**2027 Schedule of Benefits**
Plan Name: Gold HMO 3400 $0 Diabetes care
35107NV001001501

## 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<br>Family: $6,800 |
| Coinsurance | 30% |
| Annual Out-of-Pocket Maximum**<br>(includes deductible, coinsurance, and copays) | Individual: $8,000<br>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<br>(Network Providers Only) | Limit<br>(If Applicable) |
|---|---|---|
| **Preventive Services**<br>As defined by federal & state law | $0 Copay | Refer to your Evidence of Coverage |

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

| 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] | | |
| Primary Care Office Visit | $10 Copay | None |
| Specialist Office Visit | $40 Copay | None |
| Laboratory Tests | $30 Copay Per Test | 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[5] | 30% Coinsurance after deductible<br>If received from a Chiropractor, see Chiropractic Care Services for cost share. | None |
| Advanced Imaging (PET, MRI, MRA, CT, SPECT)[6] | 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 | |

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| 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 | 120 Combined Rehabilitative OT/PT/ST Inpatient Days / Outpatient Visits Per Year |
| Skilled Nursing Facility | 30% Coinsurance after deductible | 100 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**[7] | | |
| Medical Services, Drugs, and Self-Management Supplies | $0 Copay | Refer to caresource.com/NVMPElite2027 for full list. |
| **Ambulance Services** | 30% Coinsurance after deductible | Balance billing may apply to emergency ground transportation for out-of-network providers. |
| **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 | 30% Coinsurance after deductible | See **Habilitative Services – Outpatient Therapy** Manipulation Therapy |
| Physical Therapy | 30% Coinsurance after deductible | See **Habilitative Services – Outpatient Therapy** Physical Therapy |
| Rehabilitative Services | | |
| Manipulation Therapy | 30% Coinsurance after deductible | See **Rehabilitative Services – Outpatient Therapy** Manipulation Therapy |
| Physical Therapy | 30% Coinsurance after deductible | 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<br>If received from a Chiropractor, see Chiropractic Care Services for cost share. | 120 Combined Habilitative OT/PT/ST Inpatient Days/Outpatient Visits Per Year |
| Speech Therapy (ST)[4] | 30% Coinsurance after deductible | 120 Combined Habilitative OT/PT/ST Inpatient Days/Outpatient Visits Per Year |
| Manipulation Therapy (MT) | 30% Coinsurance after deductible<br>If received from a Chiropractor, see Chiropractic Care Services for cost share. | 20 Visits Per Year |
| **Hearing Aids** | 30% Coinsurance after deductible | 1 Hearing Aid Every 36 Months Per Hearing Impaired Ear. |
| **Home Health Care Services** | | |
| Private Duty Nursing | 30% Coinsurance after deductible | None |
| Covered Services | 30% Coinsurance after deductible | Refer to your Evidence of Coverage |
| **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<br>If received from a Chiropractor, see Chiropractic Care Services for cost share. | 120 Combined Rehabilitative OT/PT/ST Inpatient Days/Outpatient Visits Per Year |
| Speech Therapy (ST)[4] | 30% Coinsurance after deductible | 120 Combined Rehabilitative OT/PT/ST Inpatient Days/Outpatient Visits Per Year |
| Cardiac Rehabilitation Services | 30% Coinsurance after deductible | None |
| Manipulation Therapy (MT) | 30% Coinsurance after deductible<br>If received from a Chiropractor, see Chiropractic Care Services for cost share. | 20 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** | | None |
| Primary Care Office Visit | $10 Copay | |
| Specialist Office Visit | $40 Copay | |
| Inpatient Facility | 30% Coinsurance after deductible | |
| Outpatient Facility | 30% Coinsurance after deductible | |
| **Transplant Services** | | Refer to your Evidence of Coverage |
| Primary Care Office Visit | $10 Copay | |
| Specialist Office Visit | $40 Copay | |
| Inpatient Facility | 30% Coinsurance after deductible | |
| Outpatient Facility | 30% Coinsurance after deductible | |

| Covered Service | You Pay (Network Providers Only) | Limit (If Applicable) |
|---|---|---|
| **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. |
| **Prescription Drugs** | | 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<br>Specialty Drugs: Up to 30-day supply per fill at Retail and Mail Order<br>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.<br>Insulin cost share not to exceed $35 per 30-day supply in aggregate. |
| Preventive | $0 Copay | |
| 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 | 50% Coinsurance after deductible | |
| Non-Preferred Specialty Drugs | 50% Coinsurance after deductible | |

[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 limit quantities.

[5] 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.

[6] 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.

[7] 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-NV-pa**.

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

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] |

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Jwenn èd gratis nan lang ou ak entèprèt ansanm ak lòt materyèl ekri. Jwenn èd ak sipò gratis si w gen yon andikap. Rele **1-833-230-2099** (TTY: 711).

احصل على مساعدة مجانية بلغتك من خلال المترجمين الفوريين والمواد المكتوبة الأخرى. إذا كنت من ذوي الاحتياجات الخاصة، ستحصل على المساعدات والدعم مجانًا. اتصل على الرقم **1-833-230-2099** (TTY "الهاتف النصيّ للصم وضعاف السمع": 711).

通过口译员和其他书面材料，获得您所使用语言的免费帮助。 如果您有残疾，可以获得免费的辅助设备和支持。 请致电：**1-833-230-2099**（听语障人士专用电话：711）。

Erhalten Sie kostenlose Hilfe in Ihrer Sprache durch Dolmetscher und andere schriftliche Unterlagen. Beziehen Sie kostenlose Hilfsmittel und Unterstützung, wenn Sie eine Behinderung haben. Rufen Sie folgende Telefonnummer an: **1-833-230-2099** (TTY: 711).

Obtenez une aide gratuite dans votre langue grâce à des interprètes et à d’autres documents écrits. Si vous souffrez d’un handicap, vous bénéficiez d’aides et d’assistance gratuites. Appelez le **1-833-230-2099** (ATS : 711).

Nhận trợ giúp miễn phí bằng ngôn ngữ của quý vị với thông dịch viên và các tài liệu bằng văn bản khác. Nhận trợ giúp và hỗ trợ miễn phí nếu quý vị bị khuyết tật. Gọi **1-833-230-2099** (TTY: 711).

Grick Helfe mitaus Koscht in dei Schprooch mit Iwwersetzer un annere schriftliche Dinge. Grick Aids un Helfe mitaus Koscht wann du en Behinderung hoscht. Ruf **1-833-230-2099** (TTY: 711).

आपकी भाषा के इंटरप्रेटर तथा आपकी भाषा में अन्य लिखित सामग्रियों संबंधी फ्री मदद पाएं। यदि आपको कोई डिसएबिलिटी हो, तो मुफ्त सहायता और सपोर्ट प्राप्त करें। कॉल करें **1-833-230-2099** (TTY: 711).

통역사와 기타 서면 자료의 도움을 귀하의 언어로 무료로 받으세요. 장애가 있을 경우, 보조와 지원을 무료로 받으세요. **1-833-230-2099** (TTY: 711) 로 문의하세요.

በአስተርጓሚዎች እና በሌሎች የጽሑፍ ቁሳቁሶች በቋንቋዎ ከክፍያ ነፃ እርዳታ ያግኙ። የአካል ጉዳት ካለብዎት ከክፍያ ነፃ እርዳታ እና ድጋፍ ያግኙ። ወደ **1-833-230-2099** (TTY 711) ይደውሉ።

Gba ìrànlọ́wọ́ ọ̀fẹ́ ní èdè rẹ pèlú àwọn ògbifọ̀ àti àwọn ohun èlò míràn tí a kọ sílẹ̀. Gba àwọn ìrànlọ́wọ́ àti àtilẹ́yìn ọ̀fẹ́ bí o bá ní àìlera kan. Pe **1-833-230-2099** (TTY: 711).

Makakuha ng libreng tulong sa wika mo gamit ang mga interpreter at mga ibang nakasulat na materyales. Makakuha ng mga libreng pantulong at suporta kung may kapansanan ka. Tumawag sa **1-833-230-2099** (TTY: 711).

په خپله ژبه کې د ژباړونکو او نورو لیکلي شوو موادو له لارې وړیا مرسته ترلاسه کړئ. که تاسو معلولیت لرئ نو وړیا ملاتړ او مرستې ترلاسه کړئ. دې شمېرې ته زنګ ووهئ **1-833-230-2099** (TTY: 711).

వ్యాఖ్యాతలు మరియు ఇతర రాతపూర్వక మెటీరియల్స్‌తో మీ భాషలో ఉచిత సహాయాన్ని పొందండి. ఒకవేళ మీకు వైకల్యం ఉంటే, ఉచిత ఉపకరణాలు మరియు మద్దతు పొందండి. కాల్ చేయండి:**1-833-230-2099** (TTY: 711).

दोभाषे र अन्य लिखित सामग्रीहरूको माध्यमद्वारा आफ्नो भाषामा निःशुल्क मद्दत प्राप्त गर्नुहोस्। तपाईंलाई अशक्तता छ भने निःशुल्क सहायता र समर्थन प्राप्त गर्नुहोस्। **1-833-230-2099** (TTY: 711) मा कल गर्नुहोस्।

သင့်ဘာသာစကားအတွက် စကားပြန်များနှင့် အခြားပုံနှိပ်စာရွက်များကို  အခမဲ့အကူအညီရယူပါ။ သင်သည် မသန်စွမ်းသူတစ်ဦးဖြစ်ပါက အခမဲ့အကူအညီများနှင့် အထောက်အပံ့များ ရယူပါ။ ဖုန်းခေါ်ရန် - **1-833-230-2099** (TTY: 711)

Bōk jibañ ilo an ejjelok wōnāān ikkijjien kajin eo am ibbān rukok ro im wāween ko jet ilo jeje. Bōk jerbalin jibañ ko ilo an ejjelok wōnāer im jibañ ko ñe ewōr am nañinmejin utamwe. Kalle **1-833-230-2099** (TTY: 711).

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