2026 Schedule of Benefits
Plan Name: Low Premium Gold 1500 $20 Generic Drugs + Adult Vision & Fitness
35107NV002001301

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: $1,500 Family: $3,000
Coinsurance	25%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $8,400 Family: $16,800

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	$0	Refer to your Evidence of Coverage
Office Visits[2] Teladoc	$0	Refer to your Evidence of Coverage
Primary		
Includes Primary Care Provider, Mental Health/Substance Abuse, and Retail Clinics	$20 copay	None
Specialist	$50 copay	None
Urgent Care[1]	$40 copay	None

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Diagnostic Services[1]		
Lab	$30 copay	None
X-Ray/Radiology	25% coinsurance after deductible	None If received from a Chiropractor, see Chiropractic Care Services for cost share.
Advanced Imaging (PET, MRI, MRA, CT, SPECT)	25% coinsurance after deductible	None
Mammograms (Outpatient)		
Preventive	$0	Refer to your Evidence of Coverage
Diagnostic[1]	$0	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	100 Day limit per Benefit Year
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	$50 copay	None
Inpatient Services	25% coinsurance after deductible	None
Outpatient Services	25% coinsurance after deductible	None
Ambulance Services	25% coinsurance after deductible	Refer to your Evidence of Coverage
Emergency Health Care Services[1]	10% 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.
Habilitative Services		
Physical/Occupational Therapy	$20 copay	120 Combined max of inpatient/outpatient days/visits for PT/OT/ST per Benefit Year If received from a Chiropractor, see Chiropractic Care Services for cost share.
Speech Therapy[4]	$20 copay	120 Combined max of inpatient/outpatient days/visits for PT/OT/ST per Benefit Year
Manipulation Therapy	25% coinsurance after deductible	20 visits per Benefit Year

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services		
Physical/Occupational Therapy	$20 copay	120 Combined max of inpatient/outpatient days/visits for PT/OT/ST per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Speech Therapy[4]	$20 copay	120 Combined max of inpatient/outpatient days/visits for PT/OT/ST per Benefit Year
Pulmonary Rehabilitation	25% coinsurance after deductible	None
Cardiac Rehabilitation Services	25% coinsurance after deductible	None
Manipulation Therapy	25% coinsurance after deductible	20 visits per Benefit Year If received from a Chiropractor, see Chiropractor Care Services for cost share.
Post-Cochlear Implant Aural Therapy	$20 copay	Combined Limit with Speech Therapy
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	25% coinsurance after deductible	Refer to your Evidence of Coverage
Chiropractor Care Services		
X-Ray/Radiology	$50 copay	None
Rehabilitative Services		
Physical Therapy	$50 copay	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	$50 copay	Limits for Physical Therapy and Manipulation apply
Habilitation Services		
Physical Therapy	$50 copay	Limits for Physical Therapy and Manipulation apply
Manipulation Therapy	$50 copay	Limits for Physical Therapy and Manipulation apply
Autism Spectrum Disorder Services		
Physical/Occupational Therapy	$20 copay	None
Speech Therapy	$20 copay	None
Adaptive Behavior Treatment	$20 copay	Includes Applied Behavior Analysis (ABA)

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		
Primary Care Office Visit	$20 copay	Refer to your Evidence of Coverage
Specialist Office Visit	$50 copay	
Inpatient Facility	25% coinsurance after deductible	
Outpatient Facility	25% coinsurance after deductible	
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder		
Primary Care Office Visit	$20 copay	None
Specialist Office Visit	$50 copay	
Inpatient Facility	25% coinsurance after deductible	
Outpatient Facility	25% coinsurance after deductible	
Home Health		
Private Duty Nursing	25% coinsurance after deductible	None
All Other Services	25% coinsurance after deductible	None
Hospice Care	25% coinsurance after deductible	Refer to your Evidence of Coverage

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Medical Supplies, Durable Medical Equipment, and Appliances		
Appliances	25% coinsurance after deductible	Refer to your Evidence of Coverage
Durable Medical Equipment	25% coinsurance after deductible	Refer to your Evidence of Coverage
Medical Supplies	25% coinsurance after deductible	Refer to your Evidence of Coverage
Orthotic Device	25% coinsurance after deductible	Refer to your Evidence of Coverage
Prosthetics	25% coinsurance after deductible	Refer to your Evidence of Coverage
Hearing Aids	25% coinsurance after deductible	1 hearing aid per hearing-impaired ear every 36 months.
Prescription Drugs		
Preventive Drugs	$0	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 2.5 times the copay for Mail Order. Insulin cost share not to exceed $35 per 30-day supply in aggregate.
Generic Drugs	Up to $20 copay	
Preferred Brand Drugs	Up to $50 copay	
Non-Preferred Brand Drugs	40% coinsurance after deductible	
Specialty Drugs	50% coinsurance after deductible	
Vision (pediatric)		
Children's Eye Exam	$0	1 routine eye exam per Benefit Year
Low Vision Testing and Aids	$0	Limited to one evaluation and aid per Benefit Year.
Children's Eyewear	$0	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	$50 copay	1 routine eye exam per Benefit Year
Low Vision Testing and Aids		Limited to one evaluation and aid per Benefit Year.
Eyewear	$0	1 pair of glasses/contacts per Benefit Year up to a $250 allowance
Other Dental Services		
Accidental Dental	25% coinsurance after deductible	Injury as a result of chewing or biting is not considered an accidental injury.
Dental Anesthesia	25% coinsurance after deductible	Refer to your Evidence of Coverage
Fitness Program	$0	Refer to your Evidence of Coverage

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Other Covered Services[3]		
Allergy Testing		None
Primary Care Office Visit	$20 copay	
Specialist Office Visit	$50 copay	
Lab	$30 copay	
Allergy Injections	25% coinsurance after deductible	None
Allergy Serum	25% coinsurance after deductible	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.

[4] Speech therapy for the treatment of stuttering will not be subject to any day/visit limits.

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-NV-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.

Dependent Information

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