The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.healthplanofnevada.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-777-1840 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	There is no deductible for HMO Providers. $1,500 / Member and $3,000 / Family for Plan Providers and $3,000 / Member and $6,000 / Family for Non-Plan Providers .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care provided by HMO/Plan Providers is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,500 / Member and $9,000 / Family for HMO Providers; $6,250 / Member and $12,500 / Family for Plan Providers and $12,500 / Member and $25,000 / Family for Non-Plan Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for not obtaining any required prior authorization, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthplanofnevada.com/Member/Doctor-or-Provider or call 1-800-777-1840 for a list of Plan Providers.	You pay the least if you use an HMO provider. You pay more if you use a network provider. You will pay the most if you use an out-of-network provider and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

*For more information about limitations and exceptions, see the plan or policy document at www.healthplanofnevada.com

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		HMO Provider (You will pay the least)	Plan Provider (You pay more)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	$35 copay/visit; deductible does not apply	50% coinsurance	None
	Specialist visit	$40 copay/visit	$55 copay/visit; deductible does not apply	50% coinsurance	Member pays for cost of services or 50% benefit reduction if required prior authorization is not obtained.
	Preventive care/ screening/ immunization	No charge	No charge	50% coinsurance	Deductible applies when services are obtained from Non-Plan Providers. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $25 copay/service Lab: $15 copay/service	X-ray: $40 copay/service; deductible does not apply Lab: $30 copay/service; deductible does not apply	50% coinsurance	Member pays for cost of services or 50% benefit reduction if required prior authorization is not obtained.
	Imaging (CT/PET scans, MRIs)	MRI: $100 copay/service PET Scan: $100 copay/service CT: $100 copay/service	20% coinsurance	50% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.healthplanofnevada.com

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		HMO Provider (You will pay the least)	Plan Provider (You pay more)	Non-Plan Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthplanofnevada.com	Tier 1	$10 copay/prescription (retail) $25 copay/prescription (mail)	$10 copay/prescription (retail) $25 copay/prescription (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 2	$35 copay/prescription (retail) $87.50 copay/prescription (mail)	$35 copay/prescription (retail) $87.50 copay/prescription (mail)	Not Covered	
	Tier 3	$60 copay/prescription (retail) $150 copay/prescription (mail)	$60 copay/prescription (retail) $150 copay/prescription (mail)	Not Covered	
	Tier 4	Not Applicable	Not Applicable	Not Applicable	Not Applicable.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital: $300 copay/surgery Ambulatory Surg Center: $150 copay/surgery	20% coinsurance	50% coinsurance	Member pays for cost of services or 50% benefit reduction if required prior authorization is not obtained.
	Physician/surgeon fees	Hospital: $200 copay/surgery Ambulatory Surg Center: $150 copay/surgery	20% coinsurance	50% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.healthplanofnevada.com

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		HMO Provider (You will pay the least)	Plan Provider (You pay more)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	ER Facility: $300 copay/visit ER Physician: No charge	ER Facility: $300 copay/visit; deductible does not apply ER Physician: No charge	ER Facility: $300 copay/visit; deductible does not apply ER Physician: No charge	You may be balance billed from Non-Plan Providers.
	Emergency medical transportation	$250 copay/trip	$250 copay/trip; deductible does not apply	$250 copay/trip; deductible does not apply	
	Urgent care	$40 copay/visit	$40 copay/visit; deductible does not apply	$40 copay/visit; deductible does not apply	You may be balance billed from Non-Plan Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 copay/admit	20% coinsurance	50% coinsurance	Member pays for cost of services or 50% benefit reduction if required prior authorization is not obtained.
	Physician/surgeon fees	$200 copay/surgery	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	$35 copay/visit; deductible does not apply	50% coinsurance	Member pays for cost of services or 50% benefit reduction if required prior authorization is not obtained.
	Inpatient services	$750 copay/admit	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	No charge	No charge	50% coinsurance	Routine prenatal care obtained from a Plan Provider is covered at no charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. Lab).
	Childbirth/delivery professional services	Surgical: $200 copay/admit Anesthesia: $150 copay/admit	20% coinsurance	50% coinsurance	Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services; each service has a separate cost-share. Member pays for cost of services if prior authorization is not obtained.
	Childbirth/delivery facility services	$750 copay/admit	20% coinsurance	50% coinsurance	Member pays for cost of services or 50% benefit reduction if required prior authorization is not obtained.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		HMO Provider (You will pay the least)	Plan Provider (You pay more)	Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$35 copay/visit	20% coinsurance	50% coinsurance	Does not include Specialty Prescription Drugs. Coverage is limited to a combined Plan/Non-Plan benefit of 60 days. Member pays for cost of services or 50% benefit reduction if required prior authorization is not obtained.
	Rehabilitation services	$20 copay/visit	20% coinsurance	50% coinsurance	Coverage is limited to a combined Inpatient and Outpatient, HMO/Plan/Non-Plan benefit of 120 days/visits. Member pays for cost of services or 50% benefit reduction if required prior authorization is not obtained.
	Habilitation services	$20 copay/visit	20% coinsurance	50% coinsurance	Coverage is limited to a combined Inpatient and Outpatient, HMO/Plan/Non-Plan benefit of 120 days/visits. Member pays for cost of services or 50% benefit reduction if required prior authorization is not obtained.
	Skilled nursing care	$500 copay/admit	20% coinsurance	50% coinsurance	Coverage is limited to 100 days. Member pays for cost of services or 50% benefit reduction if prior authorization is not obtained.
	Durable medical equipment	No charge	Not Covered	Not Covered	Covered under HMO Providers only. 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 or 50% benefit reduction if required prior authorization is not obtained.
	Hospice services	$750 copay/admit	Not Covered	Not Covered	Covered under HMO Providers only. Member pays for cost of services if prior authorization is not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Your plan may include certain vision and/or dental services. Please refer to your plan documents for more information.
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

*For more information about limitations and exceptions, see the plan or policy document at www.healthplanofnevada.com

- Dental Care (Adult)
- Routine eye care (Adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery - One (1) per Lifetime
- Chiropractic care - 20 visits per calendar year
- Hearing aids - One (1) every three (3) years (including repair/replace)
- Limited infertility treatment
- Private-duty nursing

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Nevada Department of Insurance at 888-872-3234 or www.doi.nv.gov or call 1-800-777-1840

Does this plan provide Minimum Essential Coverage?

Yes. Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards?

Yes. If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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 section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0.00
Specialist copayment	$40.00
Hospital (facility) copayment	$750.00
Other copayment	$150.00

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700.00
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0.00
Copayments	$2,100.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$80.00
The total Peg would pay is	$2,180.00

Managing Joe's type 2 diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0.00
Specialist copayment	$40.00
Hospital (facility) copayment	$300.00
Other copayment	$15.00

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$5,600.00
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0.00
Copayments	$800.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$40.00
The total Joe would pay is	$840.00

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$0.00
Specialist copayment	$40.00
Hospital (facility) copayment	$300.00
Other copayment	$25.00

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$2,800.00
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0.00
Copayments	$800.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	$800.00

The plan would be responsible for the other costs of these EXAMPLE covered services.

Health Plan of Nevada and Sierra Health and Life comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card or plan documents.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex; you can send a complaint to the Civil Rights Coordinator:
Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

If you need help filing a complaint, call the toll-free number on your member ID card or plan documents.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone: 1-800-368-1019 or 800-537-7697 (TDD)
Mail: U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F HHH Building
Washington D.C. 20201

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

This notice is available at:
https://healthplanofnevada.com/content/dam/hpnv-public-sites/documents/NVStandard15Taglines.pdf
https://sierrahealthandlife.com/content/dam/hpnv-public-sites/documents/NVStandard15Taglines.pdf

ATTENTION: If you speak **English**, language help and communications in other formats, like large print, are available and free to you. Call the phone number included in this document.

ATENCIÓN: Si habla **español** (**Spanish**), tiene acceso gratuito a asistencia lingüística y a materiales en otros formatos, como impresión en tamaño grande. Llame al número de teléfono que aparece en este documento.

ATENSYON: Kung nagsasalita ka ng **Tagalog**, ang tulong sa wika at komunikasyon sa iba pang mga format, tulad ng malalaking print, ay available at libre para sa iyo. Tawagan ang numero ng teleponong kasama sa dokumentong ito.

تنبيه: إذا كنت تتحدث اللغة العربية (Arabic)، فإن المساعدة اللغوية والتواصل بتنسيقات أخرى، مثل الطباعة بحروف كبيرة، متاحة لك مجانًا. يُرجى االتصال برقم الهاتف المذكور في هذا المستند.

মনোযোগ দিন: আপনি যদি **বাংলায় (Bengali),** কথা বলেন, তাহলে ভাষা সহায়তা এবং বড় প্রিন্টের মতো অন্যান্য ফর্ম্যাটে যোগাযোগ আপনার জন্য বিনামূল্যে উপলভ্য। এই নথিতে দেওয়া ফোন নম্বরে কল করুন।

ARONGORONG: Ngare' ukassal falawasch, eyoor alillis me' **arongorong** (**Carolinian**), llon akaaw met, gnare' min tuttumogh na iisch, emween ubwe ya'ya' sin ubwe abwos. Faingii numero ye eno won documento yen.

ATENSION: Yanggen fumimino' **Chamorro** hao, guaha dibåtde para hagu na ayudun lengguahi yan kumunikasion ni difirentes na fotmat, yan danglulo na tinigi'. Agang i numero nai gaige guini na dokumento.

注意：如果您說**中文(Chinese)**，您可以免費獲得語言協助和其他格式（例如大字版）的通訊。請撥打本文件內的電話號碼。

توجه: اگر به فارسی (Farsi)، صحبت میکنید، خدمات کمکی زبان و مطالب در قالبهای دیگر، مانند پرینت درشت، بصورت رایگان برای شما فراهم است. با شماره تلفنی که در این سند ذکر شده، تماس بگیرید.

ATTENTION: si vous parlez **français** (**French**), une assistance linguistique et des communications dans d'autres formats, tels que du texte en gros caractères, sont gratuitement mis à votre disposition. Appelez le numéro de téléphone inclus dans ce document.

HINWEIS: Wenn Sie **Deutsch** (**German**), sprechen, stehen Ihnen Sprachdienste und Mitteilungen in anderen Formaten, wie z. B. in Großdruck, kostenlos zur Verfügung. Rufen Sie die in dieser Mitteilung angegebene Telefonnummer an.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)**, બોલો છો, તો ભાષા સહાય અને સંદેશાવ્યવહાર અન્ય ફોર્મેટમાં, જેમ કે મોટી પ્રિન્ટમાં, તમારા માટે નિઃશુલ્ક અને ઉપલબ્ધ છે. આ દસ્તાવેજમાં આપેલા ફોન નંબર પર કૉલ કરો.

ATANSYON: Si w pale **Kreyòl Ayisyen** (**Haitian Creole**), genyen èd pou lang ou a disponib gratis pou ou ansanm ak kominikasyon nan lòt fòma, pa egzanp gwo lèt. Rele nan nimewo telefòn ki nan dokiman sa a.

ध्यान दें: यदि आप **हिन्दी (Hindi),** बोलते हैं, तो भाषा संबंधी मदद और अन्य प्रारूपों, जैसे बड़े प्रिंट, में संचार, आपके लिए उपलब्ध और निःशुल्क हैं। इस दस्तावेज़ में शामिल किए गए फ़ोन नंबर पर कॉल करें।

ATTENZIONE: se parla **italiano** (**Italian**), può usufruire gratuitamente di assistenza linguistica e comunicazioni in altri formati, come la stampa a caratteri grandi. Chiami il numero di telefono riportato in questo documento.

注意： 日本語(**Japanese**),を話される場合は、言語サポートや大きな活字などの他の形式でのコミュニケーションを無料でご利用いただけます。本書に記載されている電話番号までお電話ください。

참고: 한국어를 (**Korean**) 구사하신다면 언어 지원 및 의사소통을 큰 인쇄물과 같은 형식으로도 무료로 이용하실 수 있습니다. 본 문서에 있는 전화번호로 전화하십시오.

BAAʼ ÁKONÍNÍZIN: Diné (Navajo), bizaad bee yáníłti'go, saad bee áka'anáʼawo' dóó bee ahił dahane'í nááná łahgo át'éego bee hada'dilyaaígíí, díí nitsaa bee ak'eda'ashchíní t'áá jiik'eh ná dahóló. Díí naaltsoos bee éédahóziní bąąh námboo biká'ígíí bee hodíilnih.

WICHDICH: Wann du **Deitsch** (**Pennsylvania Dutch**), schwetzscht, kenne mer dich Schprooch-Hilf griege, wann du's brauchscht, un Information in differnti Wege, so wie gross Schreiwes (large print). All sell zellt dich nix koschde. Call der Toll-Free-Number as do debei is.

UWAGA: jeśli mówisz po **polsku** (**Polish**), oferujemy bezpłatną pomoc językową i materiały w innych formatach, w tym napisane dużym drukiem. Zadzwoń pod numer telefonu wskazany w tym dokumencie.

ATENÇÃO: se você fala **português** (**Portuguese**), a ajuda com o idioma e as comunicações em outros formatos, como letras grandes, por exemplo, estão disponíveis e são gratuitas. Ligue para o número de telefone incluído neste documento.

ВНИМАНИЕ: Если Вы говорите по-**русски**)**Russian**), Вы можете бесплатно воспользоваться помощью переводчика и информационными материалами в альтернативных форматах, например, крупным шрифтом. Позвоните по номеру телефона, указанному в этом документе.

MO LE SILAFIA: Pe afai e te tautala i le faa-**Samoa** (**Samoan**), o le fesoasoani tau gagana ma feso'ota'iga i isi auala, e pei o lomiga e lapopo'a mata'itusi, o loo avanoa mo oe aunoa ma se totogi. Valaau le numera o le telefoni o loo aofia ai i lenei pepa.

توجہ فرمائیں: اگر آپ اردو (Urdu), بولتے ہیں تو بڑے پرنٹ جیسی دوسری شکلوں میں لسانی امداد اور مواصلات آپ کے لیے مفت میں دستیاب ہوتی ہیں۔ اس دستاویز میں شامل فون نمبر پر کال کریں۔

LƯU Ý: Nếu quý vị nói tiếng **Việt**)**Vietnamese**), quý vị sẽ được hỗ trợ ngôn ngữ miễn phí và các định dạng thông tin miễn phí khác như bản in khổ lớn. Hãy gọi số điện thoại có trong tài liệu này.

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