TORCHLIGHT PLANS – Nevada

PLAN BENEFITS	TORCHLIGHT 2000		TORCHLIGHT 4000		TORCHLIGHT 6000		TORCHLIGHT 8000		TORCHLIGHT 10000	
	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	$3,000,000		$3,000,000		$3,000,000		$3,000,000		$3,000,000	
Deductible (per contract year)	$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 $24000 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
Coinsurance	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Out-of-pocket maximum (per contract year) Includes deductible and coinsurance only	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family	$8,000 Individual $16,000 Family	$16,000 Individual $32,000 Family	$12,000 Individual $24,000 Family	$24,000 Individual $48,000 Family	$16,000 Individual $32,000 Family	$32,000 Individual $64,000 Family	$20,000 Individual $40,000 Family	$40,000 Individual $80,000 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	$50 copay	50% after deductible	$50 copay	50% after deductible	$50 copay	50% after deductible	$50 copay	50% after deductible	$50 copay	50% after deductible
Specialist office visit	$70 copay	50% after deductible	$70 copay	50% after deductible	$70 copay	50% after deductible	$70 copay	50% after deductible	$70 copay	50% after deductible
Preventive/Wellness office visit ($300 maximum per contract year)	$50/$70 copay 50% after deductible	50% after deductible	$50/$70 copay 50% after deductible	50% after deductible	$50/$70 copay 50% after deductible	50% after deductible	$50/$70 copay 50% after deductible	50% after deductible	$50/$70 copay 50% after deductible	50% after deductible
Mammograms	$50 copay	50% after deductible	$50 copay	50% after deductible	$50 copay	50% after deductible	$50 copay	50% after deductible	$50 copay	50% after deductible
Urgent Care	$125 copay then 50% coinsurance		$125 copay then 50% coinsurance		$125 copay then 50% coinsurance		$125 copay then 50% coinsurance		$125 copay then 50% coinsurance	
Emergency services	50% after deductible		50% after deductible		50% after deductible		50% after deductible		50% after deductible	
Inpatient hospital**	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Outpatient hospital / facility** (X-ray, lab, diagnostic services, MRI, CAT & PET scans, surgery, anesthesia, etc.)	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Outpatient Physical, Speech and Occupational Therapy** $3000 max per contract year all therapies combined Payment Responsibility depends on the place of service	$50/$70 copay	50% after deductible	$50/$70 copay	50% after deductible	$50/$70 copay	50% after deductible	$50/$70 copay	50% after deductible	$50/$70 copay	50% after deductible
Chiropractic Limited to 10 visits per contract year	$70 copay	50% after deductible	$70 copay	50% after deductible	$70 copay	50% after deductible	$70 copay	50% after deductible	$70 copay	50% after deductible
Home Health Care** Limited to 30 visits per contract year	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Skilled Nursing Facility** Limited to 30 days per contract year	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Prescription drugs $500 deductible per year on brand name drugs only $2,000 max benefit per year on brand name 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	$40 copay		$40 copay		$40 copay		$40 copay		$40 copay	
- **Tier 3:** Nonformulary drugs; formulary brand name drugs when generic is available	$75 copay		$75 copay		$75 copay		$75 copay		$75 copay	

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