**CareSource**

**Low Premium Silver HMO 900 $15 PCP + Adult Vision & Fitness**

**35107NV002000405**

**Coverage for: Individual and Family | Plan Type: HMO**

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact www.caresource.com/marketplace or call 844-539-1733. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $900 individual/$1,800 family per Benefit Year | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| **Are there other deductibles for specific services?** | No | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | $3,550 individual/$7,100 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges (unless balance billing is prohibited), and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.caresource.com/marketplace or call 844-539-1733 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Network Provider Information* |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Teladoc Health® | $0 Copay | Not covered | Refer to your Evidence of Coverage |
| | Primary care visit to treat an injury or illness. | $15 Copay | Not covered | None |
| | Specialist visit | $40 Copay | Not covered | None |
| | Preventive care/screening/immunization | $0 Copay | Not covered | Refer to your Evidence of Coverage |
| **If you have a test†** | Diagnostic test (x-ray, blood work) | X-ray: $150 Copay Per Service after deductible | Not covered | None |
| | | Lab: $20 Copay Per Test | | None |
| | Imaging (CT/PET scans, MRIs) | $200 Copay Per Service after deductible | Not covered | None |
| **If you need drugs to treat your illness or condition†** More information about **prescription drug coverage** is available at www.caresource.com/marketplace. | Preventive | $0 Copay | Not covered | 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. |
| | Preferred generic drugs | Up to $3 Copay | Not covered | |
| | Preferred brand drugs | 20% Coinsurance after deductible | Not covered | |
| | Non-preferred generic and brand drugs | 50% Coinsurance after deductible | Not covered | |
| | Preferred specialty drugs | 50% Coinsurance after deductible | Not covered | |
| | Non-preferred specialty drugs | 50% Coinsurance after deductible | Not covered | |
| **If you have outpatient surgery†** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance after deductible | Not covered | None |
| | Physician/surgeon fees | 20% Coinsurance after deductible | Not covered | None |

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 844-539-1733.

†Prior authorization may be required, for more details see www.caresource.com/mp-NV-pa.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Network Provider Information* |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | Facility: 20% Coinsurance after deductible<br>Physician: 20% Coinsurance after deductible | Facility: 20% Coinsurance after deductible<br>Physician: 20% 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 medical transportation | 20% Coinsurance after deductible | 20% Coinsurance after deductible | Balance billing may apply to emergency ground transportation for out-of-network providers. |
| | Urgent care | $25 Copay | $25 Copay | If you receive services in addition to urgent care, additional copayments, deductibles, or coinsurance may apply. |
| **If you have a hospital stay†** | Facility fee (e.g., hospital room) | $350 Copay Per Stay after deductible | Not covered | None |
| | Physician/surgeon fees | $0 Copay after deductible | Not covered | 1 Visit Per Day Per Physician |
| **If you need mental health, behavioral health, or substance abuse services†** | Outpatient services | $15 Copay for office visits<br>20% Coinsurance after deductible for other outpatient services | Not covered | None |
| | Inpatient services | $350 Copay Per Stay after deductible | Not covered | None |
| **If you are pregnant** | Office visits | $40 Copay | Not covered | Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services† | $0 Copay after deductible | Not covered | |
| | Childbirth/delivery facility services† | $350 Copay Per Stay after deductible | Not covered | Your cost for inpatient services only. See above for physician delivery charges. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Network Provider Information* |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care† | 20% Coinsurance after deductible | Not covered | Refer to your Evidence of Coverage |
| | Rehabilitation services† | | | |
| | Physical (PT)/Occupational therapy (OT) | 20% Coinsurance after deductible | Not covered | 120 Combined Rehabilitative OT/PT/ST Inpatient Days/Outpatient Visits Per Year |
| | Speech therapy (ST) | 20% Coinsurance after deductible | Not covered | 120 Combined Rehabilitative OT/PT/ST Inpatient Days/Outpatient Visits Per Year |
| | Post-cochlear implant aural therapy | 20% Coinsurance after deductible | Not covered | See Rehabilitative Speech Therapy |
| | All other services | 20% Coinsurance after deductible | Not covered | Refer to your Evidence of Coverage |
| | Habilitation services† | | | |
| | Physical (PT)/Occupational therapy (OT) | 20% Coinsurance after deductible | Not covered | 120 Combined Habilitative OT/PT/ST Inpatient Days/Outpatient Visits Per Year |
| | Speech therapy (ST) | 20% Coinsurance after deductible | Not covered | 120 Combined Habilitative OT/PT/ST Inpatient Days/Outpatient Visits Per Year |
| | Hearing aids | 20% Coinsurance after deductible | Not covered | 1 Hearing Aid Every 36 Months Per Hearing Impaired Ear. |
| | Skilled nursing care† | $300 Copay Per Stay after deductible | Not covered | 100 Days Per Year |
| | Durable medical equipment† | 20% Coinsurance after deductible | Not covered | Refer to your Evidence of Coverage |
| | Hospice services | 20% Coinsurance after deductible | Not covered | Refer to your Evidence of Coverage |

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†Prior authorization may be required, for more details see www.caresource.com/mp-NV-pa.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Network Provider Information* |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | $0 Copay | Not covered | 1 Routine Eye Exam Per Year |
| | Children's eyewear | $0 Copay | Not covered | 1 Pair of Glasses Per Year or 1 Choice of Contact Supply Per Year. Refer to your Evidence of Coverage for more detail. |
| | Children's dental check-up | Not covered | Not covered | |

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

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)
  - $30 Copay for eye exam with retinal imaging included
  - No cost for glasses or contacts, with $250 annual allowance
- Routine foot care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-888-872-3234. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Nevada Division of Insurance: 1-888-872-3234.

**Does this plan provide Minimum Essential Coverage?** **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards?** **Not Applicable**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 844-539-1733.

†Prior authorization may be required, for more details see www.caresource.com/mp-NV-pa.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 844-539-1733

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-539-1733

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 844-539-1733

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-539-1733.

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

*For more information about limitations and exceptions, see the plan or policy document at www.caresource.com/marketplace or call 844-539-1733.

†Prior authorization may be required, for more details see www.caresource.com/mp-NV-pa.

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

- **The plan's overall deductible** **$900**
- **Specialist *Copayment*** **$40**
- **Hospital (facility) *Copayment*** **$350**
- **Other *coinsurance*** **20%**

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $900 |
| Copayments | $700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,660** |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$900**
- **Specialist *Copayment*** **$40**
- **Hospital (facility) *Copayment*** **$350**
- **Other *coinsurance*** **20%**

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $900 |
| Copayments | $400 |
| Coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,920** |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$900**
- **Specialist *Copayment*** **$40**
- **Hospital (facility) *Copayment*** **$350**
- **Other *coinsurance*** **20%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $900 |
| Copayments | $200 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,400** |

The plan would be responsible for the other costs of these EXAMPLE covered services

# Get free help in your language with interpreters and other written materials. Get free aids and support if you have a disability. Call **1-833-230-2099** (TTY: 711).

Obtenga ayuda gratuita en su idioma a través de intérpretes y otros materiales en formato escrito. Obtenga ayudas y apoyo gratuitos si tiene una discapacidad. Llame al: **1-833-230-2099** (TTY: 711).

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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