2027 Schedule of Benefits
Plan Name: Gold HMO 3400 $10 $0 Diabetes care and Adult Vision and Fitness
60224GA002001201

Plan Information

Primary Member	[John Doe]
Member ID	[104000000]
Date of Birth	[01/01/1965]
Effective Date	[01/01/2027]
Last Coverage Change Date	[01/01/2026]

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

Highlights

Annual Deductible*	Individual: $3,400 Family: $6,800
Coinsurance	30%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $8,000 Family: $16,000

* 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 a member has reached their individual Out-of-Pocket Limit, the plan will pay 100% of their Covered Services. 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.

Cost sharing shown applies to services received in-person or via telehealth

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Preventive Services As defined by federal & state law	$0 Copay	Refer to your Evidence of Coverage

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Physician Services – Office Visits[2]		
Teladoc Health®	$0 Copay	Refer to your Evidence of Coverage
Retail Clinics	$10 Copay	None
Primary Care Provider	$10 Copay	None
Specialist	$40 Copay	None
Allergy Testing[3]	See Primary Care Provider, Specialist, or Diagnostic Services since cost share is dependent on services rendered and place of service.	None
Allergy Treatment[3]		
Allergy Injections	30% Coinsurance after deductible	None
Allergy Serum	30% Coinsurance after deductible	None
Behavioral Health Care and Substance Use Disorder Services		
Office Visits[2]	$10 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 Treatment Services	30% Coinsurance after deductible	None
Opioid Treatment Program	30% Coinsurance after deductible	None
Inpatient Services[1]	30% Coinsurance after deductible	None
Diagnostic Services[1]		
Laboratory Tests	$30 Copay Per Test	None
X-Ray/Radiology[4]	30% Coinsurance after deductible	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)[5]	30% Coinsurance after deductible	None
Emergency Health Care Services		
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	

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Inpatient Services		
Facility Fee	30% Coinsurance after deductible	None
Physician/Surgeon Fees	30% Coinsurance after deductible	1 Visit Per Day Per Physician
Inpatient Rehabilitation Facility	30% Coinsurance after deductible	60 Days Per Year
Skilled Nursing Facility	30% Coinsurance after deductible	60 Days Per Year
Outpatient Services		
Facility Fee	30% Coinsurance after deductible	None
Physician/Surgeon Fees	30% Coinsurance after deductible	None
Urgent Care Services[1]	$30 Copay	None
$0 Diabetes care[6]		
Medical Services, Drugs, and Self-Management Supplies	$0 Copay	Refer to caresource.com/GAMPElite2027 for full list.
Ambulance Services	30% Coinsurance after deductible	Refer to your Evidence of Coverage
Autism Spectrum Disorder Services		
Physical/Occupational Therapy	30% Coinsurance after deductible	None
Speech Therapy	30% Coinsurance after deductible	None
Adaptive Behavior Treatment	$10 Copay	Includes Applied Behavior Analysis (ABA)
Chiropractic Care Services		
Habilitative Services		
Manipulation Therapy	$40 Copay Per Therapy Type Per Day	See **Habilitative Services – Outpatient Therapy** Manipulation Therapy
Physical Therapy	$40 Copay Per Therapy Type Per Day	See **Habilitative Services – Outpatient Therapy** Physical Therapy
Rehabilitative Services		
Manipulation Therapy	$40 Copay Per Therapy Type Per Day	See **Rehabilitative Services – Outpatient Therapy** Manipulation Therapy
Physical Therapy	$40 Copay Per Therapy Type Per Day	See **Rehabilitative Services – Outpatient Therapy** Physical Therapy
X-Ray/Radiology	30% Coinsurance after deductible	None

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Dental Services[1]		
Accidental Dental Services	See Categories "Diagnostic Services", "Durable Medical Equipment, Medical and Surgical Supply, Orthotics and Prosthetics", "Inpatient Services", or "Outpatient Services" as cost share is dependent on place of service.	Refer to your Evidence of Coverage
Dental Anesthesia	30% Coinsurance after deductible	Refer to your Evidence of Coverage
Durable Medical Equipment, Medical and Surgical Supplies, Orthotics and Prosthetics	30% Coinsurance after deductible	Refer to your Evidence of Coverage
Habilitative Services – Outpatient Therapy		
Physical (PT)/Occupational Therapy (OT)	30% Coinsurance after deductible If received from a Chiropractor, see Chiropractic Care Services for cost share.	40 Combined Audiology/MT/OT/PT Visits Per Year
Speech Therapy (ST)	30% Coinsurance after deductible	40 Combined Audiology/MT/OT/PT Visits Per Year
Audiology	30% Coinsurance after deductible	40 Combined Audiology/MT/OT/PT Visits Per Year
Manipulation Therapy (MT)	30% Coinsurance after deductible If received from a Chiropractor, see Chiropractic Care Services for cost share.	40 Combined Audiology/MT/OT/PT Visits Per Year
Home Health Care Services		
Home Infusion Therapy	30% Coinsurance after deductible	120 Combined Home Infusion Therapy and Covered Services Visits Per Year. A visit equals 2 hours or less.
Covered Services	30% Coinsurance after deductible	120 Combined Home Infusion Therapy and Covered Services Visits Per Year. A visit equals 2 hours or less.
Hospice Services	30% Coinsurance after deductible	Refer to your Evidence of Coverage
Maternity Services[1]		
Prenatal Visit, Office Visits, and Postpartum Care	$40 Copay	None
Inpatient Services	30% Coinsurance after deductible	None
Outpatient Services	30% Coinsurance after deductible	None

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services – Outpatient Therapy		
Physical (PT)/Occupational Therapy (OT)	30% Coinsurance after deductible If received from a Chiropractor, see Chiropractic Care Services for cost share.	40 Combined Cognitive Rehabilitative Therapy/MT/OT/PT/ST Visits Per Year
Speech Therapy (ST)	30% Coinsurance after deductible	40 Combined Cognitive Rehabilitative Therapy/MT/OT/PT/ST Visits Per Year
Cardiac Rehabilitation Services	30% Coinsurance after deductible	None
Cognitive Rehabilitation Therapy	30% Coinsurance after deductible	40 Combined Cognitive Rehabilitative Therapy/MT/OT/PT/ST Visits Per Year
Manipulation Therapy (MT)	30% Coinsurance after deductible If received from a Chiropractor, see Chiropractic Care Services for cost share.	40 Combined Cognitive Rehabilitative Therapy/MT/OT/PT/ST Visits Per Year
Post-Cochlear Implant Aural Therapy	30% Coinsurance after deductible	See Rehabilitative Speech Therapy
Pulmonary Rehabilitation	30% Coinsurance after deductible	None
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	30% Coinsurance after deductible	Refer to your Evidence of Coverage
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	See Physician Services - Office Visits, Outpatient Services, or Inpatient Services since cost share is dependent on services rendered and place of service.	None
Transplant Services	See Physician Services - Office Visits, Outpatient Services, or Inpatient Services since cost share is dependent on services rendered and place of service.	Refer to your Evidence of Coverage
Vision Services		
Children's Eye Exam	$0 Copay	1 Routine Eye Exam Per Year
All Other Vision Services	For cost share, refer to your Evidence of Coverage since cost share is dependent on services rendered.	Refer to your Evidence of Coverage
Children's Eyewear	$0 Copay	1 Pair of Glasses Per Year or 1 Choice of Contact Supply Per Year. Refer to your Evidence of Coverage for more detail.

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Prescription Drugs		
Preventive	$0 Copay	Generic, Preferred Brand and Non-Preferred Brand Drugs: Up to 30-day supply per fill at Retail; up to 90-day supply for Mail Order Specialty Drugs: Up to 30-day supply per fill at Retail and Mail Order Displayed cost share is for a 30-day supply. 90-day supply is available at 2.5 times the cost of a 30-day supply.
Preferred Generic Drugs	Up to $10 Copay	
Preferred Brand Drugs	Up to $60 Copay	
Non-Preferred Generic and Brand Drugs	50% Coinsurance after deductible	
Preferred Specialty Drugs	55% Coinsurance after deductible	
Non-Preferred Specialty Drugs	60% Coinsurance after deductible	
Adult Vision and Fitness		
Vision Benefits		
Eye Exam	$0 Copay	1 Routine Eye Exam Per Year
All Other Vision Services	For cost share, refer to your Evidence of Coverage since cost share is dependent on services rendered.	Refer to your Evidence of Coverage
Eyewear	$0 Copay	1 Pair of Glasses Per Year or 1 Choice of Contact Supply Per Year up to a $250 allowance.
Active & Fit Fitness Program	$0 Copay	Refer to your Evidence 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] Coverage for mammogram and breast ultrasound is covered at $0 to the Member. If the Member is enrolled in a high deductible health plan, the Member may need to satisfy the minimum deductible of the plan prior to the service being covered at no cost share.

[5] Coverage for breast MRI is covered at $0 to the Member. If the Member is enrolled in a high deductible health plan, the Member may need to satisfy the minimum deductible of the plan prior to the service being covered at no cost share.

[6] Medical services include diabetes self-management education, nutritional counseling, routine diabetic foot care, A1C testing, retinopathy eye screening, and diabetic kidney disease screening. Self-management supplies include continuous glucose monitors, diabetic supplies, glucose test strips, and disposable insulin delivery devices. For a complete list of $0 Drugs and Supplies, please see the formulary.

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 a non-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-GA-pa**.

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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 healthcare 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	[01/01/2027]