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 by calling **1-775-826-7200**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **or** www.healthcare.gov

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** Individual/**$750** Family Doesn't apply to: routine preventive care, specific outpatient laboratory procedures performed in Lab Corp or Quest labs, or mail order prescription drugs	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your 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**. Three family members must meet the $250 deductible for the family deductible of $750 to be met.
Are there other deductibles for specific services?	Yes. $8.50 per prescription drug and $50 for vision care expenses. 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. Up to $2,000 per Individual/In-Network plus cost of non-covered charges. No limit for out of network charges.	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?	Balance-billed charges, health care this plan doesn't cover, copayments, deductibles, mail order and prescription drug charges.	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?	Yes. $2 million	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of visits, days of confinement, or dollar maximums.
Does this plan use a network of providers?	Yes. For a list of participating providers, call: 1-775-826-7200 or email, www.skerr.bpa@sbcglobal.net.	If you use an in-network doctor or healthcare **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 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 5. See your 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 network **providers** by charging you lower **deductibles**, **copayments** for mail-order prescription drugs, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an 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	20% coinsurance after deductible met	30% coinsurance after deductible met subject to non-PPO fee schedule	Limited to allowed amount under In-network PPO contract rate or Non-PPO fee schedule
	Specialist visit	20% coinsurance after deductible met	30% coinsurance subject to non-PPO fee schedule	Limited to allowed amount under the In-network PPO contract rate or Non-PPO fee schedule
If you visit a health care provider's office or clinic (continued)	Alcohol/Substance Abuse Treatment – Inpatient	20% coinsurance after deductible met	30% coinsurance subject to non-PPO fee schedule	1 confinement per calendar year. Requires treatment to be pre-certified by Professional Review Organization (PRO) prior to confinement.. No outpatient care in an acute hospital solely for detoxification
	Alcohol/Substance Abuse Treatment – Outpatient	20% coinsurance of In-network PPO contract rate	30% coinsurance subject to non-PPO fee schedule	Please refer to your booklet for more information
	Mental/Nervous Disorders Inpatient	20% coinsurance of In-network PPO contract rate	30% coinsurance subject to non-PPO fee schedule	Must be precertified by the Professional Review Organization (PRO). Limited to 60 inpatient days per 24 months
	Mental/Nervous Disorders Outpatient	20% coinsurance of In-network PPO contract rate	30% coinsurance subject to non-PPO fee schedule	Please refer to your booklet for more information

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Preventive care/Annual office visit, well child care up to age 2	20% coinsurance of In-network PPO contract rate	30% coinsurance subject to non-PPO fee schedule	Colonoscopy for ages 50 and older
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	Services received at LabCorp and Quest covered at 100% of In-network contract rate with no Deductible
If you have a test (continued)	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	Requires pre-certification by Professional Review Organization (PRO) prior to testing.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at CVS Caremark at www.cvscaremark.com	Retail	$8.50 copayment	$8.50 non covered charge	34 day supply. Must pay discounted price at the time of purchase.
	Mail Order: Generic Brand	$8.50 per month	Not Covered Not Covered	Mail Order: Covers up to 90 day supply for maintenance drugs, equal $25.50 copayment
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	Pre-Authorization Required.
	Physician/surgeon fees	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	Limited to allowed amount In-Network PPO provider contract rate or Non-network fee schedule.
If you need immediate medical attention	Emergency room services	20% coinsurance plus $25.00 co-pay per visit	30% coinsurance plus $25.00 co-pay per visit	Limited to 6 visits per calendar year
	Emergency medical transportation	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	Limited to allowed amount In-Network PPO provider contract rate or Non-network fee schedule.
	Urgent care	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	Limited to allowed amount In-Network PPO provider contract rate or Non-network fee schedule.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	Pre-Authorization Required.
	Physician/surgeon fee	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	Limited to allowed amount In-Network PPO provider contract rate or Non-network fee schedule.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	Not covered when dependent daughter is mother. Limited to allowed amount In-Network PPO provider contract rate or Non-network fee schedule.
	Delivery and all inpatient services	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance subject to non-PPO fee schedule	100 visits max per calendar year
	Rehabilitation services	20% coinsurance	30% coinsurance subject to non-PPO fee schedule	
	Skilled nursing care	50% coinsurance	50% coinsurance subject to non-PPO fee schedule	Maximum of 100 days per confinement. Successive periods of confinement must be separated by 30 days.
	Durable medical equipment	0-20% coinsurance	30% coinsurance subject to non-PPO fee schedule	
	Hospice service	0% coinsurance	0% coinsurance subject to non-PPO fee schedule	Coverage limited to annual maximum of $7,500.
If your child needs dental or eye care	Eye exam	40% coinsurance after $50 deductible	40% coinsurance after $50 deductible	1 every 12 months
	Glasses/Contacts	40% coinsurance after $50 deductible	40% coinsurance after $50 deductible	Lenses once every 12 months, frames and contacts once every 24 months
	Dental check-up	Not covered under medical plan (unlimited calendar year maximum under age 19)	Not covered under medical plan (unlimited calendar year maximum under age 19)	Normal plan benefits apply for members over age 19.

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
- Infertility Treatment
- Private-duty nursing
- Long-term Care
- Hearing Aids
- Bariatric Surgery
- Weight Loss Programs
- Lasik Eye Surgery
- Routine foot care

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, if provided by a physician or certified acupuncturist, 15 visits per calendar year
- Non-emergency care when traveling outside U.S.
- Physical Therapy, 30 visits per calendar year
- Routine eye care (Adult), once every 12 months
- Chiropractic Care for Vertebrae, Spine, Back and Neck only, 25 visits per calendar year
- Dental care (Adult)

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 1-775-826-7200. 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 Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789. You can also contact the Plan Administrator at 1-775-826-7200. Additionally, a consumer assistance program may be able to help you file your appeal. For assistance, please contact the Nevada Office of Consumer Health Assistance at 1-888-333-1597. Or visit www.govcha.nv.gov.

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. These examples were completed using costs associated with individual coverage.

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** $5,712
- **Patient pays** $ 1,828

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
Coinsurance	$1,428
Limits or exclusions	$0
Total	**$1,828**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,000
- **Plan pays** $3,920
- **Patient pays** $1,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education (not covered)	-0-
Laboratory tests	$100
Vaccines, other preventive (not covered over age 24)	-0-
Total	**$5,000**

Patient pays:

Deductibles	$100
Coinsurance	$980
Limits or exclusions	-0-
Total	**$1,080**

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.

*Only certain part-time, COBRA and non-bargained employees pay a premium.