2027 Schedule of Benefits
Plan Name: Low Premium Silver HMO 600 $0 PCP
35107NV001000406

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: $600 Family: $1,200
Coinsurance	15%
Annual Out-of-Pocket Maximum** (includes deductible, coinsurance, and copays)	Individual: $2,000 Family: $4,000

* 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

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	$0 Copay	None
Primary Care Provider	$0 Copay	None
Specialist	$15 Copay	None
Allergy Testing[3]		
Primary Care Office Visit	$0 Copay	None
Specialist Office Visit	$15 Copay	None
Laboratory Tests	$10 Copay Per Test	None
Allergy Treatment[3]		
Allergy Injections	15% Coinsurance after deductible	None
Allergy Serum	15% Coinsurance after deductible	None
Behavioral Health Care and Substance Use Disorder Services		
Office Visits[2]	$0 Copay	None
Outpatient Services[1]		
Intensive Outpatient Program (IOP) Services	15% Coinsurance after deductible	None
Partial Hospitalization Program (PHP) Services	15% Coinsurance after deductible	None
Residential Treatment Services	$200 Copay Per Stay after deductible	None
Opioid Treatment Program	15% Coinsurance after deductible	None
Inpatient Services[1]	$300 Copay Per Stay after deductible	None
Diagnostic Services[1]		
Laboratory Tests	$10 Copay Per Test	None
X-Ray/Radiology[5]	$50 Copay Per Service after deductible If received from a Chiropractor, see Chiropractic Care Services for cost share.	None
Advanced Imaging (PET, MRI, MRA, CT, SPECT)[6]	$100 Copay Per Service after deductible	None
Emergency Health Care Services		
Emergency Room Facility	15% 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	15% Coinsurance after deductible	

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Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Inpatient Services		
Facility Fee	$300 Copay Per Stay after deductible	None
Physician/Surgeon Fees	$0 Copay after deductible	1 Visit Per Day Per Physician
Inpatient Rehabilitation Facility	$300 Copay Per Stay after deductible	120 Combined Rehabilitative OT/PT/ST Inpatient Days / Outpatient Visits Per Year
Skilled Nursing Facility	$200 Copay Per Stay after deductible	100 Days Per Year
Outpatient Services		
Facility Fee	15% Coinsurance after deductible	None
Physician/Surgeon Fees	15% Coinsurance after deductible	None
Urgent Care Services[1]	$25 Copay	None
Ambulance Services	15% Coinsurance after deductible	Balance billing may apply to emergency ground transportation for out-of-network providers.
Autism Spectrum Disorder Services		
Physical/Occupational Therapy	15% Coinsurance after deductible	None
Speech Therapy	15% Coinsurance after deductible	None
Adaptive Behavior Treatment	$0 Copay	Includes Applied Behavior Analysis (ABA)
Chiropractic Care Services		
Habilitative Services		
Manipulation Therapy	15% Coinsurance after deductible	See **Habilitative Services – Outpatient Therapy** Manipulation Therapy
Physical Therapy	15% Coinsurance after deductible	See **Habilitative Services – Outpatient Therapy** Physical Therapy
Rehabilitative Services		
Manipulation Therapy	15% Coinsurance after deductible	See **Rehabilitative Services – Outpatient Therapy** Manipulation Therapy
Physical Therapy	15% Coinsurance after deductible	See **Rehabilitative Services – Outpatient Therapy** Physical Therapy
X-Ray/Radiology	$50 Copay Per Service 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	15% Coinsurance after deductible	Refer to your Evidence of Coverage
Durable Medical Equipment, Medical and Surgical Supplies, Orthotics and Prosthetics	15% Coinsurance after deductible	Refer to your Evidence of Coverage
Habilitative Services – Outpatient Therapy		
Physical (PT)/Occupational Therapy (OT)	15% Coinsurance after deductible 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]	15% Coinsurance after deductible	120 Combined Habilitative OT/PT/ST Inpatient Days/Outpatient Visits Per Year
Manipulation Therapy (MT)	15% Coinsurance after deductible If received from a Chiropractor, see Chiropractic Care Services for cost share.	20 Visits Per Year
Hearing Aids	15% Coinsurance after deductible	1 Hearing Aid Every 36 Months Per Hearing Impaired Ear.
Home Health Care Services		
Private Duty Nursing	15% Coinsurance after deductible	None
Covered Services	15% Coinsurance after deductible	Refer to your Evidence of Coverage
Hospice Services	15% Coinsurance after deductible	Refer to your Evidence of Coverage
Maternity Services[1]		
Prenatal Visit, Office Visits, and Postpartum Care	$15 Copay	None
Inpatient Services	$300 Copay Per Stay after deductible	None
Outpatient Services	15% Coinsurance after deductible	None

Covered Service	You Pay (Network Providers Only)	Limit (If Applicable)
Rehabilitative Services – Outpatient Therapy		
Physical (PT)/Occupational Therapy (OT)	15% Coinsurance after deductible 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]	15% Coinsurance after deductible	120 Combined Rehabilitative OT/PT/ST Inpatient Days/Outpatient Visits Per Year
Cardiac Rehabilitation Services	15% Coinsurance after deductible	None
Manipulation Therapy (MT)	15% Coinsurance after deductible If received from a Chiropractor, see Chiropractic Care Services for cost share.	20 Visits Per Year
Post-Cochlear Implant Aural Therapy	15% Coinsurance after deductible	See Rehabilitative Speech Therapy
Pulmonary Rehabilitation	15% Coinsurance after deductible	None
Other Rehabilitative Services		
Includes Chemotherapy, Dialysis, and Radiation	15% Coinsurance after deductible	Refer to your Evidence of Coverage
Temporomandibular/Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder		None
Primary Care Office Visit	$0 Copay	
Specialist Office Visit	$15 Copay	
Inpatient Facility	$300 Copay Per Stay after deductible	
Outpatient Facility	15% Coinsurance after deductible	
Transplant Services		Refer to your Evidence of Coverage
Primary Care Office Visit	$0 Copay	
Specialist Office Visit	$15 Copay	
Inpatient Facility	$300 Copay Per Stay after deductible	
Outpatient Facility	15% 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 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. Insulin cost share not to exceed $35 per 30-day supply in aggregate.
Preventive	$0 Copay	
Preferred Generic Drugs	Up to $2 Copay	
Preferred Brand Drugs	15% Coinsurance after deductible	
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.

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**.

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**.

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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]

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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