COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 2400/80/Copay 35 — 94%
Silver 0 Ded/Copay 5/Max 600 CSR

(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible	$0	$2,500 single/$5,000 family
Coinsurance (applies only to certain services)	20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)	$600 single/$1,200 family	$5,000 single/$10,000 family
Office Visits		
Primary Care Provider Visit (to treat an illness or injury)[1]	$5 Copay	Deductible/Coinsurance
Obstetrics/Gynecology Visit	$5 Copay	Deductible/Coinsurance
Specialist Visit	$10 Copay	Deductible/Coinsurance
Chiropractic Visit	$5 Copay	Deductible/Coinsurance
Hearing Exam	$5 Copay	Deductible/Coinsurance
Diagnostic Services		
Diagnostic Laboratory Tests	Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays	Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only) ✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse		
Outpatient - Office	$5 Copay	Deductible/Coinsurance
Outpatient - All Other Services	Deductible/Coinsurance	Deductible/Coinsurance
Transitional	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient ✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services		
Emergency Room[2] (waived if admitted)	$100 Copay	$100 Copay
Physician Services	Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care	$5 Copay	Deductible/Coinsurance
Ambulance (ground and air)[3] ✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services		
Outpatient Surgical/Ambulatory Surgical Care Centers ✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services ✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services		
Prenatal Care	Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services ✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services		
Preventive Service[4]	Covered in Full	No Coverage
Vision Services		
Children's Vision Exam (1 exam per year)	Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)	Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)	Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[5]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[6]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[7]		Please see below.[7]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[8] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive		Tier 1 — $5 Copay Tier 2 — $15 Copay Tier 3 — $35 Copay **Preventive** - $0 (see formulary for details)	Tier 1 — $5 Copay Tier 2 — $15 Copay Tier 3 — $35 Copay **Preventive** - $0 (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2]Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

[3] Prior Authorization is only required for non-emergent ground and air ambulance.

[4] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[5]Examples 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.

[6] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[7] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[8] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 3600/80 — 94%
Silver 0 Ded/Copay 5/Max 1000 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$0	$2,500 single/$5,000 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$1,000 single/$2,000 family	$5,000 single/$10,000 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		$5 Copay	Deductible/Coinsurance
Obstetrics/Gynecology Visit		$5 Copay	Deductible/Coinsurance
Specialist Visit		$10 Copay	Deductible/Coinsurance
Chiropractic Visit		$5 Copay	Deductible/Coinsurance
Hearing Exam		$5 Copay	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		$5 Copay	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room[2] (waived if admitted)		$100 Copay	$100 Copay
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		$5 Copay	Deductible/Coinsurance
Ambulance (ground and air)[3]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[4]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[5]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[6]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[7]		Please see below.[7]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[8] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1 — $10 Copay Tier 2 — $15 Copay Tier 3 — $40 Copay Preventive - $0 (see formulary for details)	Tier 1 — $10 Copay Tier 2 — $15 Copay Tier 3 — $40 Copay Preventive - $0 (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2]Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

[3] Prior Authorization is only required for non-emergent ground and air ambulance.

[4] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[5]Examples 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.

[6] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[7] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[8] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 2400/80/Copay 35 — 87%
Silver 0 Ded/Copay 25 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$0	$2,500 single/$5,000 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$2,250 single/$4,500 family	$5,000 single/$10,000 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		$25 Copay	Deductible/Coinsurance
Obstetrics/Gynecology Visit		$25 Copay	Deductible/Coinsurance
Specialist Visit		$40 Copay	Deductible/Coinsurance
Chiropractic Visit		$25 Copay	Deductible/Coinsurance
Hearing Exam		$25 Copay	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		$25 Copay	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room[2] (waived if admitted)		$200 Copay	$200 Copay
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		$25 Copay	Deductible/Coinsurance
Ambulance (ground and air)[3]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[4]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[5]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[6]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[7]		Please see below.[7]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[8] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1 — $10 Copay Tier 2 — $50 Copay Tier 3 — $75 Copay **Preventive** - $0 (see formulary for details)	Tier 1 — $10 Copay Tier 2 — $50 Copay Tier 3 — $75 Copay **Preventive** - $0 (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2]Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

[3] Prior Authorization is only required for non-emergent ground and air ambulance.

[4] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[5]Examples 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.

[6] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[7] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[8] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 3600/80 — 87%
Silver 0 Ded/Copay 30 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$0	$2,500 single/$5,000 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$2,250 single/$4,500 family	$5,000 single/$10,000 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		$30 Copay	Deductible/Coinsurance
Obstetrics/Gynecology Visit		$30 Copay	Deductible/Coinsurance
Specialist Visit		$40 Copay	Deductible/Coinsurance
Chiropractic Visit		$30 Copay	Deductible/Coinsurance
Hearing Exam		$30 Copay	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		$30 Copay	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room[2] (waived if admitted)		$200 Copay	$200 Copay
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		$30 Copay	Deductible/Coinsurance
Ambulance (ground and air)[3]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[4]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[5]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[6]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[7]		Please see below.[7]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[8] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1 — $10 Copay Tier 2 — $50 Copay Tier 3 — $75 Copay **Preventive** - $0 (see formulary for details)	Tier 1 — $10 Copay Tier 2 — $50 Copay Tier 3 — $75 Copay **Preventive** - $0 (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2]Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

[3] Prior Authorization is only required for non-emergent ground and air ambulance.

[4] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[5]Examples 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.

[6] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[7] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[8] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 1800/80 — 94%
Silver 0 Ded/Max 550 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$0	$2,500 single/$5,000 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$550 single/$1,100 family	$5,000 single/$10,000 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room		Deductible/Coinsurance	In Network Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)[2]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[3]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[5]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[6]		Please see below.[6]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[7] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

This is a Schedule of Benefits only and 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 Member Certificate and any amendments to your Benefit Plan. If you have questions regarding Common Ground Healthcare Cooperative Benefits, please call Customer Service at 1-877-514-CGHC (2442).

✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2] Prior Authorization is only required for non-emergent ground and air ambulance.

[3] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[4] Examples 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.

[5] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[6] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[7] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 2400/80 — 94%
Silver 0 Ded/Max 830 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$0	$2,500 single/$5,000 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$830 single/$1,660 family	$5,000 single/$10,000 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room		Deductible/Coinsurance	In Network Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)[2]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[3]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[5]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[6]		Please see below.[6]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[7] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2] Prior Authorization is only required for non-emergent ground and air ambulance.

[3] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[4] Examples 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.

[5] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[6] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[7] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver HSA 3000/80 — 94%
Silver 50 Ded/Max 760 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$50 self only/$100 family[1]	$2,500 self only/$5,000 family[1]
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$760 self only / $1,520 family[1]	$5,000 self only / $10,000 family[1]
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[2]		Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room[3] (waived if admitted)		Deductible/Coinsurance	Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/ Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[5]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[6]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[7]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[8]		Please see below.[8]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[9] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1] If you have more than one covered person under your policy, the family deductible must be satisfied before coinsurance will apply. In addition, the Family Out-of-Pocket must be met before the Plan will pay services in full.

[2] Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[3] Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

[4] Prior Authorization is only required for non-emergent ground and air ambulance.

[5] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[6] Examples 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.

[7] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[8] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[9] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 1800/80 — 87%
Silver 150/80 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$150 single/$300 family	$2,500 single/$5,000 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$2,250 single/$4,500 family	$5,000 single/$10,000 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room		Deductible/Coinsurance	In Network Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)[2]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[3]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[5]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[6]		Please see below.[6]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[7] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

This is a Schedule of Benefits only and 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 Member Certificate and any amendments to your Benefit Plan. If you have questions regarding Common Ground Healthcare Cooperative Benefits, please call Customer Service at 1-877-514-CGHC (2442).

✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2] Prior Authorization is only required for non-emergent ground and air ambulance.

[3] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[4] Examples 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.

[5] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[6] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[7] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 2400/80 — 87%
Silver 200/80 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$200 single/$400 family	$2,500 single/$5,000 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$2,250 single/$4,500 family	$5,000 single/$10,000 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room		Deductible/Coinsurance	In Network Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)[2]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[3]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[5]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[6]		Please see below.[6]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[7] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2] Prior Authorization is only required for non-emergent ground and air ambulance.

[3] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[4] Examples 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.

[5] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[6] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[7] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver HSA 3000/80 — 87%
Silver 250/80 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$250 self only/$500 family[1]	$2,500 self only/$5,000 family[1]
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$2,250 self only / $4,500 family[1]	$5,000 self only / $10,000 family[1]
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[2]		Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room[3] (waived if admitted)		Deductible/Coinsurance	Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/ Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[5]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[6]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[7]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[8]		Please see below.[8]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[9] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1] If you have more than one covered person under your policy, the family deductible must be satisfied before coinsurance will apply. In addition, the Family Out-of-Pocket must be met before the Plan will pay services in full.

[2] Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[3] Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

[4] Prior Authorization is only required for non-emergent ground and air ambulance.

[5] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[6] Examples 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.

[7] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[8] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[9] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 1800/80 — 73%
Silver 1500/80 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$1,500 single/$3,000 family	$3,000 single/$6,000 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$5,450 single/$10,900 family	$10,900 single/$21,800 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room		Deductible/Coinsurance	In Network Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)[2]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[3]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[5]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[6]		Please see below.[6]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[7] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2] Prior Authorization is only required for non-emergent ground and air ambulance.

[3] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[4] Examples 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.

[5] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[6] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[7] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 2400/80 — 73%
Silver 1600/80 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$1,600 single/$3,200 family	$3,200 single/$6,400 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$5,450 single/$10,900 family	$10,900 single/$21,800 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room		Deductible/Coinsurance	In Network Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)[2]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[3]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[5]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[6]		Please see below.[6]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[7] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Tier 1—Deductible/Coinsurance Tier 2—Deductible/Coinsurance Tier 3—Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2] Prior Authorization is only required for non-emergent ground and air ambulance.

[3] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[4] Examples 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.

[5] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[6] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[7] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver HSA 3000/80 — 73%
Silver 1900/80 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$1,900 self only/$3,800 family[1]	$3,800 self only/$7,600 family[1]
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$4,500 self only / $9,000 family[1]	$9,000 self only / $18,000 family[1]
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[2]		Deductible/Coinsurance	Deductible/Coinsurance
Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room[3] (waived if admitted)		Deductible/Coinsurance	Deductible/Coinsurance
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
Ambulance (ground and air)[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/ Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[5]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[6]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[7]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[8]		Please see below.[8]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[9] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

[1] If you have more than one covered person under your policy, the family deductible must be satisfied before coinsurance will apply. In addition, the Family Out-of-Pocket must be met before the Plan will pay services in full.

[2] Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[3] Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

[4] Prior Authorization is only required for non-emergent ground and air ambulance.

[5] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[6] Examples 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.

[7] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[8] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[9] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 2400/80/Copay 35 — 73%
Silver 2400 Copay 30 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$2,400 single/$4,800 family	$4,800 single/$9,600 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$5,450 single/$10,900 family	$10,900 single/$21,800 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		$30 Copay	Deductible/Coinsurance
Obstetrics/Gynecology Visit		$30 Copay	Deductible/Coinsurance
Specialist Visit		$50 Copay	Deductible/Coinsurance
Chiropractic Visit		$30 Copay	Deductible/Coinsurance
Hearing Exam		$30 Copay	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		$30 Copay	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room[2] (waived if admitted)		$250 Copay	$250 Copay
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		$30 Copay	Deductible/Coinsurance
Ambulance (ground and air)[3]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[4]		Covered in Full	No Coverage
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[5]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[6]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[7]		Please see below.[7]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[8] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1 — $20 Copay Tier 2 — $50 Copay Tier 3 — $75 Copay **Preventive** - $0 (see formulary for details)	Tier 1 — $20 Copay Tier 2 — $50 Copay Tier 3 — $75 Copay **Preventive** - $0 (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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[1]Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[2]Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

[3] Prior Authorization is only required for non-emergent ground and air ambulance.

[4] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[5]Examples 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.

[6] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[7] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[8] Only certain Prescription Drug products are available through mail order.

COMMON GROUND
HEALTHCARE COOPERATIVE

Silver 3600/80 — 73%
Silver 2400 Copay 35 CSR

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$2,400 single/$4,800 family	$4,800 single/$9,600 family
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$5,450 single/$10,900 family	$10,900 single/$21,800 family
Office Visits			
Primary Care Provider Visit (to treat an illness or injury)[1]		$35 Copay	Deductible/Coinsurance
Obstetrics/Gynecology Visit		$35 Copay	Deductible/Coinsurance
Specialist Visit		$50 Copay	Deductible/Coinsurance
Chiropractic Visit		$35 Copay	Deductible/Coinsurance
Hearing Exam		$35 Copay	Deductible/Coinsurance
Diagnostic Services			
Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
Outpatient - Office		$35 Copay	Deductible/Coinsurance
Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
Transitional		Deductible/Coinsurance	Deductible/Coinsurance
Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
Emergency Room[2] (waived if admitted)		$250 Copay	$250 Copay
Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care		$35 Copay	Deductible/Coinsurance
Ambulance (ground and air)[3]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
Outpatient Surgical/Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
Delivery and Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
Preventive Service[4]		Covered in Full	No Covearge
Vision Services			
Children's Vision Exam (1 exam per year)		Covered in Full	Deductible/Coinsurance
Children's Eye Glasses (1 pair per year)		Deductible/Coinsurance	Deductible/Coinsurance
Adult Vision Exam (1 exam per 2 years)		Covered in Full	Deductible/Coinsurance

Other Services			
Transplants[5]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
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Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[6]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[7]		Please see below.[7]	
Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[8] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Tier 1 — $20 Copay Tier 2 — $50 Copay Tier 3 — $75 Copay **Preventive** - $0 (see formulary for details)	Tier 1 — $20 Copay Tier 2 — $50 Copay Tier 3 — $75 Copay **Preventive** - $0 (see formulary for details)
Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids and Cochlear Implants for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance

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[3] Prior Authorization is only required for non-emergent ground and air ambulance.

[4] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

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