

2026 Schedule of Benefits

Plan Name: CareSource (Common Ground Healthcare) Silver Standard
\$700 CSR 87% - Vision Exam

Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2026]
Last Coverage Change Date	[01/01/2025]

[Dependent information can be found at the end of this document.]

Highlights

Annual Deductible*	Individual: \$700 Family: \$1,400
Coinsurance	30%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: \$3,300 Family: \$6,600



- * Deductible: The individual Deductible applies to each covered family member. No one person can contribute more than the individual Deductible amount. Once two or more covered family members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Calendar Year.
- ** Out-of-Pocket Maximum: The individual Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Preventive Services⁶ As defined by federal & state law	No charge	Refer to your Certificate of Coverage
Office Visits² Teladoc	No charge	None
Primary		
Includes Primary Care Provider and Mental Health/Substance Abuse	\$20 copay	None
Specialist	\$40 copay	None
Urgent Care¹	\$30 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services¹		
Lab	30% coinsurance after deductible	None
X-Ray/Radiology	30% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	30% coinsurance after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Certificate of Coverage
Diagnostic ¹	30% coinsurance after deductible	None
Inpatient Services		
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	1 visit per physician per day
Skilled Nursing Facility	30% coinsurance after deductible	30 day limit per stay
Outpatient Services		
Facility Fee	30% coinsurance after deductible	None
Physician/Surgeon Fees	30% coinsurance after deductible	None
Maternity Services¹		
Prenatal Visit, Office Visits, and Postpartum Care	30% coinsurance after deductible	None
Inpatient Services	30% coinsurance after deductible	None
Outpatient Services	30% coinsurance after deductible	None
Ambulance Services	30% coinsurance after deductible	Balance billing may apply to emergency ground transportation for out-of-network providers.
Emergency Health Care Services⁵		
Emergency Room Facility	30% coinsurance after deductible	If admitted to the hospital directly from the Emergency Department, these services will be covered the same as inpatient services and the applicable copayment and coinsurance will apply.
Emergency Room Physician	30% coinsurance after deductible	
Habilitative Services		
Physical/Occupational Therapy	\$20 copay per therapy type per day	20 visits each per Benefit Year If received from a Chiropractor, see Chiropractic Care Services for cost share.
Speech Therapy	\$20 copay per therapy type per day	20 visits per Benefit Year
Manipulation Therapy	30% coinsurance after deductible	None If received from a Chiropractor, see Chiropractor Services for cost share

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical/Occupational Therapy	\$20 copay per therapy type per day	20 visits each per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Speech Therapy	\$20 copay per therapy type per day	20 visits per Benefit Year
Pulmonary Rehabilitation	30% coinsurance after deductible	36 visits per Benefit Year
Cardiac Rehabilitation Services	30% coinsurance after deductible	36 visits per Benefit Year
Inpatient Rehabilitation	30% coinsurance after deductible	60 days per Benefit Year
Manipulation Therapy	30% coinsurance after deductible	None If received from a Chiropractor, see Chiropractor Care Services for cost share.
Post-Cochlear Implant Aural Therapy	30% coinsurance after deductible	30 visits per Benefit Year
Cognitive Rehabilitation Therapy	30% coinsurance after deductible	20 visits per Benefit Year
Other Rehabilitative Services Includes Chemotherapy, Dialysis, and Radiation	30% coinsurance after deductible	Refer to your Certificate of Coverage
Chiropractor Care Services⁴		
X-Ray/Radiology	30% coinsurance after deductible	None
Rehabilitative Services		
Physical Therapy	\$20 copay per therapy type per day	Limits for Physical Therapy apply
Manipulation Therapy	\$20 copay	None
Habilitation Services		
Physical Therapy	\$20 copay per therapy type per day	Limits for Physical Therapy apply
Manipulation Therapy	\$20 copay	None
Autism Spectrum Disorder Services		
Physical/Occupational Therapy	\$20 copay per therapy type per day	None
Speech Therapy	\$20 copay per therapy type per day	None
Adaptive Behavior Treatment	30% coinsurance after deductible	Includes Applied Behavior Analysis (ABA)

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Behavioral Health Services		
Office Visits ²	\$20 copay	None
Outpatient Services ¹		
Intensive Outpatient Program (IOP) Services	30% coinsurance after deductible	None
Partial Hospitalization Program (PHP) Services	30% coinsurance after deductible	None
Residential Services	30% coinsurance after deductible	None
Opioid Treatment Program	30% coinsurance after deductible	None
Inpatient Services ¹	30% coinsurance after deductible	None
Transplant Services	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Certificate of Coverage
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services, and outpatient services	None
Home Health		
Home Infusion Therapy	30% coinsurance after deductible	60 combined visits with All Other Services per Benefit Year
All Other Services	30% coinsurance after deductible	60 combined visits with Home Infusion Therapy per Benefit Year
Hospice Care	30% coinsurance after deductible	None
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	30% coinsurance after deductible	None
Durable Medical Equipment	30% coinsurance after deductible	None
Medical Supplies	30% coinsurance after deductible	None
Orthotic Device	30% coinsurance after deductible	None
Prosthetics	30% coinsurance after deductible	None
Hearing Aids	30% coinsurance after deductible	1 hearing aid per hearing-impaired ear every 36 months.

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Prescription Drugs Preventive Drugs Generic Drugs Preferred Brand Drugs Preferred Insulin Non-Preferred Brand Drugs Specialty Drugs Oral Chemotherapy Drugs	No charge \$10 copay \$20 copay \$15 copay \$60 copay after deductible \$250 copay after deductible 30% coinsurance after deductible	Up to a 30-day supply for brand name drugs filled at Retail and Specialty Drugs Up to a 90-day supply for all other Retail and Mail Order. Any copays shown are for a 30-day supply. 90-day supplies available at 3 times the copay for Retail and 2 times the copay for Mail Order.
Vision (pediatric) Children's Eye Exam Low Vision Testing and Aids Children's Eyewear	No charge 30% coinsurance after deductible 30% coinsurance after deductible	1 routine eye exam per Benefit Year None Limited to one pair of glasses or a 12-month supply of contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed. Refer to your Certificate of Coverage for additional eyewear options that may have an additional charge.
Vision (adults) Eye Exam	No charge	1 routine eye exam per Benefit Year. Refractions and dilation are not covered.
Other Dental Services Accidental Dental Dental Anesthesia	30% coinsurance after deductible 30% coinsurance after deductible	None Refer to your Certificate of Coverage

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- ¹ When receiving covered services at an office, urgent care or hospital visit, member may be subject to cost share charges from both the facility and the physician/surgeon.
- ² Charge shown for the office visit. Additional services rendered during the office visit may be subject to their applicable additional copayment or deductible/coinsurance as specified in the Schedule of Benefits. Charges applied per provider, per date of service.
- ³ Member cost-sharing may vary based on the place of service where it is rendered. Additional services and evaluations rendered during the visit may be subject to their applicable additional copayment or deductible/coinsurance as specified in the Schedule of Benefits.
- ⁴ Each modality will be subject to an additional copay or will apply towards your deductible and/or coinsurance.
- ⁵ Copay applies to the facility ER charge. All other charges rendered as part of your ER visit are subject to their applicable additional copayment or deductible/coinsurance as specified in this Schedule of Benefits.
- ⁶ The Affordable Care Act (ACA) provides for coverage of certain preventive services based on age, gender and other health factors at no cost to the member. Visit [www.commongroundhealthcare.org/coverage-details] for a complete listing. During a preventive care visit, you may receive services that aren't required to be covered at no cost to you under the ACA. Those services may require a copay, or the charges may apply towards your deductible and/or coinsurance.

Prior Authorization: Some services and items require prior authorization, which is the process used by the Plan to determine if it meets medical necessity and coverage requirements prior to the service being provided. The provider, or the member when using an out-of-network provider, is responsible for obtaining prior authorization for the services and items described on the prior authorization list. Please refer to the prior authorization list attached to your Certificate of Coverage for additional detail or you can obtain the list at www.caresource.com/mp-WI-pa.

This Schedule of Benefits is a summary of your financial responsibility when you receive health care services from a physician, pharmacy, facility, or other provider. All Covered Services are subject to the conditions, exclusions, limitations, terms, and rules of the Certificate of Coverage including any rider/enhancements or amendments. Except as otherwise provided in the Certificate of Coverage, Covered Services must be provided to you by a network provider and medically necessary. The Plan does not cover all health care service expenses. In the event of any discrepancy between this Schedule of Benefits and your Certificate of Coverage, the Certificate of Coverage shall control. For more detailed information about your Covered Services, please refer to the Certificate of Coverage at www.caresource.com/marketplace.

For Covered Services listed in the Certificate of Coverage that are not specifically listed on this Schedule of Benefits, the cost sharing is equal to the coinsurance after the deductible.

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

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Dependent Information

Dependent Name	[John Doe]
Relationship to You	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2026]

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