Health Plan of Nevada
Sierra Health and Life
P.O. Box 15645
Las Vegas, NV 89114-5645

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

9/25/2012

STATE OF NEVADA
DO NOT MAIL INVOICE 901 S STEWART ST STE 1001
CARSON CITY, NV 89701

Dear STATE OF NEVADA,

The Affordable Care Act requires all health plan issuers and group health plans to provide eligible enrollees with a Summary of Benefits and Coverage (SBC). You are receiving this letter for one of the following scenarios and must take appropriate action.

At Employee Enrollment/Application:

- SBC must be provided to eligible enrollees, including new hires, at the time written application materials for enrollment are distributed.
- If no written application materials are distributed for enrollment, then the SBC must be provided no later than the first date on which the subscriber is eligible to enroll.

Special Enrollees:

- Special enrollees must be given an SBC within 90 days of enrollment. HPN/SHL will fulfill this requirement.

Renewal:

- SBC must be provided 30-days prior to the renewal date for the plan the member is currently enrolled in, unless the group has not provided its intent to renew by that time, in which case the SBC must be delivered within 7 business days of receiving their intent to renew. HPN/SHL will typically fulfill this requirement by sending enrolled members an SBC for the plan in which they are currently enrolled 30-days prior to their renewal effective date. If the employer makes plan changes for renewal, then a new SBC must be distributed by the first day of coverage or upon 7 business days of notice of intent to renew.

Upon Request:

- An SBC must be delivered to members within 7 business days of a request for the SBC. HPN/SHL will fulfill this requirement.

Mid-Year Plan Change:

- SBC must be provided 60 days in advance of effective date of a material modification to a plan.

Unless HPN/SHL is fulfilling the distribution, you must distribute a copy of the SBC to all eligible employees within the timeframes noted above. If you need additional assistance, please contact your Sales or Account Representative by calling the main sales number at 1-800-873-0004 or 702-821-2200.

Sincerely,

Donald J. Giancursio
President

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

State of Nevada HPN-15 $7/35/55

Coverage Period: 07/01/2012 - 06/30/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | **Plan Type**: HMO

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.healthplanofnevada.com or by calling (702) 242-7300 or 1-800-777-1840.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, 200% of the total premium rate the member would pay if enrolled under a Health Benefit Plan Certificate without **copayments** when using HMO Providers.	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?	Premium, balance-billed charges, penalties for failure to obtain prior authorization, prescription drug copayments and health care this plan doesn't cover.	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.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **Plan Providers**, see www.healthplanofnevada.com or call 702-242-7300 or 1-800-777-1840.	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 kind of **providers**.
Do I need a referral to see a specialist?	Yes. A written referral is required to see a specialist.	This plan will pay some or all of the costs to see a **specialist** but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call (702) 242-7300 or 1-800-777-1840 or visit us at www.healthplanofnevada.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call (702) 242-7300 or 1-800-777-1840 to request a copy.

- **Copayments** (copay) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** (co-ins) 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 **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 **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 **Plan Providers** by charging you lower **copayments**.

Common Medical Event	Services You May Need	Your Cost If You Use a HMO Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	Not Covered	None
	Specialist visit	$15 copay/visit	Not Covered	Failure to receive a written referral and/or prior authorization for HMO services means you will be responsible for the costs of services.
	Other practitioner office visit	$15 copay/visit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
	Preventive care/ screening/ immunization	$0 copay/visit	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/service	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
	Imaging (CT/PET scans, MRIs)	PET Scan: $750 copay/service MRI, CT: $15 copay/service	Not Covered	
If you need drugs to treat your illness or condition	Preferred generic drugs	$7 copay (retail) $14 copay (mail)	Not Covered	Covers up to a 30-day retail supply or up to a 90-day mail order supply. Failure to receive prior authorization or step therapy means you will be responsible for the costs of services.

Common Medical Event	Services You May Need	Your Cost If You Use a HMO Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.healthplanofnevada.com.	Preferred brand drugs	$35 copay (retail) $70 copay (mail)	Not Covered	Covers up to a 30-day retail supply or up to a 90-day mail order supply. Failure to receive prior authorization or step therapy means you will be responsible for the costs of services.
	Non-Preferred generic and brand drugs	$55 copay (retail)	Not Covered	Covers up to a 30-day retail supply. Failure to receive prior authorization or step therapy means you will be responsible for the costs of services.
	Specialty drugs	$7, $35 or $55 copay (retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay/admit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
	Physician/surgeon fees	$0 copay/surgery	Not Covered	
If you need immediate medical attention	Emergency room services	ER Physician: $0 copay/visit ER Facility: $75 copay/visit	ER Physician: $0 copay/visit ER Facility: $75 copay/visit	You may be balance billed from Non-Plan Providers.
	Emergency medical transportation	Ground: $0 copay/trip Air: 50% coinsurance	Ground: $0 copay/trip Air: 50% coinsurance	
	Urgent care	$15 copay/visit	$15 copay/visit	You may be balance billed from Non-Plan Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
	Physician/surgeon fee	$0 copay/surgery	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$15 copay/visit	Not Covered	Failure to receive prior authorization for certain services means you will be responsible for the costs of services.
	Mental/behavioral health inpatient services	$200 copay/admit	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a HMO Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Substance abuse disorder outpatient services	$15 copay/visit	Not Covered	Failure to receive prior authorization for certain services means you will be responsible for the costs of services.
	Substance abuse disorder inpatient services	$200 copay/admit	Not Covered	
If you become pregnant	Prenatal and postnatal care	$0 copay/visit	Not Covered	Routine prenatal care obtained from a Plan Provider is covered at no charge.
	Delivery and all inpatient services	Room: $200 copay/admit Surgical, Anesthesia: $0 copay/admit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
If you have a recovery or other special health need	Home health care	$0 copay/visit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
	Rehabilitation services	$15 copay/visit	Not Covered	Coverage is limited to 60 days/visits per member per calendar year. Failure to receive prior authorization means you will be responsible for the costs of services.
	Habilitation services	Not Covered	Not Covered	Not covered
	Skilled nursing care	$200 copay/admit	Not Covered	Coverage is limited to 100 days per member per calendar year. Failure to receive prior authorization means you will be responsible for the costs of services.
	Durable medical equipment	$100 copay/device or 50% coinsurance	Not Covered	Whichever DME copayment is less applies. Failure to receive prior authorization means you will be responsible for the costs of services.
	Hospice services	$200 copay/admit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Your Plan may include certain vision and/or dental services. Please refer to you Plan documents for more information.
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

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**.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitative services
- 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.)

- Hearing aids
- Bariatric surgery
- Chiropractic care
- Private-duty nursing
- Limited infertility treatment

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 (702) 242-7300 or 1-800-777-1840. 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 may contact: your human resource department, Health Plan of Nevada at (702) 242-7300 or 1-800-777-1840 or the Nevada Division of Insurance at (775) 687-0700 (Carson City), (702) 486-4009 (Las Vegas), 1-800-992-0900 (toll-free) or visit http://www.doi.state.nv.us. If your employer determines that your plan is a fully insured ERISA Plan, then you may also contact the Employee Benefits Security Administration at 1-866-444-3272 or visit http://www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Office for Consumer Health Assistance, 555 E. Washington Ave., Suite 4800, Las Vegas, NV 89101, (702) 486-3587 or 1-888-333-1597, Fax: (702) 486-3586 or visit www.govcha.nv.gov. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/index.html.

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.

Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.

若需要中文协助，请拨打本文件内的客户服务电话。

Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

----------*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** $6,960
- **Patient pays** $580

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	$0
Copays	$580
Coinsurance	$0
Limits or Exclusions	$0
Total	**$580**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,330
- **Patient pays** $1,070

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	$0
Copays	$1,070
Coinsurance	$0
Limits or Exclusions	$0
Total	**$1,070**

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.
- If other than individual coverage, the Patient Pays amount may be more.

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.

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

State of Nevada HPN-15 $7/35/55

Coverage Period: 07/01/2012 - 06/30/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | **Plan Type**: HMO

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, 200% of the total premium rate the member would pay if enrolled under a Health Benefit Plan Certificate without **copayments** when using HMO Providers.	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?	Premium, balance-billed charges, penalties for failure to obtain prior authorization, prescription drug copayments and health care this plan doesn't cover.	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.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **Plan Providers**, see www.healthplanofnevada.com or call 702-242-7300 or 1-800-777-1840.	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 kind of **providers**.
Do I need a referral to see a specialist?	Yes. A written referral is required to see a specialist.	This plan will pay some or all of the costs to see a **specialist** but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call (702) 242-7300 or 1-800-777-1840 or visit us at www.healthplanofnevada.com.
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- **Copayments** (copay) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** (co-ins) 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 **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 **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 **Plan Providers** by charging you lower **copayments**.

Common Medical Event	Services You May Need	Your Cost If You Use a HMO Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	Not Covered	None
	Specialist visit	$15 copay/visit	Not Covered	Failure to receive a written referral and/or prior authorization for HMO services means you will be responsible for the costs of services.
	Other practitioner office visit	$15 copay/visit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
	Preventive care/ screening/ immunization	$0 copay/visit	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/service	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
	Imaging (CT/PET scans, MRIs)	PET Scan: $750 copay/service MRI, CT: $15 copay/service	Not Covered	
If you need drugs to treat your illness or condition	Preferred generic drugs	$7 copay (retail) $14 copay (mail)	Not Covered	Covers up to a 30-day retail supply or up to a 90-day mail order supply. Failure to receive prior authorization or step therapy means you will be responsible for the costs of services.

Common Medical Event	Services You May Need	Your Cost If You Use a HMO Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.healthplanofnevada.com.	Preferred brand drugs	$35 copay (retail) $70 copay (mail)	Not Covered	Covers up to a 30-day retail supply or up to a 90-day mail order supply. Failure to receive prior authorization or step therapy means you will be responsible for the costs of services.
	Non-Preferred generic and brand drugs	$55 copay (retail)	Not Covered	Covers up to a 30-day retail supply. Failure to receive prior authorization or step therapy means you will be responsible for the costs of services.
	Specialty drugs	$7, $35 or $55 copay (retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay/admit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
	Physician/surgeon fees	$0 copay/surgery	Not Covered	
If you need immediate medical attention	Emergency room services	ER Physician: $0 copay/visit ER Facility: $75 copay/visit	ER Physician: $0 copay/visit ER Facility: $75 copay/visit	You may be balance billed from Non-Plan Providers.
	Emergency medical transportation	Ground: $0 copay/trip Air: 50% coinsurance	Ground: $0 copay/trip Air: 50% coinsurance	
	Urgent care	$15 copay/visit	$15 copay/visit	You may be balance billed from Non-Plan Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
	Physician/surgeon fee	$0 copay/surgery	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$15 copay/visit	Not Covered	Failure to receive prior authorization for certain services means you will be responsible for the costs of services.
	Mental/behavioral health inpatient services	$200 copay/admit	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a HMO Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Substance abuse disorder outpatient services	$15 copay/visit	Not Covered	Failure to receive prior authorization for certain services means you will be responsible for the costs of services.
	Substance abuse disorder inpatient services	$200 copay/admit	Not Covered	
If you become pregnant	Prenatal and postnatal care	$0 copay/visit	Not Covered	Routine prenatal care obtained from a Plan Provider is covered at no charge.
	Delivery and all inpatient services	Room: $200 copay/admit Surgical, Anesthesia: $0 copay/admit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
If you have a recovery or other special health need	Home health care	$0 copay/visit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
	Rehabilitation services	$15 copay/visit	Not Covered	Coverage is limited to 60 days/visits per member per calendar year. Failure to receive prior authorization means you will be responsible for the costs of services.
	Habilitation services	Not Covered	Not Covered	Not covered
	Skilled nursing care	$200 copay/admit	Not Covered	Coverage is limited to 100 days per member per calendar year. Failure to receive prior authorization means you will be responsible for the costs of services.
	Durable medical equipment	$100 copay/device or 50% coinsurance	Not Covered	Whichever DME copayment is less applies. Failure to receive prior authorization means you will be responsible for the costs of services.
	Hospice services	$200 copay/admit	Not Covered	Failure to receive prior authorization means you will be responsible for the costs of services.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Your Plan may include certain vision and/or dental services. Please refer to you Plan documents for more information.
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

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**.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitative services
- 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.)

- Hearing aids
- Bariatric surgery
- Chiropractic care
- Private-duty nursing
- Limited infertility treatment

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 (702) 242-7300 or 1-800-777-1840. 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 may contact: your human resource department, Health Plan of Nevada at (702) 242-7300 or 1-800-777-1840 or the Nevada Division of Insurance at (775) 687-0700 (Carson City), (702) 486-4009 (Las Vegas), 1-800-992-0900 (toll-free) or visit http://www.doi.state.nv.us. If your employer determines that your plan is a fully insured ERISA Plan, then you may also contact the Employee Benefits Security Administration at 1-866-444-3272 or visit http://www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Office for Consumer Health Assistance, 555 E. Washington Ave., Suite 4800, Las Vegas, NV 89101, (702) 486-3587 or 1-888-333-1597, Fax: (702) 486-3586 or visit www.govcha.nv.gov. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/index.html.

Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.

Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.

若需要中文协助，请拨打本文件内的客户服务电话。

Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

----------*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** $6,960
- **Patient pays** $580

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	$0
Copays	$580
Coinsurance	$0
Limits or Exclusions	$0
Total	**$580**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,330
- **Patient pays** $1,070

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	$0
Copays	$1,070
Coinsurance	$0
Limits or Exclusions	$0
Total	**$1,070**

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.
- If other than individual coverage, the Patient Pays amount may be more.

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.