Coventry*One* Select Network HMO Plans
Nevada

PLAN BENEFITS	C1 Select HMO 1	C1 Select HMO 2	C1 Select HMO 3	C1 Select HMO 4 Maternity coverage (12-month wait)
	Select Network	**Select Network**	**Select Network**	**Select Network**
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Copayment Maximum (per calendar year)	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family
PCP Office Visit (copay may apply for additional services)	$10 copay per visit	$20 copay per visit	$30 copay per visit	$30 copay per visit
Specialist Office Visit (copay may apply for additional services)	$20 copay per visit	$40 copay per visit	$60 copay per visit	$60 copay per visit
Routine Diagnostic Lab or X-ray In-office visit or independent lab facility	X-ray - $15 copay Lab - $0 copay	X-ray - $15 copay Lab - $0 copay	X-ray - $15 copay Lab - $0 copay	X-ray - $15 copay Lab - $0 copay
Preventive/Wellness Services (mammograms, well-baby care, immunizations, etc.)	$0 copay per visit	$0 copay per visit	$0 copay per visit	$0 copay per visit
Urgent Care	$50 copay per visit	$50 copay per visit	$50 copay per visit	$50 copay per visit
Emergency Room Services	$75 copay per visit	$150 copay per visit	$150 copay per visit	$150 copay per visit
Inpatient Hospital** (copay includes surgeon, anesthesia and other services)	$100 per day, not to exceed $300 per admission	$300 per day, not to exceed $900 per admission	$400 per day, not to exceed $1,200 per admission	$400 per day, not to exceed $1,200 per admission
Outpatient Surgery** (copay includes facility, surgeon and anesthesia)	$100 per visit	$200 per visit	$200 per visit	$200 per visit
Outpatient Physical, Speech and Occupational Therapy Limited to 20 visits per calendar year for each type of therapy	$10 per visit	$20 per visit	$30 per visit	$30 per visit
Chiropractic/Spinal Manipulation Limited to combined benefit of 20 visits per calendar year	$10 per visit	$20 per visit	$30 per visit	$30 per visit
Home Health Care** Limited to 60 visits per calendar year	$10 per visit	$20 per visit	$30 per visit	$30 per visit
Maternity Benefits	Not covered except for complications only	Not covered except for complications only	Not covered except for complications only	$400 per day, not to exceed $1,200 per admission
Dental Limited to one exam, X-ray and cleaning per calendar year, up to $250 max.	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Vision Exam Limited to one per calendar year - VSP Plus Plan	$10 copay	$10 copay	$10 copay	$10 copay
Prescription Drugs (per order or refill up to a 30-day supply)				
- **Tier 1:** Formulary generic drugs and select formulary brand drugs	$10 copay	$10 copay	$10 copay	$10 copay
- **Tier 2:** Formulary brand-name drugs when no generic is available	$35 copay	$35 copay	$35 copay	$35 copay
- **Tier 3:** Nonformulary drugs; formulary brand-name drugs when generic is available	$60 copay	$60 copay	$60 copay	$60 copay

*** Prior Authorization Required*

Maternity benefits on plans 1, 2 and 3 are not covered except for complications of pregnancy. Refer to Certificate of Insurance for Plan Terms and Limitations. Maternity benefits for Plan 4 are available after 12 months of enrollment in the plan.

The copayment maximum, which is the calendar year total of all copays, is described in the Certificate of Insurance.

You must designate a primary care physician (PCP) in the Select Network, through which services are rendered or referred. Services received from non-participating providers inside the service area will not be covered, except for emergent care. Services received outside of the service area will not be covered, except for emergent or urgent care.

Coventry*One* Select Network HMO is a health insurance product underwritten and administered by Coventry Health Care of Nevada. This information is a partial description of the benefits and in no way details all of the benefits, limitations or exclusions of the plan. Please refer to the Individual Policy, Schedule of Payments, and applicable Riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

Coventry*One* Select Network HMO Deductible Plans

Nevada

PLAN BENEFITS	C1 Select HMO 1 - 250	C1 Select HMO 2 - 500	C1 Select HMO 3 - 750	C1 Select HMO 4 - 1000 Maternity coverage (12-month wait)
	Select Network	Select Network	Select Network	Select Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Deductible (per calendar year)	$250 Individual $500 Family	$500 Individual $1,000 Family	$750 Individual $1,500 Family	$1,000 Individual $2,000 Family
Copayment Maximum (per calendar year)	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family
PCP Office Visit (copay may apply for additional services)	$10 copay per visit	$20 copay per visit	$30 copay per visit	$30 copay per visit
Specialist Office Visit (copay may apply for additional services)	$20 copay per visit	$40 copay per visit	$60 copay per visit	$60 copay per visit
Routine Diagnostic Lab or X-ray In-office visit or independent lab facility	X-ray - $15 copay Lab - $0 copay	X-ray - $15 copay Lab - $0 copay	X-ray - $15 copay Lab - $0 copay	X-ray - $15 copay Lab - $0 copay
Preventive/Wellness Services (mammograms, well-baby care, immunizations, etc.)	$0 copay per visit	$0 copay per visit	$0 copay per visit	$0 copay per visit
Urgent Care	$50 copay per visit	$50 copay per visit	$50 copay per visit	$50 copay per visit
Emergency Room Services	$75 copay per visit, after deductible	$150 copay per visit, after deductible	$150 copay per visit, after deductible	$150 copay per visit, after deductible
Inpatient Hospital** (copay includes surgeon, anesthesia and other services)	$100 per day, not to exceed $300 per admission, after deductible	$300 per day, not to exceed $900 per admission, after deductible	$400 per day, not to exceed $1,200 per admission, after deductible	$400 per day, not to exceed $1,200 per admission, after deductible
Outpatient Surgery** (copay includes facility, surgeon and anesthesia)	$100 per visit, after deductible	$200 per visit, after deductible	$200 per visit, after deductible	$200 per visit, after deductible
Outpatient Physical, Speech and Occupational Therapy Limited to 20 visits per calendar year for each type of therapy	$10 per visit, after deductible	$20 per visit, after deductible	$30 per visit, after deductible	$30 per visit, after deductible
Chiropractic/Spinal Manipulation Limited to combined benefit of 20 visits per calendar year	$10 per visit, after deductible	$20 per visit, after deductible	$30 per visit, after deductible	$30 per visit, after deductible
Home Health Care** Limited to 60 visits per calendar year	$10 per visit, after deductible	$20 per visit, after deductible	$30 per visit, after deductible	$30 per visit, after deductible
Maternity Benefits	Not covered except for complications only	Not covered except for complications only	Not covered except for complications only	$400 per day, not to exceed $1,200 per admission, after deductible
Dental Limited to one exam, X-ray and cleaning per calendar year, up to $250 max.	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Vision Exam Limited to one per calendar year - VSP Plus plan	$10 copay	$10 copay	$10 copay	$10 copay
Prescription Drugs (per order or refill up to a 30-day supply)				
- **Tier 1:** Formulary generic drugs and select formulary brand drugs	$10 copay	$10 copay	$10 copay	$10 copay
- **Tier 2:** Formulary brand-name drugs when no generic is available	$35 copay	$35 copay	$35 copay	$35 copay
- **Tier 3:** Nonformulary drugs; formulary brand-name drugs when generic is available	$60 copay	$60 copay	$60 copay	$60 copay

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