2026 Schedule of Benefits
Plan Name: CareSource (Common Ground Healthcare) Silver $800 CSR 87% ($20 PCP Copay) - 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: 800 Family: $1,600
Coinsurance	25%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $3,450 Family: $6,900

This summary shows in-network benefits only.

* 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 Services[6]		
As defined by federal & state law	No charge	Refer to your Certificate of Coverage
Office Visits[2]		
Teladoc	No charge	None
Primary		
Includes Primary Care Provider and Mental Health/Substance Abuse	$20 copay	None
Specialist	$40 copay	None
Urgent Care[1]	25% coinsurance after deductible	None

Learn more about CareSource and all our plan options at **www.caresource.com/marketplace.**

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services[1]		
Lab	25% coinsurance after deductible	None
X-Ray/Radiology	25% coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	25% coinsurance after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Certificate of Coverage
Diagnostic[1]	25% coinsurance after deductible	None
Inpatient Services		
Facility Fee	25% coinsurance after deductible	None
Physician/Surgeon Fees	25% coinsurance after deductible	1 visit per physician per day
Skilled Nursing Facility	25% coinsurance after deductible	30 day limit per stay
Outpatient Services		
Facility Fee	25% coinsurance after deductible	None
Physician/Surgeon Fees	25% coinsurance after deductible	None
Maternity Services[1]		
Prenatal Visit, Office Visits, and Postpartum Care	25% coinsurance after deductible	None
Inpatient Services	25% coinsurance after deductible	None
Outpatient Services	25% coinsurance after deductible	None
Ambulance Services	25% coinsurance after deductible	Balance billing may apply to emergency ground transportation for out-of-network providers.
Emergency Health Care Services[5]		
Emergency Room Facility	25% 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	25% coinsurance after deductible	
Habilitative Services		
Physical/Occupational Therapy	25% coinsurance after deductible	20 visits each per Benefit Year If received from a Chiropractor, see Chiropractic Care Services for cost share.
Speech Therapy	25% coinsurance after deductible	20 visits per Benefit Year
Manipulation Therapy	25% coinsurance after deductible	None If received from a Chiropractor, see Chiropractor Services for cost share

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical/Occupational Therapy	25% coinsurance after deductible	20 visits each per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Speech Therapy	25% coinsurance after deductible	20 visits per Benefit Year
Pulmonary Rehabilitation	25% coinsurance after deductible	36 visits per Benefit Year
Cardiac Rehabilitation Services	25% coinsurance after deductible	36 visits per Benefit Year
Inpatient Rehabilitation	25% coinsurance after deductible	60 days per Benefit Year
Manipulation Therapy	25% coinsurance after deductible	None If received from a Chiropractor, see Chiropractor Care Services for cost share.
Post-Cochlear Implant Aural Therapy	25% coinsurance after deductible	30 visits per Benefit Year
Cognitive Rehabilitation Therapy	25% coinsurance after deductible	20 visits per Benefit Year
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	25% coinsurance after deductible	Refer to your Certificate of Coverage
Chiropractor Care Services[4]		
X-Ray/Radiology	25% coinsurance after deductible	None
Rehabilitative Services		
Physical Therapy	25% coinsurance after deductible	Limits for Physical Therapy apply
Manipulation Therapy	$20 copay	None
Habilitation Services		
Physical Therapy	25% coinsurance after deductible	Limits for Physical Therapy apply
Manipulation Therapy	$20 copay	None
Autism Spectrum Disorder Services		
Physical/Occupational Therapy	25% coinsurance after deductible	None
Speech Therapy	25% coinsurance after deductible	None
Adaptive Behavior Treatment	25% 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	25% coinsurance after deductible	None
Partial Hospitalization Program (PHP) Services	25% coinsurance after deductible	None
Residential Services	25% coinsurance after deductible	None
Opioid Treatment Program	25% coinsurance after deductible	None
Inpatient Services[1]	25% 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	25% coinsurance after deductible	60 combined visits with All Other Services per Benefit Year
All Other Services	25% coinsurance after deductible	60 combined visits with Home Infusion Therapy per Benefit Year
Hospice Care	25% coinsurance after deductible	None
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	25% coinsurance after deductible	None
Durable Medical Equipment	25% coinsurance after deductible	None
Medical Supplies	25% coinsurance after deductible	None
Orthotic Device	25% coinsurance after deductible	None
Prosthetics	25% coinsurance after deductible	None
Hearing Aids	25% 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	No charge	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.
Generic Drugs	$5 copay	
Preferred Brand Drugs	$50 copay	
Preferred Insulin	$15 copay	
Non-Preferred Brand Drugs	25% coinsurance after deductible	
Specialty Drugs	40% coinsurance after deductible	
Oral Chemotherapy Drugs	25% coinsurance after deductible	
Vision (pediatric)		
Children's Eye Exam	No charge	1 routine eye exam per Benefit Year
Low Vision Testing and Aids	25% coinsurance after deductible	None
Children's Eyewear	25% coinsurance after deductible	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	25% coinsurance after deductible	None
Dental Anesthesia	25% coinsurance after deductible	Refer to your Certificate of Coverage

[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.

Dependent Information

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