covered in FullChildren's Eye Glasses or Contacts (1 pair per year)Deductible/CoinsuranceRoutine Vision Exam for Adults <sup>8</sup> (1 exam/year)Covered in FullMiscellaneous ServicesAccidental Dental ServicesAccidental Dental ServicesDeductible/CoinsuranceAllergy TestingNot CoveredAnesthesia Services (any place of service)Deductible/CoinsuranceAutism Spectrum Disorder TreatmentDeductible/CoinsuranceCardiac/Pulmonary Rehabilitation (up to 36 visits/year)Deductible/CoinsuranceCognitive Rehabilitation Therapy (up to 20 visits/year)Deductible/CoinsuranceHabilitative ServicesImage: Comparison of the period of th	Preventive Services <sup>7</sup>		Covered in Full
Children's Eye Glasses or Contacts (1 pair per year)Deductible/CoinsuranceRoutine Vision Exam for Adults <sup>8</sup> (1 exam/year)Covered in FullMiscellaneous ServicesDeductible/CoinsuranceAccidental Dental ServicesDeductible/CoinsuranceAllergy TestingNot CoveredAnesthesia Services (any place of service)Deductible/CoinsuranceAutism Spectrum Disorder TreatmentDeductible/CoinsuranceCardiac/Pulmonary Rehabilitation (up to 36 visits/year)Deductible/CoinsuranceCognitive Rehabilitation Therapy (up to 20 visits/year)Deductible/CoinsuranceHabilitative ServicesHabilitative Services	Vision Services		
Routine Vision Exam for Adults <sup>8</sup> (1 exam/year)       Covered in Full         Miscellaneous Services       Deductible/Coinsurance         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       Habilitative Services	Children's Vision Exam (1 exam per 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       Habilitation Services	Children's Eye Glasses or Contacts (1 pair per year)		Deductible/Coinsurance
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       Habilitation Services	Routine Vision Exam for Adults <sup>8</sup> (1 exam/year)		Covered in Full
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       Image: Comparison of the service of the ser	Miscellaneous Services		
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     Habilitative Services	Accidental Dental Services		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     Deductible/Coinsurance	Allergy Testing		Not Covered
Cardiac/Pulmonary Rehabilitation (up to 36 visits/year)     Deductible/Coinsurance       Cognitive Rehabilitation Therapy (up to 20 visits/year)     Deductible/Coinsurance       Habilitative Services     Habilitative Services			Deductible/Coinsurance
Cognitive Rehabilitation Therapy (up to 20 visits/year)     Deductible/Coinsurance       Habilitative Services	Autism Spectrum Disorder Treatment		Deductible/Coinsurance
Cognitive Rehabilitation Therapy (up to 20 visits/year)     Deductible/Coinsurance       Habilitative Services	Cardiac/Pulmonary Rehabilitation (up to 36 visits/year)		Deductible/Coinsurance
Habilitative Services			
(Physical, Speech, Occupational Therapy - 20 visits per therapy type per year) Deductible/Coinsurance	Habilitative Services		
			Deductible/Coinsurance

РА	= Prior Authorization	In Network Benefits Only <sup>1</sup> (You Pay)
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 <sup>9</sup>		Not Covered
Rehabilitative Services		
(Physical, Speech, Occupational Therapy - 20 visits per therapy type per year)		Deductible/Coinsurance
Routine Dental Care (Pediatric dental coverage or a stand-alone d	ental 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>10</sup>	PA	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment		
Separate Rx Deductible		Does Not Apply; Under Medical Deductible.
See formulary to determine tier and if medication is preventi	ve. Diabetic test strips o	are included. Drugs are available in Retail setting
(30-day supply) at coinsurance or 1 copay or usin	ng Mail Order <sup>11</sup> (90-da	y supply) at coinsurance or 2 copays.
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		\$10 Copay
Tier 2 - Preferred Drugs <sup>12</sup>		\$50 Copay
Tier 2 - Preferred Insulin Copay		\$15 Copay
Tier 3 - Non-Preferred Drugs <sup>12</sup>		\$100 Copay after Deductible
Tier 4 - Specialty Drugs	PA	Deductible/30% Coinsurance
Supplies & Equipment		
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)).

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

<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 innetwork 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 <u>www.commongroundhealthcare.org/coverage-details</u> 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>If you purchased a plan that includes routine vision exams for adults, refraction and dilation are not included in the adult eye exam.

<sup>9</sup>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).

<sup>10</sup>Please refer to the Certificate of Coverage to determine what oral surgery procedures are covered.

<sup>11</sup>Only certain Prescription Drug products are available through mail order.

<sup>12</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>13</sup>Copay is applied per provider, per date of service.