SPECTRUM PLANS – Nevada

PLAN BENEFITS	SPECTRUM 1000		SPECTRUM 2000		SPECTRUM 3000		SPECTRUM 4000		SPECTRUM 5000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime maximum	$5,000,000		$5,000,000		$5,000,000		$5,000,000		$5,000,000	
Deductible (per contract year)	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Coinsurance	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Out-of-pocket maximum (per contract year) Includes deductible and coinsurance only	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family	$6,000 Individual $12,000 Family	$12,000 Individual $24,000 Family	$8,000 Individual $16,000 Family	$16,000 Individual $32,000 Family	$10,000 Individual $20,000 Family	$20,000 Individual $40,000 Family
Medical benefits shown with copays are not subject to deductibles	**In-Network You Pay**	**Out-of-Network You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**	**In-Network You Pay**	**Out-of-Network You Pay**
PCP office visit	$30 copay	40% after deductible	$30 copay	40% after deductible	$30 copay	40% after deductible	$30 copay	40% after deductible	$30 copay	40% after deductible
Specialist office visit	$50 copay	40% after deductible	$50 copay	40% after deductible	$50 copay	40% after deductible	$50 copay	40% after deductible	$50 copay	40% after deductible
Preventive/Wellness office visit ($300 maximum per contract year)	$30/$50 copay 20% after deductible	40% after deductible	$30/$50 copay 20% after deductible	40% after deductible	$30/$50 copay 20% after deductible	40% after deductible	$30/$50 copay 20% after deductible	40% after deductible	$30/$50 copay 20% after deductible	40% after deductible
Mammograms See below for further details.	$30 copay	40% after deductible	$30 copay	40% after deductible	$30 copay	40% after deductible	$30 copay	40% after deductible	$30 copay	40% after deductible
Urgent Care	$75 copay then 20% coinsurance		$75 copay then 20% coinsurance		$75 copay then 20% coinsurance		$75 copay then 20% coinsurance		$75 copay then 20% coinsurance	
Emergency services	20% after deductible		20% after deductible		20% after deductible		20% after deductible		20% after deductible	
Inpatient hospital**	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient hospital / facility** (X-ray, lab, diagnostic services, MRI, CAT & PET scans, surgery, anesthesia, etc.)	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Physical, Speech and Occupational Therapy** $3000 max per contract year all therapies combined Payment Responsibility depends on the place of service	$30/$50 copay	40% after deductible	$30/$50 copay	40% after deductible	$30/$50 copay	40% after deductible	$30/$50 copay	40% after deductible	$30/$50 copay	40% after deductible
Chiropractic Limited to 10 visits per contract year	$50 copay	40% after deductible	$50 copay	40% after deductible	$50 copay	40% after deductible	$50 copay	40% after deductible	$50 copay	40% after deductible
Home Health Care** Limited to 30 visits per contract year	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Skilled Nursing Facility** Limited to 30 visits per contract year	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Prescription drugs										
- **Tier 1:** Formulary generic drugs and select formulary brand drugs	$10 copay		$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		$35 copay	
- **Tier 3:** Nonformulary drugs; formulary brand name drugs when generic is available	$60 copay		$60 copay		$60 copay		$60 copay		$60 copay	

** *Prior Authorization Required - your payment responsibility will depend on the deductible, coinsurance or copay that applies to the chosen Spectrum Plan Benefits.*

Maternity Services are not covered except for Complications of Pregnancy – Refer to Certificate of Insurance for Plan Terms and Limitations.

CoventryOne is a health insurance product underwritten by Coventry Health and Life Insurance Company and administered by Coventry Health Care. 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.

Mammograms - Preventive is covered at the PCP co-pay level – any other mammogram is paid at deductible/coinsurance level. Benefit limitations are a combination of in-network and out-of-network benefits.

Pre-existing conditions may have benefit limitations. A pre-existing condition is a sickness or injury that was diagnosed or treated during the 12 month period before the covered person's effective date of coverage.