Nevada Basic Health Benefit Plan – Exhibit 1

Benefit Features	Basic Indemnity Plan	Basic PPO Network Benefit	Basic PPO Non-Network Benefit[i]	Basic HMO Plan
Lifetime Maximum Benefit	**None**	**None**		**None**
Calendar Year Deductible **(NO FAMILY Deductible)**	**$5,000 Deductible Per Person**	**$3,000 Deductible Per Person**	**$6,000 Deductible Per Person**	**None**
Coinsurance Maximum	**50% of the first $10,000 of eligible expenses; 100% thereafter**	**60% of the first $10,000 of eligible expenses; 100% thereafter**	**40% of the first $10,000 of eligible expenses; 100% thereafter**	**None**
Out-of-Pocket Maximum[ii] **Individual** **Family**	**$10,000 Per Person** **NA**	**$7,000 Per Person** **NA**	**$12,000 Per Person** **NA**	**$6,000 Per Person** **$12,000 Per Family**
Facility Services • Acute Hospital • Skilled Nursing/ Rehabilitation/Hospice • Outpatient and Ambulatory Surgical Facility	50%	60%	40%	• $500/day not to exceed $1,500/admission • $300/admission • $500/admission
Emergency Care[iii] • Emergency Facility • Urgent Care Facility • Ambulance	50%	60%	60%	• $250/visit • $75/visit • $250/trip

Physician Services • Office Visit • Specialist Visit • Preventive Services[iv] (deductible does not apply) • Surgery in a Facility • Other Physician Services	50% 50% 100%	$30 per visit[v] $60 per visit[v] $0 per visit 60% 60%	40% 40%	• $30/visit • $60/visit • $0/visit • $300/procedure • $300/procedure
Outpatient Treatment • Laboratory & X-ray Services • All others	50%	60%	40%	• $30/visit • $60/visit
Prescription Drugs[vi]	50%[vii]	60%[viii]	40%	• $15/generic 30 day supply • $40/brand name 30 day supply

Nevada Basic Health Benefit Plan Limitations

Durable Medical Equipment – No limitation applies.

Skilled Nursing/Rehabilitation – 30 days per Calendar Year.

Home Health Care – 30 visits per Calendar Year.

Mental Health Services
- Outpatient – Not Covered.
- Inpatient – Not Covered.

Severe Mental Health Services
- Outpatient – Not Covered.
- Inpatient – Not Covered.

Substance Abuse Services
- Outpatient – Not Covered.
- Inpatient – Not Covered.

Manual Manipulation & Subluxation of the Spine – Not Covered.

Transplant - No limitation applies.

Maternity – Not covered on Individual plan. Optional coverage must be offered to groups of 2 to 14. Covered for groups of 15 to 50. Complications of pregnancy are covered.

Physical, Speech, or Occupational Therapy – 30 days per Calendar Year.

TMJ (Medical Treatment Only) - No limitation applies..

Conversion Basic Plans – A conversion plan cannot contain a provision for subrogation, coordination of benefits with a group plan nor binding arbitration other than IME.

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[i] Non-Network expenses accumulate separately from network expenses.

[ii] Out-of-Pocket maximum includes the deductible and coinsurance payments made by the member. This does not include copayments paid (except on HMO plans) on ineligible expenses.

[iii] Emergency care can be limited to medically necessary care subject to Nevada statute and regulation.

[iv] Preventive services include services with an "A" or "B" rating from the United States Preventive Services Task Force, immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents.

[v] The PPO office and specialist visit copayments include office visit expenses only. All other services billed with the office visit will be applied to the deductible and coinsurance.

[vi] A third tier prescription drug benefit may be offered when a preferred drug list is used. Copayments are $15 for preferred generic, $40 for preferred brand name and $60 for the non-preferred drug tier. Mail Order Delivery pharmacy benefits may be provided.

[vii] A prescription drug card may be offered in addition to the Basic Plan prescription benefits.

[viii] A $15 generic/$40 brand name/$60 non-preferred prescription drug card may be substituted by the carrier for deductible and coinsurance under the prescription drug benefit.

Nevada Standard Health Benefit Plan – Exhibit 2

Benefit Features	Standard Indemnity	Standard PPO Network Benefit	Standard PPO Non-Network Benefit[i]	Standard HMO Plan
Lifetime Maximum Benefit	**None**	**None**		**None**
Calendar Year Deductible **Individual** **Family**	**$3,000** **$6,000**	**$1,500** **$3,000**	**$3,000** **$6,000**	**None** **None**
Coinsurance Maximum	**70% of the first $10,000 of eligible expenses; 100% thereafter**	**70% of the first $10,000 of eligible expenses; 100% thereafter**	**50% of the first $10,000 of eligible expenses; 100% thereafter**	**None**
Out-of-Pocket Maximum[ii] **Individual** **Family**	**$6,000** **$12,000**	**$4,500** **$9,000**	**$8,000** **$16,000**	**$3,000** **$6,000**
Facility Services • Acute Hospital • Skilled Nursing/ Rehabilitation/Hospice • Outpatient and Ambulatory Surgical Facility	70%	70%	50%	• $300/day not to exceed $900/admission • $150/admission • $300/admission
Emergency Care[iii] • Emergency Facility • Urgent Care Facility • Ambulance	70%	70%	70%	• $150/visit • $50/visit • $150/trip

Physician Services • Office Visit • Specialist Visit • Preventive Services[iv] (deductible does not apply) • Surgery in a Facility • Other Physician Services	70% 70% 100%	$20 per visit[v] $40 per visit[v] $0 per visit 70% 70%	50%	• $20/visit • $40/visit • $0/visit • $100 • $100
Outpatient Treatment • Laboratory & X-ray Services • All others	70%	70%	50%	• $20/visit • $20/visit
Prescription Drugs[vi]	70%[vii]	70%[viii]	50%	• $10/generic 30 day supply • $30/brand name 30 day supply

Nevada Standard Health Benefit Plan Limitations

Durable Medical Equipment – No limitation applies.

Skilled Nursing/Rehabilitation – 100 days per Calendar Year.

Home Health Care – 100 visits per Calendar Year.

Mental Health Services
- Outpatient - Maximum 20 visits per Calendar Year.
- Inpatient – Maximum 30 days per Calendar Year.

Severe Mental Health Services
- Outpatient - Maximum 40 visits per Calendar Year.
- Inpatient – Maximum 40 days per Calendar Year.

Substance Abuse Services
- Treatment for withdrawal – No limitation applies.
- Treatment when admitted to a facility - No limitation applies.
- Counseling for a person, group or family - No limitation applies.

Manual Manipulation & Subluxation of the Spine – 10 visits maximum per Calendar Year.

Transplant - No limitation applies.

Maternity – Covered as any other illness.

Physical, Speech, or Occupational Therapy – 30 days per Calendar Year.

TMJ (Medical Treatment Only) - No limitation applies.

Conversion Standard Plans – A conversion plan cannot contain a provision for subrogation, coordination of benefits with a group plan nor binding arbitration other than IME.

Coverage for Autism Spectrum Disorders- Carriers issuing a Standard Plan to a small employer are required to provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders with a maximum benefit of $36,000 per year for applied behavior analysis treatment. Carriers issuing an individual or conversion Standard Plan are required to offer coverage for autism spectrum disorders.

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[i] Non-Network expenses accumulate separately from network expenses.

[ii] Out-of-Pocket maximum includes the deductible and coinsurance payments made by the individual or family. This does not include copayments paid (except on HMO plans) or ineligible expenses. This amount will not exceed 200% of premium for federally qualified HMO plans.

[iii] Emergency care can be limited to medically necessary care subject to Nevada statute and regulation.

[iv] Preventive services include services with an "A" or "B" rating from the United States Preventive Services Task Force, immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents.

[v] The PPO office and specialist visit copayments include office visit expenses only. All other services billed with the office visit will be applied to the deductible and coinsurance.

[vi] A third tier prescription drug benefit may be offered when a preferred drug list is used. Copayments are $10 for preferred generic, $30 for preferred brand name and $50 for the non-preferred drug tier. Mail Order Delivery pharmacy benefits may be provided.

[vii] A prescription drug card may be offered in addition to the Standard Plan prescription benefits.

[viii] A $10 generic/$30 brand name/$50 non-preferred prescription drug card may be substituted by the carrier for coinsurance under the prescription drug benefit.

Required Exclusions
Nevada Basic and Standard Health Benefit Plans – Exhibit 3

The following services are not covered:

1. Services for which coverage is not specifically provided, complications resulting from non-Covered Services, or services which are not Medically Necessary, whether or not recommended or provided by a Provider.

2. Personal comfort, hygiene, or convenience items such as a Hospital television, telephone, or private room when not medically Necessary. Housekeeping or meal services as part of Home Health Care. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.

3. For a private room in excess of the average semi-private room and board rate.

4. Dental or orthodontic splints or dental prostheses, or any treatment on or to teeth, gums, or jaws and other services customarily provided by a dentist. Charges for dental services in connection with temporomandibular joint dysfunction are also not covered unless they are determined to be Medically Necessary. Such dental-related services are subject to the limitation shown in the Benefit Schedule.

5. Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function.

6. Third-party physical exams for employment, licensing, insurance, school, camp, sports, or adoption purposes. Immunizations related to foreign travel. Expenses for medical reports, including presentation and preparation. Exams or treatment ordered by a court, or in connection with legal proceedings if not medically necessary or a covered service.

7. For fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for any treatment related to or connected in any way with the restoration or enhancement of fertility or conception by artificial means including Embryo transplants, in vitro fertilization, GIFT and ZIFT procedures and low tubal transfer.

8. For the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and implantation of a penile prosthesis. Reversal of surgically performed sterilization or subsequent resterilization. Charges for genetic testing, counseling, treatment or therapy.

9. Elective abortions.

10. Surgical or invasive treatment (including gastric balloon) or reversal for reduction of weight regardless of associated medical or psychological conditions, unless determined to be Medically Necessary. Any weight loss programs, whether or not recommended, provided or prescribed by a physician or other medical practitioner.

11. Treatment of chronic marital or family problems; occupational, religious, or other social maladjustments; chronic behavior disorders; codependency; impulse control disorders, organic disorders, learning disabilities or mental retardation.

12. Institutional care which is determined to be for the primary purpose of controlling Member's environment and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures.

13. Vision exams to determine refractive errors of vision and eye glasses or contact. Coverage is provided for vision exams only when required to diagnose an Illness or Injury.

14. Hearing exams to determine the need for or the appropriate type of hearing aid or similar. Coverage is provided for hearing exams only when required to diagnose an Illness or Injury.

15. Ecological or environmental medicine. Use of chelation, orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for treatment; electrodiagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns; replacement of metal dental fillings; laetrile; gerovital.

16. Services for chronic, intractable pain by a pain control center or under a pain control program.

17. Acupuncture or hypnosis.

18. Treatment of an Illness or Injury resulting from riots, war, insurrection; rebellion; or armed invasion or aggression.

19. Treatment of an occupational Injury or Illness which is any Injury or Illness arising out of or in the course of employment for pay or profit.

20. Travel and accommodations, whether or not recommended or prescribed by a Provider.

21. Vitamins, herbal medicines, appetite suppressants, and other over-the-counter drugs. Drugs and medicines approved by the FDA for experimental or investigational use.

22. Any services provided before the Effective Date or after the termination of coverage.

23. Care for conditions that federal, state or local law requires to be treated in a public facility for which a charge is not normally made.

24. Any equipment or supplies that condition the air, arch supports, support stockings, special shoe accessories or corrective shoes unless they are an integral part of a lower-body brace, heating pads, hot water bottles, wigs and their care and other primarily non-medical equipment.

25. Special formulas, food supplements other than as specifically covered or special diets on an outpatient basis. (Except for the treatment of inherited metabolic disease.

26. Services, supplies or accommodations provided without cost to the Member or which the Member is not legally required to pay.

27. Milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolffing, residential treatment, vocational rehabilitation and wilderness programs.

28. Experimental or investigational treatment or devices.

29. Sports medicine treatment plans intended to primarily improve athletic ability.

30. Radial keratotomy or any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses.

31. Any services given by a Provider to himself or to members of his family.

32. Ambulance services when a Member could be safely transported by other means. Air ambulance services when a Member could be safely transported by ground Ambulance or other means.

33. Late discharge billing and charges resulting from a canceled appointment or procedure.

34. Care or treatment of an illness or injury caused by or arising out of participation in a riot, war, insurrection, rebellion, armed invasion or aggression; or sustained by a Member while in the act of committing a felony.

35. If you are eligible for Medicare, any services covered by Medicare under Parts A and B are excluded to the extent actually paid for by Medicare (applicable to individual coverage only).

36. [Manual manipulation and sublaxation of the spine is not covered under the Basic Plan.]

37. [Maternity care is not covered under the Individual Basic Plan. Maternity care is an optional benefit for groups of 2 to 15. Covered for groups of 15 to 50. Complications of pregnancy are covered. Maternity is covered as any other illness under the Standard Plan.]

38. [Alcohol and Drug Abuse Treatment Services, Mental Health Services, and Services for Treatment of Severe Mental Illness are not covered under the Basic Plan.]

39. [Coverage for medical treatment for Phase I study or clinical trial for the treatment of cancer is not covered under the Basic Plan.]

40. [Coverage for autism spectrum disorders is not covered under the Basic Plan.]

41. [If not purchased, coverage for autism spectrum disorders is not covered under the individual or conversion Standard Plans.]