

2026 Schedule of Benefits  
Plan Name: CareSource (Common Ground Healthcare) HSA Silver  
\$3500 - Vision Exam + Allergy Test

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: \$3,500<br>Family: \$7,000  |
| Coinsurance                                                                      | 20%                                     |
| Annual Out-of-Pocket Maximum**<br>(includes deductible, coinsurance, and copays) | Individual: \$8,500<br>Family: \$17,000 |



\* 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<br>(Network Providers Only) | Limit<br>(If Applicable)              |
|-----------------------------------------------------------------------------|-------------------------------------|---------------------------------------|
| <b>Preventive Services<sup>6</sup></b><br>As defined by federal & state law | No charge                           | Refer to your Certificate of Coverage |
| <b>Office Visits<sup>2</sup></b><br>Teladoc                                 | 20% coinsurance after deductible    | None                                  |
| Primary                                                                     |                                     |                                       |
| Includes Primary Care Provider and Mental Health/Substance Abuse            | \$15 copay after deductible         | None                                  |
| Specialist                                                                  | \$35 copay after deductible         | None                                  |
| <b>Urgent Care<sup>1</sup></b>                                              | 20% coinsurance after deductible    | None                                  |

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| Covered Service                                    | You Pay<br>(Network Providers Only) | Limit<br>(If Applicable)                                                                                                                                                                   |
|----------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Diagnostic Services<sup>1</sup></b>             |                                     |                                                                                                                                                                                            |
| Lab                                                | 20% coinsurance after deductible    | None                                                                                                                                                                                       |
| X-Ray/Radiology                                    | 20% coinsurance after deductible    | None                                                                                                                                                                                       |
| Advanced Imaging (PET, MRI, MRA, CT, SPECT)        | 20% coinsurance after deductible    | None                                                                                                                                                                                       |
| <b>Mammograms (Outpatient)</b>                     |                                     |                                                                                                                                                                                            |
| Preventive                                         | No charge                           | Refer to your Certificate of Coverage                                                                                                                                                      |
| Diagnostic <sup>1</sup>                            | 20% coinsurance after deductible    | None                                                                                                                                                                                       |
| <b>Inpatient Services</b>                          |                                     |                                                                                                                                                                                            |
| Facility Fee                                       | 20% coinsurance after deductible    | None                                                                                                                                                                                       |
| Physician/Surgeon Fees                             | 20% coinsurance after deductible    | 1 visit per physician per day                                                                                                                                                              |
| Skilled Nursing Facility                           | 20% coinsurance after deductible    | 30 day limit per stay                                                                                                                                                                      |
| <b>Outpatient Services</b>                         |                                     |                                                                                                                                                                                            |
| Facility Fee                                       | 20% coinsurance after deductible    | None                                                                                                                                                                                       |
| Physician/Surgeon Fees                             | 20% coinsurance after deductible    | None                                                                                                                                                                                       |
| <b>Maternity Services<sup>1</sup></b>              |                                     |                                                                                                                                                                                            |
| Prenatal Visit, Office Visits, and Postpartum Care | 20% coinsurance after deductible    | None                                                                                                                                                                                       |
| Inpatient Services                                 | 20% coinsurance after deductible    | None                                                                                                                                                                                       |
| Outpatient Services                                | 20% coinsurance after deductible    | None                                                                                                                                                                                       |
| <b>Ambulance Services</b>                          | 20% coinsurance after deductible    | Balance billing may apply to emergency ground transportation for out-of-network providers.                                                                                                 |
| <b>Emergency Health Care Services<sup>5</sup></b>  |                                     |                                                                                                                                                                                            |
| Emergency Room Facility                            | 20% 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                           | 20% coinsurance after deductible    |                                                                                                                                                                                            |
| <b>Habilitative Services</b>                       |                                     |                                                                                                                                                                                            |
| Physical/Occupational Therapy                      | 20% coinsurance after deductible    | 20 visits each per Benefit Year<br>If received from a Chiropractor, see Chiropractic Care Services for cost share.                                                                         |
| Speech Therapy                                     | 20% coinsurance after deductible    | 20 visits per Benefit Year                                                                                                                                                                 |
| Manipulation Therapy                               | 20% coinsurance after deductible    | None<br>If received from a Chiropractor, see Chiropractor Services for cost share                                                                                                          |

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| Covered Service                                                                 | You Pay<br>(Network Providers Only) | Limit<br>(If Applicable)                                                                                           |
|---------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>Rehabilitative Services</b>                                                  |                                     |                                                                                                                    |
| Physical/Occupational Therapy                                                   | 20% coinsurance after deductible    | 20 visits each per Benefit Year<br>If received from a Chiropractor, see Chiropractor Care Services for cost share. |
| Speech Therapy                                                                  | 20% coinsurance after deductible    | 20 visits per Benefit Year                                                                                         |
| Pulmonary Rehabilitation                                                        | 20% coinsurance after deductible    | 36 visits per Benefit Year                                                                                         |
| Cardiac Rehabilitation Services                                                 | 20% coinsurance after deductible    | 36 visits per Benefit Year                                                                                         |
| Inpatient Rehabilitation                                                        | 20% coinsurance after deductible    | 60 days per Benefit Year                                                                                           |
| Manipulation Therapy                                                            | 20% coinsurance after deductible    | None<br>If received from a Chiropractor, see Chiropractor Care Services for cost share.                            |
| Post-Cochlear Implant Aural Therapy                                             | 20% coinsurance after deductible    | 30 visits per Benefit Year                                                                                         |
| Cognitive Rehabilitation Therapy                                                | 20% coinsurance after deductible    | 20 visits per Benefit Year                                                                                         |
| Other Rehabilitative Services<br>Includes Chemotherapy, Dialysis, and Radiation | 20% coinsurance after deductible    | Refer to your Certificate of Coverage                                                                              |
| <b>Chiropractor Care Services<sup>4</sup></b>                                   |                                     |                                                                                                                    |
| X-Ray/Radiology                                                                 | 20% coinsurance after deductible    | None                                                                                                               |
| Rehabilitative Services                                                         |                                     |                                                                                                                    |
| Physical Therapy                                                                | 20% coinsurance after deductible    | Limits for Physical Therapy apply                                                                                  |
| Manipulation Therapy                                                            | 20% coinsurance after deductible    | None                                                                                                               |
| Habilitation Services                                                           |                                     |                                                                                                                    |
| Physical Therapy                                                                | 20% coinsurance after deductible    | Limits for Physical Therapy apply                                                                                  |
| Manipulation Therapy                                                            | 20% coinsurance after deductible    | None                                                                                                               |
| <b>Autism Spectrum Disorder Services</b>                                        |                                     |                                                                                                                    |
| Physical/Occupational Therapy                                                   | 20% coinsurance after deductible    | None                                                                                                               |
| Speech Therapy                                                                  | 20% coinsurance after deductible    | None                                                                                                               |
| Adaptive Behavior Treatment                                                     | 20% coinsurance after deductible    | Includes Applied Behavior Analysis (ABA)                                                                           |

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| Covered Service                                                                            | You Pay<br>(Network Providers Only)                                            | Limit<br>(If Applicable)                                       |
|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------|
| <b>Behavioral Health Services</b>                                                          |                                                                                |                                                                |
| Office Visits <sup>2</sup>                                                                 | \$15 copay after deductible                                                    | None                                                           |
| Outpatient Services <sup>1</sup>                                                           |                                                                                |                                                                |
| Intensive Outpatient Program (IOP) Services                                                | 20% coinsurance after deductible                                               | None                                                           |
| Partial Hospitalization Program (PHP) Services                                             | 20% coinsurance after deductible                                               | None                                                           |
| Residential Services                                                                       | 20% coinsurance after deductible                                               | None                                                           |
| Opioid Treatment Program                                                                   | 20% coinsurance after deductible                                               | None                                                           |
| Inpatient Services <sup>1</sup>                                                            | 20% coinsurance after deductible                                               | None                                                           |
| <b>Transplant Services</b>                                                                 | Covered the same as office visits, inpatient services, and outpatient services | Refer to your Certificate of Coverage                          |
| <b>Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder</b> | Covered the same as office visits, inpatient services, and outpatient services | None                                                           |
| <b>Home Health</b>                                                                         |                                                                                |                                                                |
| Home Infusion Therapy                                                                      | 20% coinsurance after deductible                                               | 60 combined visits with All Other Services per Benefit Year    |
| All Other Services                                                                         | 20% coinsurance after deductible                                               | 60 combined visits with Home Infusion Therapy per Benefit Year |
| <b>Hospice Care</b>                                                                        | 20% coinsurance after deductible                                               | None                                                           |
| <b>Medical Supplies, Durable Medical Equipment, and Appliances</b>                         |                                                                                |                                                                |
| Appliances                                                                                 | 20% coinsurance after deductible                                               | None                                                           |
| Durable Medical Equipment                                                                  | 20% coinsurance after deductible                                               | None                                                           |
| Medical Supplies                                                                           | 20% coinsurance after deductible                                               | None                                                           |
| Orthotic Device                                                                            | 20% coinsurance after deductible                                               | None                                                           |
| Prosthetics                                                                                | 20% coinsurance after deductible                                               | None                                                           |
| <b>Hearing Aids</b>                                                                        | 20% coinsurance after deductible                                               | 1 hearing aid per hearing-impaired ear every 36 months.        |

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| Covered Service                                                                                                                                                                                     | You Pay<br>(Network Providers Only)                                                                                                                                                                                        | Limit<br>(If Applicable)                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prescription Drugs</b><br>Preventive Drugs<br>Generic Drugs<br>Preferred Brand Drugs<br>Preferred Insulin<br><br>Non-Preferred Brand Drugs<br><br>Specialty Drugs<br><br>Oral Chemotherapy Drugs | No charge<br><br>\$15 copay after deductible<br><br>20% coinsurance after deductible<br>\$15 copay<br><br>50% coinsurance after deductible<br><br>50% coinsurance after deductible<br><br>20% coinsurance after deductible | Up to a 30-day supply for brand name drugs filled at Retail and Specialty Drugs<br><br>Up to a 90-day supply for all other Retail and Mail Order.<br><br>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.                        |
| <b>Vision (pediatric)</b><br>Children's Eye Exam<br>Low Vision Testing and Aids<br><br>Children's Eyewear                                                                                           | No charge<br><br>20% coinsurance after deductible<br><br>20% coinsurance after deductible                                                                                                                                  | 1 routine eye exam per Benefit Year<br><br>None<br><br>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. |
| <b>Vision (adults)</b><br>Eye Exam                                                                                                                                                                  | No charge                                                                                                                                                                                                                  | 1 routine eye exam per Benefit Year. Refractions and dilation are not covered.                                                                                                                                                                                                                                            |
| <b>Other Dental Services</b><br>Accidental Dental<br><br>Dental Anesthesia                                                                                                                          | 20% coinsurance after deductible<br><br>20% coinsurance after deductible                                                                                                                                                   | None<br><br>Refer to your Certificate of Coverage                                                                                                                                                                                                                                                                         |
| <b>Other Covered Services<sup>3</sup></b><br>Allergy Testing                                                                                                                                        | 20% coinsurance after deductible                                                                                                                                                                                           | None                                                                                                                                                                                                                                                                                                                      |

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- <sup>1</sup> 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.
- <sup>2</sup> 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.
- <sup>3</sup> 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.
- <sup>4</sup> Each modality will be subject to an additional copay or will apply towards your deductible and/or coinsurance.
- <sup>5</sup> Copay applies to the facility ER charge. All other charges rendered as part of your ER visit are subject to their applicable additional copayment or deductible/coinsurance as specified in this Schedule of Benefits.
- <sup>6</sup> The Affordable Care Act (ACA) provides for coverage of certain preventive services based on age, gender and other health factors at no cost to the member. Visit [[www.commongroundhealthcare.org/coverage-details](http://www.commongroundhealthcare.org/coverage-details)] for a complete listing. During a preventive care visit, you may receive services that aren't required to be covered at no cost to you under the ACA. Those services may require a copay, or the charges may apply towards your deductible and/or coinsurance.

**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](http://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](http://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.

Your CareSource marketplace plan was designed to meet certain requirements set by the Internal Revenue Service and qualifies as a high deductible health plan (HDHP). As such, your CareSource marketplace plan is compatible for use with a Health Savings Account (HSA). However, please be aware that CareSource is not offering or administering an HSA in conjunction with your CareSource marketplace HDHP. In addition, your enrollment in a CareSource marketplace HDHP is only one of the eligibility requirements for establishing and maintaining an HSA. You are responsible for determining whether you are eligible to establish an HSA. You should consult your financial, tax, or legal advisor for more information regarding your obligations and eligibility for establishing and maintaining an HSA.

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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