This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at **www.cdsgrouphealth.com** or by calling **1-800-455-4236.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$350** For participating and non-participating network providers/individual **$700** For participating and non-participating network providers/family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Your deductible starts over every January 1. See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, there is a **$50/**individual deductible for dental services. There are no other specific **deductibles**.	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 participating providers **$3,350** for Medical **/$6,700** family Medical. For non-participating providers **$6,350** person**/$12,700** family. **Prescription Drug Program** **$6,350** per individual.	The **out-of-pocket limit** is the most you could pay during a coverage period 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?	Amounts applied or paid to satisfy co-payments, expenses in excess of Usual and Customary, expenses which become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Is there an overall annual limit on what the plan pays?	No	
Does this plan use a network of providers?	Yes, it is Universal Health Network at www.uhnppo.com. Phone: (800) 776-6959	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 3 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 4. See your plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **network allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** 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 **network allowed amount**. If an out-of-network **provider** charges more than the **network 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 **network 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Specialist visit	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Other practitioner office visit	deductible + 20% co-insurance	deductible + 20% co-insurance	Chiropractic care limited to 25 visits per calendar year
	Preventive care	No charge	No charge up to Usual and Customary charges	Non-participating providers subject to Usual and Customary charges
If you have a test	Diagnostic test (x-ray, blood work)	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Imaging (CT/PET scans, MRIs)	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **cvs.com**	Generic drugs	$5 co-pay	N/A	none
	Preferred brand drugs	$25 co-pay	N/A	none
	Non-preferred brand drugs	$40 co-pay	N/A	none

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge if services rendered by Nevada Health Partner's list of preferred providers - see your plan document for a full list of preferred providers deductible +20% co-insurance if services rendered by a participating provider	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Physician/surgeon fees	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
If you need immediate medical attention	Emergency room services	$75 co-pay, deductible + 20% co-insurance	$75 co-pay, deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Emergency medical transportation	deductible + 20% co-insurance	deductible + 20% co-insurance	none
	Urgent care	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
If you have a hospital stay	Facility fee (e.g., hospital room)	deductible + 20% co-insurance	$500 co-pay , deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Physician/surgeon fee	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Mental/Behavioral health inpatient services	deductible + 20% co-insurance	$500 co-pay, deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Substance use disorder outpatient services	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Substance use disorder inpatient services	deductible + 20% co-insurance	$500 co-pay, deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
If you are pregnant	Prenatal and postnatal care	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Delivery and all inpatient services	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
If you need help recovering or have other special health needs	Home health care	deductible + 20% co-insurance	deductible + 20% co-insurance	Limited to 100 visits per year.
	Rehabilitation services	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Habilitation services	Not Covered	Not Covered	none
	Skilled nursing care	deductible + 20% co-insurance	deductible + 20% co-insurance	Limited to 60 days per calendar year
	Durable medical equipment	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges
	Hospice service	deductible + 20% co-insurance	deductible + 20% co-insurance	Non-participating providers subject to Usual and Customary charges

If your child needs dental or eye care. Vision benefits provided by Vision Service Plan (VSP)	Eye exam	$10 co-pay for exam and single lens glasses	Plan pays 100% up to $45 towards eye exam	
	Glasses	Up to: $150 towards frames Single lens included with exam $55 standard progressive lens $105 premium progressive lens $175 custom progressive lens	Up to: $70 towards frames $40 single vision lens $50 lined bifocal lens $55 lined trifocal lens $50 progressive lens	Lenses limited to 1 pair every twelve months Frames limited to 1 pair every twenty-four months
	Dental check-up	No charge	No charge	Up to 4 cleanings per year, subject to Usual, Customary and Reasonable Charge (UCR)

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
- Custodial Care
- Educational or Vocational Testing or Training
- Hair replacement
- Modifications of homes or vehicles
- Non-prescription drugs

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.)

- Ambulance
- Anesthesia
- Chiropractic care
- Home Health
- Occupational Therapy
- Speech therapy

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 administrator at 775-352-6900. 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 your plan administrator at (775) 352-6900.

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** $5,736
- **Patient pays** $1,804

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	$350
Co-pays	$20
Co-insurance	$1,434
Limits or exclusions	$0
Total	**$1,804**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $3,095
- **Patient pays** $ 1,005

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$350
Co-pays	$300
Co-insurance	$355
Limits or exclusions	$0
Total	**$1,005**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.