Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Health Plan of Nevada: POS 15-30/750_20%/6850-1D $10/35/75/150

Coverage Period: 01/01/2020 - 12/31/2020
Coverage for: Subscriber and Family | **Plan Type:** POS

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. $750/Member and $1,500/Family for Plan Providers and $2,000/Member and $4,000/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?	$6,850/Member and $13,700/Family for HMO Providers; $6,850/Member and $13,700/Family for Plan Providers and $20,000/Member and $40,000/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.

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	$15 copay/visit	$30 copay/visit; deductible does not apply	50% coinsurance	None
	Specialist visit	$30 copay/visit	$60 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: $20 copay/service Lab: $10 copay/service	X-ray: $50 copay/service; deductible does not apply Lab: $25 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)	CT: $100 copay/service PET Scan: $100 copay/service MRI: $100 copay/service	20% coinsurance	50% coinsurance	

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) $10 copay/prescription (mail)	$10 copay/prescription (retail) $10 copay/prescription (mail)	Not Covered	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) $35 copay/prescription (mail)	$35 copay/prescription (retail) $35 copay/prescription (mail)	Not Covered	
	Tier 3	$75 copay/prescription (retail) $75 copay/prescription (mail)	$75 copay/prescription (retail) $75 copay/prescription (mail)	Not Covered	
	Tier 4	$150 copay/prescription (retail) $150 copay/prescription (mail)	$150 copay/prescription (retail) $150 copay/prescription (mail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 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	$100 copay/surgery	20% coinsurance	50% coinsurance	

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 Physician: No charge ER Facility: $500 copay/visit	ER Physician: No charge ER Facility: $500 copay/visit; deductible does not apply	ER Physician: No charge ER Facility: $500 copay/visit; deductible does not apply	You may be balance billed from Non-Plan Providers.
	Emergency medical transportation	$400 copay/trip	$400 copay/trip; deductible does not apply	$400 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)	$500 copay/day $1500 max/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	$150 copay/surgery	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	$30 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	$500 copay/day $1500 max/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: $150 copay/admit Anesthesia: $100 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	$500 copay/day $1500 max/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	$30 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	$15 copay/visit	20% coinsurance	50% coinsurance	Coverage is limited to a combined benefit of 60 days/visits. Member pays for cost of services or 50% benefit reduction if required prior authorization is not obtained.
	Habilitation services	$15 copay/visit	20% coinsurance	50% coinsurance	Coverage is limited to a combined benefit of 60 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	$500 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.)

- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery - One (1) per Lifetime	• Hearing aids - One (1) every three (3) years (including repair/replace)	• Private-duty nursing
• Chiropractic care - 20 visits per calendar year	• Limited infertility treatment	

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 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 Nevada Department of Insurance at 888-872-3234or www.doi.nv.gov or call 1-800-777-1840

Does this plan provide Minimum Essential Coverage?

Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	$30.00
Hospital (facility) copayment	$500.00
Other copayment	$100.00

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	$1,500.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	$1,500.00

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	$30.00
Hospital (facility) copayment	$500.00
Other copayment	$10.00

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	$7,400.00
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0.00
Copayments	$1,300.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	$1,300.00

Mia's Simple Fracture

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

The plan's overall deductible	$0.00
Specialist copayment	$30.00
Hospital (facility) copayment	$500.00
Other copayment	$20.00

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	$1,900.00
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0.00
Copayments	$900.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	$900.00

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

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the phone number listed within your Summary of Benefits and Coverage (SBC).

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the phone number listed within your Summary of Benefits and Coverage (SBC).

English: You have the right to get help and information in your language at no cost. To request an interpreter, call the phone number listed within this Summary of Benefits and Coverage (SBC).

This letter is also available in other formats like large print. To request the document in another format, please call the phone number listed within your Summary of Benefits and Coverage (SBC).

Español (Spanish): Usted tiene derecho a recibir ayuda e información en su idioma sin costo. Para pedir un intérprete, llame al número de teléfono que figura en este Resumen de Beneficios y Cobertura.

Tagalog (Tagalog): May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang libre. Upang humiling ng interpreter, tawagan ang numero ng telepono na nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

繁體中文 (Chinese):
您有權利以您的母語免費取得協助和資訊。若需申請口譯服務，請打本福利摘要 (SBC) 內含的電話號碼。

한국어(Korean): 귀하는 무료로 귀하의 언어를 통해 도움 및 정보를 받으실 권리가 있습니다. 통역사를 요청하시려면 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 전화번호로 전화하십시오.

Tiếng Việt (Vietnamese): Quý vị có quyền nhận hỗ trợ và thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu thông dịch viên, hãy gọi số điện thoại được liệt kê trong Tóm tắt quyền lợi và khoản đài thọ (Summary of Benefits and Coverage, SBC) này.

አማርኛ (Amharic):- የለምንም ወጪ እርዳታና መረጃ የማግኘት መብት አለዎት። አስተርጓሚ ለመጠየቅ፣ በዚህ Summary of Benefits and Coverage/የጥቅማጥቅሞችና የሽፋን ማጠቃለያ (SBC) ውስጥ የተዘረዘረውን የቴሌፎን ቁጥር ይደውሉ።

ภาษาไทย (Thai):
คุณมีสิทธิ์รับความช่วยเหลือและข้อมูลเป็นภาษาของคุณเองได้โดยไม่เสียค่าใช้จ่ายใด ๆ ถ้าต้องการล่ามแปล โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่ในเอกสาร "สาระสำคัญเกี่ยวกับผลประโยชน์และการคุ้มครอง (Summary of Benefits and Coverage หรือ SBC)" นี้

日本語 (Japanese):
ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、本「保障および給付の概要」（Summary of Benefits and Coverage、SBC）に記載されている電話番号にお電話ください。

العربية (Arabic): لديك الحق في الحصول على المساعدة بلغتك دون تكلفة. لطلب مترجم، اتصل برقم الهاتف المدرج في موجز المزايا والتغطية هذا (SBC).

Русский (Russian): Вы вправе получать помощь и информацию на родном языке без дополнительной оплаты. Чтобы заказать услуги переводчика, обращайтесь по номеру, указанному в данном Обзоре льгот и страхового покрытия (Summary of Benefits and Coverage, SBC)

Français (French): Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander l'aide d'un interprète, veuillez appeler le numéro de téléphone figurant dans ce Sommaire des prestations et de la couverture.

فارسی (Persian): شما حق دارید که راهنمایی و اطلاعات را به طور رایگان به زبان خودتان دریافت کنید. برای درخواست مترجم شفاهی، با شماره ای که در این خلاصه مزایا و پوشش (SBC) قید شده تماس بگیرید.

Gagana fa'a Sāmoa (Samoan): E iai lau aia tatau e maua ai le fesoasoani ma faamatalaga i lau gagana e aunoa ma se totogi. Ina ia talosaga mo se tagata faaliliu, telefoni i le numera o lisi atu i totonu o lenei Otootoga o Faamanuiaga ma le Kavaina (SBC).

Deutsch (German): Sie haben das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Zur Anforderung eines Dolmetschers wenden Sie sich bitte telefonisch an die in dieser Zusammenfassung der Leistungen und des Versicherungsschutzes aufgeführte Rufnummer.

Ilokano (Ilocano): Addaan ka ti karbengan nga makaala iti tulong ken impormasion ayan iti lenguahem nga awan bayad na. Tapno agkiddaw iti tagapataros, awagan ti numero ti telepono nga nakalista iti uneg iti Dagup dagiti Benipisyo ken Pannakasakup (SBC).

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