This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.nevadahealthcoop.org or by calling 702-823-2667 or 1-855-606-2667.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$400** person / **$800** family For out-of-network providers **$6,350** person / **$12,700** family Does not apply to preventive care, inpatient or tele-health physician services, medical supplies, prenatal and postnatal care. Does not apply to out-of-network coinsurance / copayments.	Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for Pediatric Dental Services Class II, Class III, and Class IV.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For Tier I & II in-network providers **$2,000** person / **$4,000** family For out-of-network providers **$20,000** person / **$40,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **www.nevadahealthcoop.org** or call **702-823-2667 or 1-855-606-2667** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Tier I plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use Tier I In-network Provider	Your Cost If You Use Tier II In-network Provider	Your Cost If You Use Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/visit	$30 copay/visit	50% coinsurance	————none————
	Specialist visit	$25 copay/visit	$75 copay/visit	50% coinsurance	————none————
	Other practitioner office visit	$5 copay/visit for acupuncture $25 copay/visit for chiropractor	$10 copay/visit for acupuncture $25 copay/visit for chiropractor	50% coinsurance	Coverage is limited to 20 visits per member per year for acupuncture services. Coverage is limited to 30 visits per member per year for chiropractor services.
	Preventive care/screening/immunization	No charge	No charge	50% coinsurance	————none————
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay/x-ray $10 copay/lab service	$45 copay/x-ray $20 copay/lab service	50% coinsurance	Copayment applies to services rendered in a Physician's office or at an independent facility.
	Imaging (CT/PET/MRI)	$100 copay/test	$250 copay/test	50% coinsurance	All CT/PET/MRIs require prior authorization, otherwise benefits may be reduced.

Common Medical Event	Services You May Need	Your Cost If You Use Tier I In-network Provider	Your Cost If You Use Tier II In-network Provider	Your Cost If You Use Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition For more information about **prescription drug coverage** please call 702-823-2667 or 1-855-606-2667 or www.nevadahealthcoop.org	Generic drugs	Retail pharmacy for 30-day supply: $0 copay/prescription Mail Order for 90-day supply: $0 copay/prescription	Retail pharmacy for 30-day supply: $0 copay/prescription Mail Order for 90-day supply: $0 copay/prescription	No coverage	No charge for preventive services drugs. Some prescriptions are subject to prior approval, quantity limits or step therapy requirements.
	Preferred brand drugs	Retail pharmacy for 30-day supply: $15 copay/prescription Mail Order for 90-day supply: $30 copay/prescription	Retail pharmacy for 30-day supply: $15 copay/prescription Mail Order for 90-day supply: $30 copay/prescription	No coverage	Some prescriptions are subject to prior approval, quantity limits or step therapy requirements.
	Non-preferred brand drugs	Retail pharmacy for 30-day supply: $30 copay/prescription Mail Order for 90-day supply: $60 copay/prescription	Retail pharmacy for 30-day supply: $30 copay/prescription Mail Order for 90-day supply: $60 copay/prescription	No coverage	Some prescriptions are subject to prior approval, quantity limits or step therapy requirements.
	Specialty drugs	10% coinsurance	10% coinsurance	No coverage	Specialty drugs require prior approval. Call 702-823-2667 or 1-855-606-2667.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	50% coinsurance	————none————
	Physician/surgeon fees	10% coinsurance	10% coinsurance	50% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost If You Use Tier I In-network Provider	Your Cost If You Use Tier II In-network Provider	Your Cost If You Use Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$100 first visit, $450 each subsequent visit	$100 first visit, $450 each subsequent visit	$100 first visit, $450 each subsequent visit	————none————
	Emergency medical transportation	$100 first trip, $450 each additional trip	$100 first trip, $450 each additional trip	$100 first trip, $450 each additional trip	————none————
	Urgent care	$60 copay/visit	$60 copay/visit	50% coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	50% coinsurance	All hospital admissions require prior authorization, otherwise benefits may be reduced.
	Physician/surgeon fees	No charge	No charge	50% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs Please contact Harmony Healthcare 702-251-8000 or 1-855-371-5758	Mental/Behavioral health outpatient services	$5 copay/visit	$5 copay/visit	50% coinsurance	————none————
	Mental/Behavioral health inpatient services	10% coinsurance	10% coinsurance	50% coinsurance	————none————
	Substance use disorder outpatient services	$5 copay/visit	$5 copay/visit	50% coinsurance	————none————
	Substance use disorder inpatient services	10% coinsurance	10% coinsurance	50% coinsurance	————none————
If you are pregnant	Prenatal and postnatal care	No charge	No charge	50% coinsurance	OB ultrasounds require prior authorization, otherwise benefits may be reduced.
	Delivery and all inpatient services	10% coinsurance	10% coinsurance	50% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost If You Use Tier I In-network Provider	Your Cost If You Use Tier II In-network Provider	Your Cost If You Use Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$25 copay/visit	$25 copay/visit	50% coinsurance	Coverage is limited to 30 visits per year. Home health and infusion therapy requires prior authorization, otherwise benefits may be reduced.
	Rehabilitation services	$5 copay/visit	$30 copay/visit	50% coinsurance	Coverage is limited to 60 visits per year. Inpatient rehabilitation services require prior authorization, otherwise benefits may be reduced.
	Habilitation services	$5 copay/day	$30 copay/day	50% coinsurance	Coverage is limited to 60 visits per year.
	Skilled nursing care	$50 copay/day	$50 copay/day	50% coinsurance	Coverage is limited to 100 visits per year.
	Durable medical equipment	10% coinsurance	10% coinsurance	50% coinsurance	For purchase or rental at the CO-OP's option. Items over $500 (whether it is a rental or purchase) require prior authorization, otherwise benefits may be reduced.
	Hospice service	10% coinsurance	10% coinsurance	50% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost If You Use Tier I In-network Provider	Your Cost If You Use Tier II In-network Provider	Your Cost If You Use Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$5 copay/visit	$10 copay/visit	50% coinsurance	Coverage is limited to one visit per year.
	Glasses	10% coinsurance	10% coinsurance	50% coinsurance	Coverage is limited to one pair of glasses, one lens treatment and one set of contacts per year.
	Dental Class I - P&D Class II - Basic Class III - Major Class IV - Orthodontia	No charge 25% coinsurance 50% coinsurance 50% coinsurance		50% coinsurance	Covered up to age 19 Pediatric orthodontics must be Medically Necessary and require Prior Authorization.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Services, if you obtain prior authorization. May require a pre-surgery treatment plan
- Chiropractic Care
- Hearing Aids. Coverage is limited to 1 unit per year and 1 repair and replacement every three years.
- Infertility Treatment
- Private Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-606-2667. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan at 1-855-606-2667 or www.nevadahealthcoop.org, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Nevada Division of Insurance at (888) 872-3234. Additionally, a consumer assistance program can help you file your appeal. Contact Nevada Governor's Office for Consumer Health Assistance at (888) 333-1597 or (702) 486-3587.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al (702) 823-2667 o (855) 606-2667.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,700
- **Patient pays** $840

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$400
Copays	$0
Coinsurance	$320
Limits or exclusions	$0
Total	**$720**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,100
- **Patient pays** $300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$300**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.