Southern Nevada Health District

TO: SOUTHERN NEVADA DISTRICT BOARD OF HEALTH **DATE: November 17, 2016**

RE: *Approval of Group Enrollment to Interlocal Agreement between Clark County; Clark County Water Reclamation District; University Medical Center of Southern Nevada; the Las Vegas Convention and Visitors Authority; the Las Vegas Valley Water District; Clark County Regional Flood Control District; the Regional Transportation Commission of Southern Nevada; the Southern Nevada Health District; Henderson District Public Libraries, Mount Charleston Fire Protection District and the Las Vegas Metropolitan Police Department for establishing New Rates to Renew Health Plan of Nevada Group Benefits Plan, effective January 1, 2017*

PETITION #42-16

That the Southern Nevada District Board of Health *approve the Group Enrollment Agreement to Interlocal Agreement between Clark County; Clark County Water Reclamation District; University Medical Center of Southern Nevada; the Las Vegas Convention and Visitors Authority; the Las Vegas Valley Water District; Clark County Regional Flood Control District; the Regional Transportation Commission of Southern Nevada; the Southern Nevada Health District; the Henderson District Public Libraries, Mount Charleston Fire Protection District and the Las Vegas Metropolitan Police Department for establishing New Rates to Renew Health Plan of Nevada Group Benefits Plan, effective January 1, 2017*

PETITIONERS:

Shandra Hudson, *Human Resources Administrator*
Andy Glass, *Director of Administration*
Joseph P. Iser, MD, DrPH, MSc *Chief Health Officer*

DISCUSSION:

The purpose of this agreement is to allow SNHD to renew the Health Maintenance Organization (HMO) portion of the group medical and dental benefit plan for SNHD employees, retirees and their dependents. The Plan year is on a calendar year basis and offers a Health Maintenance Organization (HMO) option for employees as provided by Health Plan of Nevada. This insurance benefit program was adopted on August 1, 2009 pursuant to the labor agreements. The contract is in compliance with the District's collective bargaining agreement (CBA) with SEIU that became effective August 28, 2014. There is a rate increase of 3% for the HPN contract that will go into effect for Plan Year 2017.

The following are Plan modifications that will be effective January 1, 2017:

1. Rate premiums are increased by 3% for active members;
2. Rate premiums will be increased for Senior Dimensions members;
3. No benefit changes to medical, dental, vision and prescription;
4. Addition of benefit for self referral to specialist- *HPN network only* $50 copay

FUNDING:

Previous Board action on August 28, 2014 provided authorization for funding the employer-portion of the premiums based on the labor agreements through FY2019.

ATTACHMENTS:

- Group Enrollment Agreement
- SNHD Group Rates for Plan Year 2017
- Summary of Benefit Coverage for Health Plan of Nevada HMO Medical/Dental/Vision Benefit Plan effective January 1, 2017.

SOUTHERN NEVADA HEALTH DISTRICT

ENROLLMENT AGREEMENT

RFP NO. 604028-16; FULLY INSURED MEDICAL AND MEDICARE COVERAGE
Group Enrollment Agreement

Group Name Southern Nevada Health District
Group Number 10000219-A001 Effective Date January 1, 2017

In consideration of the payment of subscription charges in accordance with the terms and provisions of the Member Kit attached hereto and made a part hereof. Health Plan of Nevada, Inc. (hereinafter referred to as "Health Plan") and Southern Nevada Health District (hereinafter referred to as "Group") hereby agree that Health Plan shall provide and/or arrange for professional and hospital services in accordance with the terms and provisions of the Agreement to eligible Subscribers and their eligible Family Members who elect to enroll hereunder with Health Plan. It is acknowledged by the parties that this Agreement is entered into voluntarily and not as the result of any Federal or State requirement upon the Group to offer Health Plan of Nevada services. The adoption of this Agreement shall in no event be construed as a recognition of the validity of Health Plan's request for inclusion in the Group's health benefits program.

I. TERM OF AGREEMENT

The term of the Agreement shall be one (1) year commencing January 1, 2017, at 12:01 a.m. Standard Time at Las Vegas, Nevada, and will remain in effect for an initial term of twelve (12) consecutive months, ending December 31, 2017. This Agreement will have six (6) one year renewal periods contingent upon mutual agreement subject to an appropriate rate adjustment.

II. PREMIUM RATES

A. Group Premium Rate Schedule

MEDICAL/PRESCRIPTION, BHO+, DENTAL & VISION HPN Solutions HMO 10 CC, $20/$40/$70/2.5x Rx, BHO +, Dental, Vision Care Services Domestic Partner Rider Rates Guaranteed for Period 1/1/2017 to 12/31/2017	
Individual Employee	$476.19
Employee & Spouse	$891.55
Employee & Child	$871.97
Employee & Children	$871.97
Employee & Family	$1,254.11

GROUP SENIOR DIMENSIONS RISK RATES Group Senior Dimensions Risk Rates And Benefits Guaranteed For Period of 1/1/2017 to 12/31/2017			
	Senior Dimensions BHO+ W/Pres. Drugs & Vision Coverage	**Dental**	**Total**
Employee	$298.75	$40.44	$339.19
Employee & Spouse (Two Medicare A&B)	$597.50	$75.72	$673.22
Employee & Spouse (One Medicare A&B)	$678.83	$75.72	$754.55
Employee & Child/Children (One Medicare A&B)	$660.93	$74.04	$734.97
Employee & Spouse plus Child (Three Medicare A&B)	$896.25	$105.82	$1,002.07
Employee & Family (Two Medicare A&B)	$929.96	$105.82	$1,035.78
Employee & Family (One Medicare A&B)	$1,011.29	$105.82	$1,117.11

- 2017 Senior Dimension Rates have been finalized by CMS. Rates assume participation of all ten entities:

  - Clark County
  - UMC
  - LVCVA
  - LVVWD
  - CCWRD
  - RTCSNV
  - SNHD
  - Henderson Public Library
  - Mt. Charleston Fire Protection District
  - Las Vegas Metropolitan Police Department Appointed Employees

B. Premium Rate Increase 2018

CLARK COUNTY RISK MANAGEMENT

At the end of this Contract Period, for the period 1/1/18 through 12/31/18 the HMO/POS premium rate increase applied to the rates shown in Section II.A. of this agreement, will be Negotiated.

1. HPN is the exclusive HMO/POS offered by Group to its Eligible Employees.

2. The Employee contribution levels have not changed in a manner that would negatively affect the number of individuals who elect to enroll in HPN.

3. Current year benefit designs continue unchanged for the second policy period. If the benefits change, including any mandated benefits, HPN shall be permitted to adjust upward or downward the rate increase limitation described above by the entire amount or applicable percentage based on the actuarial value of such benefit change.

4. This premium rate increase limitation assumes that any adjustment for age/sex and demographic factor changes (average contract mix ratio) as determined solely by HPN does not exceed by 5% those factors used to determine the rates shown in Section II.A. of this agreement. In the event such factors change by 5% or more, HPN shall be permitted to adjust upward the rate increase limitation described above by the entire amount or applicable percentage of such change.

5. HPN shall reserve the right to adjust the premium rate increase limitation described above due to any potential known or unknown federal and state

mandated changes to benefits including those required by the Patient Protection and Affordable Care Act (PPACA).

C. Premium Due Date and Payments. On or before the fifteenth (15th) day of each month of coverage hereunder (the "Premium Due Date"), Group shall pay Health Plan the applicable Total Premium Rate set forth in Section A, above, for each Subscriber and for each of their Dependents. Such premiums shall be calculated by Clark County from current records as to number of Members enrolled. If this Agreement is terminated for any reason, the Group shall be liable for all premium payments due and unpaid. Only Members for whom payment is received by Health Plan shall be covered by such payment. If this Agreement terminates on other than the last date of the month, then the premium payment for that month shall be pro rated as defined below and Group shall be liable solely for that amount. Any overpayment by Group to Health Plan shall be refunded by Health Plan to Group within 30 days of termination.

The prorated amount of premium shall be computed by dividing the total premium which would have been due for the full month by the number of the days in the month and multiplying the resulting sum by the number of dates of that month for which this Agreement was in effect.

D. Enrollment. The Group further agrees to remit on or before the Premium Due Date the applicable premium payment for each Subscriber and his or her Eligible Family Members who enroll with Health Plan. Eligible Subscriber and his or her Eligible Family Members who enroll with Health Plan will become effective the first of the month following two (2) full months of employment except for elected officials and their Eligible Family Members which are effective the date they take the oath of office as established by Clark County. Group agrees to remit an applicable full month's premium for those eligible Subscribers and Family Members who are enrolled hereunder.

E. Termination. For each Subscriber and his or her Dependents on whose behalf Group has paid the applicable premium payments, and whose coverage under the Agreement terminates for any reason, coverage with Health Plan shall terminate effective the last day of the month in which Subscriber and his or her Dependents have terminated. Group agrees to remit applicable full month's premium.

III. ELIGIBILITY

Eligible Subscribers and their Eligible Family Members shall be those persons who reside or work within the Service Area as set forth in the Attachment B to the Evidence of Coverage and comply with the terms and provisions of the Agreement. The composition of the Group and the requirements determining eligibility for participating in Professional and Hospital Services arranged by Group are considerations material to the execution of this Agreement. During the term of this Agreement, no change in Group's eligibility or participation requirements shall be permitted to affect eligibility or enrollment in any manner deemed adverse by Health Plan unless such change is effected by mutual agreement, in writing, with Health Plan.

IV. DOMESTIC PARTNER COVERAGE

The following provision will be effective upon notification from Clark County:

Domestic Partner coverage for domestic partners who have registered with the Nevada Secretary of State.

V. LEAVE OF ABSENCE

Leave of Absence - An employee who qualifies as a subscriber under the Group Evidence of Coverage and who is on an approved Leave of Absence (LOA) or Leave Without Pay (LWOP) returns to work within six (6) months of the approved LOA or LWOP may at the end of such approved leave be eligible to enroll in Health Plan of Nevada as a Subscriber and enroll any Dependents who qualify under the Evidence of Coverage as an Eligible Family Member, who were previously enrolled, without waiting the required two (2) months waiting period.

VI. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Group hereby agrees to offer Health Plan membership to all eligible Subscribers of the Group. It is understood that eligible Subscribers of the Group shall be free to choose either Health Plan membership or such other coverage as may be available through the Group during both the initial and subsequent Open Enrollment Periods. Every eligible Subscriber of the Group shall be given a fair opportunity to elect one of such options over the other and shall not be penalized by the Group because of such a choice.

Group agrees that after the Open Enrollment Period under this Agreement each new employee will be given the opportunity to elect Health Plan membership as a procedure of employment and that enrollment in accordance with such election will become effective when such person attains the status of an eligible Subscriber as provided in this Agreement. Subject to the Group's payment of applicable monthly premiums, the receipt of an application by Health Plan for each prospective Subscriber and eligible Family Members of the Subscriber, and the provisions of this Agreement, coverage hereunder shall become effective as set forth in the Agreement except as may be provided below:

Notwithstanding any provision to the contrary, Health Plan of Nevada shall accept as timely filed any notice required, if said notice is received by the Group within thirty-one (31) days of the qualifying event or change in status, is date stamped to reflect the date received by the Group, and if Health Plan receives the notice with sixty-two (62) days of the qualifying event or the change in status. This paragraph shall also apply to any retirees of the Group, regardless of the coverage elected, including Senior Dimensions, except to the extent it conflicts with any federal law.

VII. COVERAGE

Benefit Plan Code/Description:	Clark County HPN SOLUTIONS HMO 10 CC
Option Benefit Riders:	Clark County Domestic Partner Rider
	Clark County 3-tier Group Prescription Drug Benefit Rider-$20/$40/$70
	Dental Care Plus Service Rider
	Vision Care Services Rider

VIII. GROUP CONTRIBUTION

Group shall offer Health Plan to all Subscribers of Group on terms no less favorable with respect to all Subscribers' contribution than those applicable to such other health benefits coverage as may be available through the Group. Except as hereinafter provided, the Group contributions set forth above in the Premium Rate Schedule shall not be changed during the term of the Agreement unless such change is agreed to in writing by Health Plan. If, however, the Group's contribution to any other HMO coverage as may be available through the Group is increased during the term of the Agreement, Group agrees to increase its contribution to Health Plan coverage, effective the first day of the month following such increase.

IX. OPEN ENROLLMENT PERIOD

The Open Enrollment Period for the initial term shall commence between October 1, 2016 through December 31, 2016 in a 31 day period as established by the Group. Thereafter, for the renewal periods, the open enrollment period will be mutually agreed upon and memorialized in writing by the parties.

X. NOTICE

Any notice hereunder to be given to Group and Health Plan shall be addressed to:

Clark County Risk Management
500 So. Grand Central Parkway
Las Vegas, NV 89155

Health Plan
P.O. Box 15645
Las Vegas, NV 89114-5645

XI. TERMINATION

A. This Agreement may be terminated by Health Plan for any of the following reasons:

1. If any payment required to be made by the Group is not received by the Premium Due Date, subject to a thirty (30) day grace period, Health Plan may terminate the Agreement upon written notice. Any payments made by Group after such date and accepted by Health Plan shall be subject to an interest charge of 1.50% of the total premium amount due calculated for each thirty (30) day period the amount due remains outstanding.

2. Upon written notice, in the event of insolvency or bankruptcy of the Group.

3. Upon written notice, if Group ceases to operate or relocates out of the Service Area.

4. Material breach of any of the terms and provisions of this Agreement. In this event Health Plan shall, at its election and upon one hundred and eighty (180) days' prior written notice to Group, terminate this Agreement.

B. In the event of termination, benefits hereunder shall terminate for all Members as of the effective date of termination.

C. This Agreement may be terminated by Group for any of the following reasons:

1. Upon written notice, in the event of insolvency, liquidation or bankruptcy of Health Plan.

2. Upon written notice, on revocation of Health Plan's Certificate of Authority.

3. Material breach of any of the terms and provisions of this Agreement, upon thirty (30) days' prior written notice.

4. This Agreement may be terminated by Group for its convenience, upon thirty (30) days' prior written notice. If termination is for Group's convenience, Group shall pay Health Plan that portion of the compensation which has been earned as of the effective date of termination but no amount shall be allowed for anticipated profit on performed or unperformed services or other work.

XII. MAILINGS TO MEMBERS

Health Plan hereby agrees to provide Group a copy of any mailing which is specific to members of the Group at least seventy-two (72) hours prior to any such mailing being sent for the Group's review and comment. Health Plan further agrees that any comments of Group concerning the content of such mailings will be considered in good faith.

XIII. INSURANCE

A. Health Plan shall obtain and maintain the insurance coverage required in Exhibit 1of the RFP incorporated herein by this reference. Health Plan shall comply with the terms and conditions set forth in Exhibit 1 and shall include the cost of insurance coverage in their prices.

B. If Health Plan fails to maintain any of the insurance coverage required herein, Group may withhold payment, order Health Plan to stop the work, declare Health Plan in breach or terminate the Agreement.

XIV. INDEMNIFICATION

The Group shall not be liable for any claim, injury, demand or judgment or related costs and attorney's fees based on tort, express or implied warranty, or any grounds whatsoever, arising out of the provision of health care service to one of the HMO members pursuant to the Group Enrollment Agreement and Health Plan agrees to indemnify, defend and hold harmless the Group against any and all such claims and demands and related costs and fees. It is expressly understood, however, that Health Plan shall not indemnify, defend or hold harmless the Group from any claim resulting from any representations to Group's Employees or Dependents made by the Group, its Administrator, including employees of the Administrator, Auditor, Attorney or Consultant concerning Health Plan or concerning any provider rendering health care services pursuant to the Group's Group Enrollment Agreement. Health Plan shall have the right to select and appoint counsel to represent Group in any such action.

XV. COMPLIANCE WITH APPLICABLE LAW

In performing services under this Agreement Health Plan shall observe and abide by the terms and conditions of all applicable laws, regulations, ordinances or other rules of the United States, the State of Nevada, any political subdivision thereof or any other duly constituted public authority or agency, including, but not limited to the provisions of 42 USC 300c et seq, 42 CFR Part 110, NRS Chapter 695C, and NAC Chapter 695C, regarding the licensing and operation of Health Maintenance Organizations.

XVI. ENTIRE AGREEMENT

This Agreement, together with the following Exhibits, contain the entire Agreement between Health Plan and Group relating to rights granted and obligations assumed by the parties and may only be modified, supplemented, or amended by a written agreement signed by both parties.

Exhibits:

1. Group Enrollment Agreement
2. Clark County Evidence of Coverage
3. Clark County Domestic Partner Rider
4. Clark County HPN Solutions HMO 10 CC Attachment A Benefit Schedule
5. Dental Care Gold Plus Services Rider
6. Vision Care Services Rider
7. Clark County 3-Tier Group Prescription Drug Benefit Rider - $20/$40/$70 – the January 2017 formulary list to remain unchanged for any negative impact during the calendar year 2017.
8. Senior Dimensions Member Handbook and Evidence of Coverage
9. Insurance Requirements Exhibit 1
10. Business Associate Agreement Exhibit 2
11. Performance Guarantees Exhibit 3
12. Clark County RFP No. 604028-16 (Copy maintained by Clark County and HPN

XVII. AMENDMENT AND MODIFICATION

No provisions of this Agreement or the Exhibits will be deemed waived, amended or modified by either party unless such waiver amendment or modification is in writing and signed by the authorized agents of both parties.

XVIII. CONTROLLING PROVISIONS

For purposes of resolving conflicts between the various Agreements and Exhibits which constitute the entire Agreement the provisions and language as set forth in the Group Enrollment Agreement shall be the controlling provisions and language.

XIX. ASSIGNMENT

Health Plan shall neither assign, transfer nor delegate any rights, obligations, or duties under this Agreement without the prior written consent of the Group. Group shall not unreasonably withhold the approval of such an assignment.

XX. INDEPENDENT CONTRACTOR

Health Plan is an independent contractor and not an employee of the Group. No permitted or required approval by the Group, documents or services of Health Plan shall be construed as making the Group responsible for the manner in which Health Plan performs services or for any negligence, errors or omissions of Health Plan. Such approvals are intended only to give the Group the right to review the nature of services performed by Health Plan.

XXI. FISCAL FUNDING BY COUNTY

County reasonably believes that funds can be obtained sufficiently to make all payments during the term of this Agreement. If County does not allocate funds to continue the function performed by the Contractor obtained under this Agreement, this Agreement shall be terminated when appropriate funds expire.

XXII. Health Plan of Nevada, Inc. hereby agrees to incorporate into the Group Evidence of Coverage for Clark County employees all the amendments listed below that have been previously included in the prior Group Enrollment Agreement:

Authority to Change Certificate – Authority to Change the form or Content of Certificate. No agent or employee of Health Plan or Group is authorized to change the agreement or waive any of its provisions except as otherwise provided herein. Such changes can be made only through endorsement duly approved by Health Plan and Group and shall be effective only after being executed by a duly authorized representative of both parties. Such approval of Health Plan or the Group shall not be unreasonably withheld.

Member Eligibility – By this Agreement, the Group makes Health Plan coverage available to employees who are eligible under Section I. However, this Agreement shall be subject to

amendment, modification, and termination in accordance with any provisions hereof upon duly authorized agreement thereto in writing by the Group without the consent or concurrence of the Members. Such approval by the Group shall not be unreasonably withheld. By electing medical and Hospital coverage under the Health Plan or accepting Health Plan's benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable or contracting agree to all terms, conditions and provisions hereof.

XXIII. The Senior Dimension Member Handbook and Certificate of Coverage is hereby amended as described in the so named attachments to this Enrollment Agreement.

A. Modifications - This Certificate shall be subject to amendment or modification by Health Plan upon thirty (30) days notice to Subscriber subject to the agreement of CMS and Group thereto.

Such approval of the Group shall not be unreasonably withheld. The consent or concurrence of Subscriber to such modifications is not required. By electing coverage pursuant to this Certificate or accepting Health Plan Covered Services, all Subscribers legally capable of contracting, and the legal representatives of all Subscribers incapable of contracting, agree to all terms, conditions, and provisions hereof.

B. Effective January 1, 2017, the Senior Dimensions program may be amended subject to the Group's prior written agreement thereto.

XXIV. Health Plan acknowledges that the GROUP has an obligation to ensure that public funds are not used to subsidize private discrimination. Health Plan recognizes that if they or their subcontractors are found guilty by an appropriate authority of refusing to hire or do business with an individual or company due to reasons of race, color, religion, sex, sexual orientation, gender identity or gender expression, age, disability, national origin, or any other protected status, the GROUP may declare the Health Plan in breach of the Contract, terminate the Contract, and designate the HEALTH PLAN as non-responsible.

XXV. All materials, information, and documents, whether finished, unfinished, drafted, developed, prepared, completed, or acquired by Health Plan for Group relating to the services to be performed hereunder and not otherwise used or useful in connection with services previously rendered, or services to be rendered, by Health Plan to parties other than Group shall become the property of Group and shall be delivered to Group's representative upon completion or termination of this Agreement, whichever comes first. Health Plan shall not be liable for damages, claims, and losses arising out of any reuse of any work products on any other project conducted by Group. Group shall have the right to reproduce all documentation supplied pursuant to this Agreement.

XXVI. Disclosure of Ownership Form

Health Plan agrees to provide the information on the attached Disclosure of Ownership/Principals form prior to any contract and/or contract amendment to be awarded by the Group's Board of County Commissioners.

XXVII. Authority

Group is bound only by Group agents acting within the actual scope of their authority. Group is not bound by actions of one who has apparent authority to act for Group. The acts of Group agents which exceed their contracting authority do not bind Group.

XXVIII. Severability

If any terms or provisions of Agreement shall be found to be illegal or unenforceable, then such term or provision shall be deemed stricken and the remaining portions of Agreement shall remain in full force and effect.

XXIX. Public Records

Group is a public agency as defined by state law, and as such, is subject to the Nevada Public Records Law (Chapter 239 of the Nevada Revised Statutes). Under the law, all of Group's records are public records (unless otherwise declared by law to be confidential) and are subject to inspection and copying by any person.

XXX. Immigration Reform and Control Act

In accordance with the Immigration Reform and Control Act of 1986, Health Plan agrees that it will not employ unauthorized aliens in the performance of this Contract.

XXXI. Subcontracts

A. Prior to the effective date of the Agreement, Health Plan shall supply documentation of the subcontractors being utilized by Health Plan in connection with this Agreement, if applicable. The documentation shall contain, but not limited to, subcontractor name, subcontractor contact information, brief description of the service being rendered by subcontractor, and any other additional information which may be requested by Group.

B. After the effective date of the Agreement, any proposed changes to subcontractors being utilized by Health Plan or for any additional services which were previously not subcontracted will not be authorized, without prior written approval of Group.

C. Approval by Group of Health Plan's request to subcontract, or acceptance of, or payment for, subcontracted work by Group shall not in any way relieve Health Plan of responsibility for the professional and technical accuracy and adequacy of the work. Health Plan shall be and remain liable for all damages to Group caused by negligent performance or non-performance of work under this Agreement by Health Plan's subcontractor or its sub-subcontractor.

XXXII. Agreement Transition

In the event services are scheduled to end by either Agreement expiration or termination, it shall be incumbent upon Health Plan to continue services and cooperate with Group and the successor provider in the smooth and timely transition of services and Group's

data and any data or information required by Group from Health Plan to the successor provider appointed by Group, until new services can be completely operational. Health Plan shall complete the forgoing within sixty (60) days from receipt of COUNTY's notice which will be issued prior to Agreement expiration or termination, pending that Health Plan has been provided all the necessary information by Group to successfully complete the transition. Health Plan may provide continued services for up to ninety (90) days after expiration or termination of Agreement pursuant to the terms and conditions of the Agreement which shall be addressed in writing accordingly.

XXXIII. Performance Guarantees

Health Plan shall comply with Performance Guarantees as required within Exhibit 3 of the RFP, Performance Guarantees, incorporated herein by this reference.

XXXIV. Reporting

Health Plan shall prepare on a monthly, quarterly, and annual basis, or as requested by Group, standard reports and additional report requirements as requested. Any data released shall be authorized by County or County's authorized broker of record which can only be assigned by Group.

XXXV. Additional Requirements

Health Plan shall comply with their response within Exhibit C – Questionnaire which was a part of Health Plan's proposal submitted in response to Group's RFP No. 604028-16; Fully Insured Medical and Medicare Coverage. If any response by Health Plan within Exhibit C –Questionnaire conflicts with any requirement in this Agreement, this Agreement will Control.

XXXVI. HIPAA - CONFIDENTIALITY REGARDING PARTICIPANTS OPTIONAL

Health Plan shall maintain the confidentiality of any information relating to participants, Group Employees, or third parties,(added) in accordance with any applicable laws and regulations, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Attached hereto, and incorporated by reference herein, is a HIPAA Business Associate Agreement, executed by the parties in accordance with the requirements of this sub-section. Health Plan agrees to sign the attached HIPAA Business Associate Agreement" prior to award of Agreement.

(Remainder of page intentionally left blank)

IN WITNESS WHEREOF, the parties hereto have caused this contract to be signed and intended to be legally bound thereby.

DATE:

APPROVED AS TO FORM:

BY:_____
ANNETTE BRADLEY
SNHD, Legal Counsel

Health Plan of Nevada, Inc.

BY:_____
SUSAN E. VOGEL
Chief Financial Officer
Health Plan of Nevada, Inc.

BY:_____
ANDY GLASS
Director of Administration

CLARK COUNTY, NEVADA
PERFORMANCE GUARANTEES - HMO (Fully Insured)
EFFECTIVE: JANUARY 1, 2017

VENDORS:	Client Specific or BOB?	Medical	Weighted
CLAIMS FINANCIAL ACCURACY	BOB	97%	5%
CLAIMS PROCEDURAL ACCURACY			
CLAIM TURNAROUND TIME	BOB	95% in 30 working days	5%
ID CARD TURNAROUND	BOB	Mailed within 10 working days of date of eligibility input	9%
MEMBERSHIP MATERIALS	BOB	Mailed within 10 working days of date of eligibility input	9%
SPEED OF ANSWER	BOB	Within 60 Seconds	9%
TELEPHONE ABANDONMENT RATE	BOB	5%	9%
MEMBER NOTICE OF PCPTERMINATION	BOB	30 working days	9%
TIME TO RESPOND TO WRITTEN COMPLAINTS	BOB	98% asknowledged within 30 working days	9%
PCP / MEMBER RATIO	BOB	1 to 2450	9%
PRIOR AUTH. TURNAROUND TIME	BOB	Routine requests (with supporting clinical data) - 3 business days for decision Stat Requests (complete and with supporting clinical data) - 1 business day if called in.	4.5% / 4.5%
PCP REFERRALS	BOB	Emergent/Urgent – scheduled within 24 hours Routine/Preventative - scheduled within 30 days	4.5% / 4.5%
MEMBER SATISFACTION			
IMPLEMENTATION			
ACCOUNT MANAGEMENT SATISFACTION			
MANAGEMENT REPORTS			
ELIGIBILITY UPDATES			
Trend Guarantee			
Maximum Amount at Risk		**Maximum percentage at risk for the reporting period will be 0.5% not to exceed $50,000. All above standards will be reviewed on an annual basis. Penalties for all categories are calculated on an aggegrate basis. The proposed performance guarantee matrix is for the period 01/01/2017 through 12/31/2017.**	

Vendor agrees to provide quarterly updates on the above performance guarantees and will agree to provide the year-end reconcilation 60 days after the close of the contract year.

Authorized Representive

Kim Sonerholm
Name (printed)

HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

HPN Solutions HMO 10 CC (Direct Access)

Attachment A Benefit Schedule

The Calendar Year Out of Pocket Maximum is $6,000 per Member and $12,000 per family.

The Out Of Pocket Maximum does not include; 1) amounts charged for non-Covered Services, 2) amounts exceeding applicable Plan benefit maximums or EME payments; or, 3) penalties for not obtaining any required Prior Authorization or for the Member otherwise not complying with HPN's Managed Care Program.

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Medical Office Visits and Consultations in a Medical Office Setting		
• **Primary Care Services**	No	
Convenient Care Facility		Member pays $5 per visit.
Physician Extender or Assistant		Member pays $5 per visit.
Physician		Member pays $10 per visit.
• **Specialist Services**	Yes	Member pays $20 per visit.
◦ Specialist Services – Direct Access Self-Referral. PCP referral not required	No	Member pays $50 per visit.
Preventive Healthcare Services - *Services include various recommended exams, immunizations, diagnostic tests and screenings and all FDA approved contraceptive methods. Refer to the HPN Preventive Guidelines on the HPN website (www.myhpnonline.com) located under the "Members & Guests" tab or contact the Member Services Department (702-242-7300) for the complete list of covered Adult and Pediatric Preventive Services and Immunizations. These guidelines are updated in accordance with the Federal Government standards.*	No	Member pays $0 per visit.
Routine Lab and X-ray services provided and billed by the Physician's office. (*Copayment/Cost-share is in addition to the Physician office visit Copayment/cost-share and applies to services rendered in a Physician's office.*)	Yes	
• Lab		Member pays $5 per visit.
• X-Ray		Member pays $5 per visit.

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Telemedicine Services *(Only available through select Providers.)*	No	Member pays $5 per visit.
Laboratory Services – Outpatient *Performed at an independent facility.*	Yes	Member pays $5 per visit.
Routine Radiological and Non-Radiological Diagnostic Imaging Services *Performed at a Free-Standing Diagnostic Center.*	Yes	Member pays $5 per visit.
Emergency Services		
• Urgent Care Facility	No	Member pays $20 per visit.
• Emergency Room Visit	No	Member pays $100 per visit; waived if admitted.
• Hospital Admission – Emergency Stabilization *Applies until patient is stabilized and safe for transfer as determined by the attending Physician.*	No	
UMC**		No charge
Other HPN Plan Facility		Member pays $250 per admission.
Ambulance Services		
• Emergency Transport	No	Member pays $50 per trip.
• Non-Emergency – HPN Arranged Transfers	Yes	Member pays $0.
Inpatient Hospital Facility Services *Elective and Emergency Post-Stabilization Admissions*	Yes	
UMC**		No charge
Other HPN Plan Facility		Member pays $250 per admission.
Outpatient Surgery at a Hospital Facility	Yes	
UMC**		No charge
Other HPN Plan Facility		Member pays $75 per surgery.
Ambulatory Surgical Facility Services	Yes	
UMC**		No charge
Other HPN Plan Facility		Member pays $75 per surgery.
Anesthesia Services	Yes	No charge

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Physician Surgical Services – Inpatient and Outpatient		
• Inpatient or Outpatient Hospital Facility	Yes	No charge
• Ambulatory Surgical Facility	Yes	Member pays $10 per surgery.
• Physician's Office Primary Care Physician (Includes all physician services related to the surgical procedure)	No	Member pays $10 per visit.
Specialist (Includes all physician services related to the surgical procedure)	Yes	Member pays $20 per visit.
Gastric Restrictive Surgery Services *HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member.*	Yes	
• Physician Surgical Services		Member pays 50% of EME per surgery. Subject to maximum benefit.
• Physician Office Visit		Member pays $20 per visit.
Organ and Tissue Transplant Surgical Services		
• Inpatient Hospital Facility UMC**	Yes	No charge
Other HPN Plan Facility		Member pays $250 per admission.
• Physician Surgical Services – Inpatient Hospital Facility	Yes	No charge
• Transportation, Lodging and Meals *The maximum benefit per Member per Transplant Benefit Period for transportation, lodging and meals is $10,000. The maximum daily limit for lodging and meals is $200.*	Yes	Member pays $0. Subject to maximum benefit.
• Procurement *Benefits for procurement procedures and/or services are limited to those deemed by HPN to be Medically Necessary and appropriate for an approved Organ Transplant in a single Transplant Benefit Period.*	Yes	Member pays $0.
• Retransplantation Services *Benefits are limited to one (1) Medically Necessary Retransplantation per Member per type of transplant.*	Yes	HPN pays 50% of EME. Subject to maximum benefit.

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Post-Cataract Surgical Services • Frames and Lenses	Yes	$10 per pair of glasses. Subject to maximum benefit.
• Contact Lenses *Benefits are limited to one (1) Medically Necessary pair of glasses or set of contact lenses as applicable per Member per surgery.*	Yes	$10 per set of contact lenses. Subject to maximum benefit.
Home Healthcare Services (*does not include Specialty Prescription Drugs)* *Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drugs.*	Yes	No charge
Hospice Care Services • Inpatient Hospice Facility UMC**	Yes	No charge
Other HPN Plan Facility		Member pays $250 per admission.
• Outpatient Hospice Services	Yes	Member pays $0 per visit.
• Inpatient and Outpatient Respite Services *Benefits are limited to a combined maximum benefit of five (5) Inpatient days or five (5) Outpatient visits per Member per ninety (90) days of Home Hospice Care.*	Yes	
◦ Inpatient		Member pays $250 per admission. Subject to maximum benefit.
◦ Outpatient		Member pays $10 per visit. Subject to maximum benefit.
• Bereavement Services *Benefits are limited to a maximum benefit of five (5) group therapy sessions. Treatment must be completed within six (6) months of the date of death of the Hospice patient.*	Yes	Member pays $20 per visit. Subject to maximum benefit.
Skilled Nursing Facility *Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.*	Yes	Member pays $250 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.
Manual Manipulation *Applies to Medical-Physician Services and Chiropractic office visit. Subject to a maximum benefit of twenty (20) visits per Member per Calendar Year.*	Yes	Member pays $20 per visit. Subject to maximum benefit.

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Short-Term Rehabilitation and Habilitative Services • Inpatient Hospital Facility UMC** Other HPN Plan Facility • Outpatient *All Inpatient and Outpatient Short Term Rehabilitation and Habilitative Services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year.*	Yes Yes	No charge Member pays $250 per admission. Subject to maximum benefit. Member pays $5 per visit. Subject to maximum benefit.
Durable Medical Equipment *Monthly rental or purchase at HPN's option. Purchases are limited to a single purchase of a type of DME, including repair and replacement, every three (3) years.*	Yes	No charge. Subject to maximum benefit.
Genetic Disease Testing Services • Office Visit • Lab *Includes Inpatient, Outpatient and independent Laboratory Services.*	Yes	HPN pays 75% of EME per test. HPN pays 75% of EME per test.
Infertility Office Visit Evaluation *Please refer to applicable surgical procedure Copayment/Cost-share herein for any surgical infertility procedures performed.*	Yes	Member pays $20 per visit.
Medical Supplies	Yes	Member pays $0.
Other Diagnostic and Therapeutic Services *Copayment/Cost-share is in addition to the Physician office visit Copayment/cost-share and applies to services rendered in a Physician's office or at an independent facility.* • Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services. • Dialysis • Therapeutic Radiology • Allergy Testing and Serum Injections • Otologic Evaluations	Yes \	Member pays $10 per day. Member pays $10 per day. Member pays $10 per day. Member pays $10 per visit. Member pays $10 per visit.

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Other Diagnostic and Therapeutic Services (continued)	Yes	
• Other complex diagnostic imaging services such as CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services.		Member pays $10 per test or procedure.
• Positron Emission Tomography (PET) scans		Member pays $10 per test or procedure.
Prosthetic Devices *Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.*	Yes	Member pays $200 per device. Subject to maximum benefit.
Orthotic Devices *Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.*	Yes	Member pays $200 per device. Subject to maximum benefit.
Self-Management and Treatment of Diabetes		
• Education and Training	No	Member pays $5 per visit.
• Supplies (except for Insulin Pump Supplies)	No	Member pays $5 per therapeutic supply.
Insulin Pump Supplies	Yes	Member pays $5 per therapeutic supply.
• Equipment (except for Insulin Pump)	Yes	Member pays $20 per device.
Insulin Pump	Yes	Member pays $20 per device.
Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.		
Special Food Products and Enteral Formulas *Special Food Products only are limited to a maximum benefit of one (1) thirty (30) day therapeutic supply per Member four (4) times per Calendar Year.*	Yes	Member pays $0. Subject to maximum benefit.
Temporomandibular Joint Treatment	Yes	Member pays $20 per visit.

Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
Mental Health and Severe Mental Illness		
• Inpatient Hospital Facility UMC**	Yes	No charge
Other HPN Plan Facility		Member pays $250 per admission.
• Outpatient Treatment	Yes	Member pays $10 per visit.
Substance Abuse Services		
• Inpatient Hospital Facility UMC**	Yes	No charge
Other HPN Plan Facility		Member pays $250 per admission.
• Outpatient Treatment	Yes	Member pays $10 per visit.
Hearing Aids *Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.*	Yes	No charge. Subject to maximum benefit.
Applied Behavioral Analysis (ABA) for the treatment of Autism of Members up to age 22 *Limited to two hundred fifty (250) visits not to exceed seven hundred fifty (750) total hours of therapy per Member per Calendar Year.*	Yes	Member pays $10 per visit. Subject to maximum benefit.

A Member's Copayment/cost-share will not be more than 50% of the allowed cost of providing any single service or supplying an item to a Member, after the deductible, if applicable, has been met. A Member may not contribute any more than the individual CYD amount toward the family CYD amount. A Member may not contribute any more than the individual Calendar Year Out of Pocket Maximum toward the family Calendar Year Out of Pocket Maximum amount.

Please note: For all Inpatient and Outpatient admissions, including those for Emergency or Urgent Care, in addition to specified surgical Copayment/cost-share amounts, Member is also responsible for all other applicable facility and professional Copayments/cost-share as outlined in the Attachment A Benefit Schedule.

Member is responsible for any and all amounts exceeding any stated maximum benefit amounts and/or any/all amounts exceeding the Plan's payment to Non-Plan Providers under this Plan. Further, such amounts do not accumulate to the calculation of the Calendar Year Out of Pocket Maximum.

*Referral or Prior Auth. Required – Except as otherwise noted and, with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness and Substance Abuse Services, all Covered Services not provided by the Member's Primary Care Physician require a Referral or a Prior Authorization in the form of a written referral authorization from HPN. Please refer to your HPN Evidence of Coverage for additional information.

** Benefits for Covered Services provided by UMC are subject to availability and will only be covered if provided in the HPN Service Area.

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.myhpnonline.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, $6,000/Member and $12,000/Family per Calendar Year.	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 for services 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.myhpnonline.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.

Questions: Call (702) 242-7300 or 1-800-777-1840 or visit us at www.myhpnonline.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

- **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 **Plan Providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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	$10 copay/visit	Not Covered	None
	Specialist visit	$20 copay/visit	Not Covered	Member pays for cost of services if prior authorization is not obtained. Plan Providers seen without a referral $50 copay/visit.
	Other practitioner office visit	$20 copay/visit	Not Covered	Manual manipulation (Chiropractic) coverage is limited to 20 visits. Member pays for cost of services if prior authorization is not obtained.
	Preventive care/ screening/ immunization	$0 copay/visit	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	$5 copay/service	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Imaging (CT/PET scans, MRIs)	$10 copay/service	Not Covered	
If you need drugs to treat your illness or condition	Tier 1	$20 copay (retail) $50 copay (mail)	Not Covered	You have a 3-Tier pharmacy plan. Covers up to a 30-day retail supply or up to a 90-day mail order supply. Member pays for cost of services if prior authorization or step therapy is not obtained.

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.myhpnonline.com.	Tier 2	$40 copay (retail) $100 copay (mail)	Not Covered	You have a 3-Tier pharmacy plan. Covers up to a 30-day retail supply or up to a 90-day mail order supply. Member pays for cost of services if prior authorization or step therapy is not obtained.
	Tier 3	$70 copay (retail) $175 copay (mail)	Not Covered	You have a 3-Tier pharmacy plan. Covers up to a 30-day retail supply. Member pays for cost of services if prior authorization or step therapy is not obtained.
	Tier 4	Not Covered	Not Covered	Not Applicable.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Physician/surgeon fees	$10 copay/surgery	Not Covered	
If you need immediate medical attention	Emergency room services	ER Physician: $0 copay/visit ER Facility: $100 copay/visit	ER Physician: $0 copay/visit ER Facility: $100 copay/visit	You may be balance billed from Non-Plan Providers.
	Emergency medical transportation	$50 copay/trip	$50 copay/trip	
	Urgent care	$20 copay/visit	$20 copay/visit	You may be balance billed from Non-Plan Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Physician/surgeon fee	$0 copay/surgery	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$10 copay/visit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Mental/behavioral health inpatient services	$250 copay/admit	Not Covered	
	Substance abuse disorder outpatient services	$10 copay/visit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Substance abuse disorder inpatient services	$250 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 are 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: $250 copay/admit Surgical, Anesthesia: $0 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
If you have a recovery or other special health need	Home health care	$0 copay/visit	Not Covered	Does not include Specialty Prescription Drugs. Member pays for cost of services if prior authorization is not obtained.
	Rehabilitation services	$5 copay/visit	Not Covered	Coverage is limited to 60 days/visits per year. Member pays for cost of services if prior authorization is not obtained.
	Habilitative services	$5 copay/visit	Not Covered	Coverage is limited to 60 days/visits per year. Member pays for cost of services if prior authorization is not obtained.
	Skilled nursing care	$250 copay/admit	Not Covered	Coverage is limited to 100 days. Member pays for cost of services if prior authorization is not obtained.
	Durable medical equipment	$0 copay/device	Not Covered	For purchase or rental at HPN's option. Purchases are limited to a single type of DME, including repair and replacement, every 3 years. Member pays for cost of services if prior authorization is not obtained.
	Hospice services	$250 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
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**.)

- Abortion (except for rape, incest, life at risk)
- Acupuncture
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Limited 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 (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. If your employer determines that your plan is subject to ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Office of Consumer Health Assistance at 1-888-333-1597 or http://dhhs.nv.gov. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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:

Spanish (Español): Para obtener asistencia en español, llame al número de teléfono de servicio al cliente que se incluye en este documento.

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

Chinese (中文): 若需要中文协助，请拨打本文件内的客户服务电话。

Navajo (Dine): 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:** $7,600
- **Plan pays** $6,800
- **Patient pays** $800

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$1,200
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$1,000
Total	**$7,600**

Patient pays:

Deductibles	$0
Copays	$800
Coinsurance	$0
Limits or Exclusions	$0
Total	**$800**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,800
- **Patient pays** $1,600

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	$1,600
Coinsurance	$0
Limits or Exclusions	$0
Total	**$1,600**

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.

Questions: Call (702) 242-7300 or 1-800-777-1840 or visit us at www.myhpnonline.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

MEDICAL/PRESCRIPTION, BHO+, DENTAL & VISION HPN Solutions HSIO-10 SC, $20/40/$700 6x Rx, BHO +, Dental, Vision Care Services Domestic Partner Rider Rates Guaranteed for Period 1/1/2017 to 12/31/2017	
Individual Employee	$476.19
Employee & Spouse	$891.55
Employee & Child	$871.97
Employee & Children	$871.97
Employee & Family	$1,254.11

GROUP SENIOR DIMENSIONS RISK RATES Group Senior Dimensions Risk Rates And Benefits Guaranteed For Period of 1/1/2017 to 12/31/2017			
	Senior Dimensions BHO+ W/Pres. Drugs & Vision Coverage	Dental	Total
Employee	$298.75	$40.44	$339.19
Employee & Spouse (Two Medicare A&B)	$597.50	$75.72	$673.22
Employee & Spouse (One Medicare A&B)	$678.83	$75.72	$754.55
Employee & Child/Children (One Medicare A&B)	$660.93	$74.04	$734.97
Employee & Spouse plus Child (Three Medicare A&B)	$896.25	$105.82	$1,002.07
Employee & Family (Two Medicare A&B)	$929.96	$105.82	$1,035.78
Employee & Family (One Medicare A&B)	$1,011.29	$105.82	$1,117.11