2026 Schedule of Benefits
Plan Name: Low Premium Bronze 10600 $25 Generic Drugs + Adult Vision & Fitness

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: $10,600 Family: $21,200
Coinsurance	0%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $10,600 Family: $21,200

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 As defined by federal & state law	No charge	Refer to your Evidence of Coverage
Office Visits[2] Teladoc	No charge	Refer to your Evidence of Coverage
Primary		
Includes Primary Care Provider and Mental Health/Substance Abuse	No charge after deductible	None
Specialist	No charge after deductible	None
Urgent Care[1]	No charge 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	No charge after deductible	None
X-Ray/Radiology	No charge after deductible	None If received from a Chiropractor, see Chiropractic Care Services for cost share.
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	No charge after deductible	None
Mammograms (Outpatient)		
Preventive	No charge	Refer to your Evidence of Coverage
Diagnostic[1]	No charge after deductible	None
Inpatient Services		
Facility Fee	No charge after deductible	None
Physician/Surgeon Fees	No charge after deductible	1 visit per physician per day
Skilled Nursing Facility	No charge after deductible	None
Outpatient Services		
Facility Fee	No charge after deductible	None
Physician/Surgeon Fees	No charge after deductible	None
Maternity Services[1]		
Prenatal Visit, Office Visits, and Postpartum Care	No charge after deductible	None
Inpatient Services	No charge after deductible	None
Outpatient Services	No charge after deductible	None
Ambulance Services	No charge after deductible	None
Emergency Health Care Services[1]	No charge 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.
Habilitative Services		
Physical/Occupational Therapy	No charge after deductible	30 visits each per Benefit Year If received from a Chiropractor, see Chiropractic Care Services for cost share.
Speech Therapy	No charge after deductible	None
Manipulation Therapy	No charge after deductible	30 visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical/Occupational Therapy	No charge after deductible	30 visits each per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Speech Therapy	No charge after deductible	None
Pulmonary Rehabilitation	No charge after deductible	30 visits per Benefit Year
Cardiac Rehabilitation Services	No charge after deductible	36 visits per Benefit Year
Manipulation Therapy	No charge after deductible	30 visits per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Post-Cochlear Implant Aural Therapy	No charge after deductible	None
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	No charge after deductible	Refer to your Evidence of Coverage
Chiropractor Care Services		
X-Ray/Radiology	No charge after deductible	None
Rehabilitative Services		
Physical Therapy	No charge after deductible	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	No charge after deductible	Limits for Physical Therapy and Manipulation apply
Habilitation Services		
Physical Therapy	No charge after deductible	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	No charge after deductible	Limits for Physical Therapy and Manipulation apply
Chronic Pain Treatment		
Physical/Occupational Therapy	No charge after deductible	20 combined visits per event, in addition to any Rehabilitative and Habilitative visits
Chronic Pain Management Program	No charge after deductible	
Chiropractic/Osteopathic Manipulation Services	No charge after deductible	
Autism Spectrum Disorder Services		
Physical/Occupational Therapy	No charge after deductible	Combined limit with Habilitative Services
Speech Therapy	No charge after deductible	Combined limit with Habilitative Services
Adaptive Behavior Treatment	No charge after deductible	Includes Applied Behavior Analysis (ABA)

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Behavioral Health Services		
Office Visits[2]	No charge after deductible	None
Outpatient Services[1]		
Intensive Outpatient Program (IOP) Services	No charge after deductible	None
Partial Hospitalization Program (PHP) Services	No charge after deductible	None
Residential Services	No charge after deductible	None
Opioid Treatment Program	No charge after deductible	None
Inpatient Services[1]	No charge after deductible	None
Transplant Services	Covered the same as office visits, inpatient services, and outpatient services	Refer to your Evidence of Coverage
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Covered the same as office visits, inpatient services, and outpatient services	None
Home Health		
Private Duty Nursing	No charge after deductible	35 visits per Benefit Year. A visit equals 8 hours.
Home Infusion Therapy	No charge after deductible	Included in all other services limits
All Other Services	No charge after deductible	100 combined visits per Benefit Year. A visit equals at least 4 hours.
Hospice Care	No charge after deductible	Refer to your Evidence of Coverage
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	No charge after deductible	Refer to your Evidence of Coverage
Durable Medical Equipment	No charge after deductible	Refer to your Evidence of Coverage
Medical Supplies	No charge after deductible	Refer to your Evidence of Coverage
Orthotic Device	No charge after deductible	Refer to your Evidence of Coverage
Prosthetics	No charge after deductible	Refer to your Evidence of Coverage
Prescription Drugs		
Preventive Drugs	No charge	Up to a 30-day supply for Specialty Drugs
Generic Drugs	Up to $25 copay	Up to a 90-day supply for all other Retail and Mail Order.
Preferred Brand Drugs	No charge after deductible	Any copays shown are for a 30-day supply. 90-day supplies available at 3 times the copay.
Non-Preferred Brand Drugs	No charge after deductible	Insulin cost share not to exceed $35 and diabetic devices not to exceed $100 per 30-day supply in aggregate.
Specialty Drugs	No charge after deductible	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Vision (pediatric)		
Children's Eye Exam	No charge	1 routine eye exam per Benefit Year
Low Vision Testing and Aids	No charge	Limited to one evaluation and aid per Benefit Year.
Children's Eyewear	No charge	Limited to one pair of glasses or contact lenses per Benefit Year. If medically necessary, a replacement pair of glasses is allowed. Refer to your Evidence of Coverage for additional eyewear options that may have an additional charge.
Vision (adults)		
Eye Exam	40% coinsurance	IGNORE
Low Vision Testing and Aids		Limited to one evaluation and aid per Benefit Year.
Eyewear	No charge	IGNORE
Other Dental Services		
Accidental Dental	No charge after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	No charge after deductible	Refer to your Evidence of Coverage
Fitness Program	No charge	Refer to your Evidence of Coverage
Other Covered Services[3]		
Allergy Testing	Covered the same as office visits or diagnostic services	None
Allergy Injections	Covered the same as office visits	None
Allergy Serum	Covered the same as office visits or Medical Supplies, Durable Medical Equipment, and Appliances	None

[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.

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 Evidence of Coverage for additional detail or you can obtain the list at **www.caresource.com/mp-WV-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 Evidence of Coverage including any rider/enhancements or amendments. Except as otherwise provided in the Evidence 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 Evidence of Coverage, the Evidence of Coverage shall control. For more detailed information about your Covered Services, please refer to the Evidence of Coverage at **www.caresource.com/marketplace**.

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

You may view the Access Plan required by Health Benefit Plan Network Access and Adequacy Act online at [CareSource.com]. You may also contact us at 1-855-202-0622 to request a copy.

Dependent Information

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