



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.** Please read the FEHB Plan brochure (RI 73-129) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at [www.uhcfeds.com](http://www.uhcfeds.com), and view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary). You can call 1-877-545-7378 to request a copy of either document.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not Applicable	Not Applicable
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,500/Self Only \$7,000/Self Plus One \$7,000/Self and Family	The <u>out-of-pocket limit</u> , or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Penalties for not obtaining any required <u>prior-authorization</u> , <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.HealthPlanofNevada.com/Member/Doctor-or-Provider">www.HealthPlanofNevada.com/Member/Doctor-or-Provider</a> or call 1-877-545-7378 for a list of <u>Plan Providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit	Not Covered	None
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Preventive care/ screening/ immunization</u>	No charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$10 <u>copay</u> /visit Genetic testing: 25% of EME	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	Imaging (CT/PET scans, MRIs)	PET Scan: \$200 <u>copay</u> /service All other complex procedures: \$20 <u>copay</u> /service	Not Covered	

Common Medical Event	Services You May Need	What you will pay		Limitations, Exceptions & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.uhcfeds.com">www.uhcfeds.com</a>	Tier 1	\$7 <u>copay</u> /prescription (retail); \$14 <u>copay</u> /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 <u>prior authorization</u> for step therapy is not obtained.
	Tier 2	\$35 <u>copay</u> /prescription (retail); \$70 <u>copay</u> /prescription (mail)	Not Covered	
	Tier 3	\$55 <u>copay</u> /prescription (retail) \$110 <u>copay</u> /prescription (mail)	Not Covered	
	Tier 4	\$100 <u>copay</u> /prescription (retail) \$200 <u>copay</u> /prescription (mail)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$50 <u>copay</u> /admit	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	Physician/surgeon fees	\$25 <u>copay</u> /surgery	Not Covered	

For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-129 at [www.uhcfeds.com](http://www.uhcfeds.com).

	Services You May Need	What you will pay		Limitations, Exceptions & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	Services will be reviewed for medical necessity.
	<u>Emergency medical transportation</u>	Ground: \$50 <u>copay</u> /trip Air: \$250 <u>copay</u> /trip	Ground: \$50 <u>copay</u> /trip Air: \$250 <u>copay</u> /trip	
	<u>Urgent care</u>	\$30 <u>copay</u> /visit	\$30 <u>copay</u> /visit	Services will be reviewed for medical necessity.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$300 <u>copay</u> /admission	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	Physician/surgeon fees	\$25 <u>copay</u> /surgery	Not Covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$10 <u>copay</u> /office visit or \$50 <u>copay</u> /outpatient services	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	Inpatient services	\$300 <u>copay</u> /admission	Not Covered	

Common Medical Event	Services You May Need	What you will pay		Limitations, Exceptions & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
<b>If you are pregnant</b>	Office visits	No charge	Not Covered	Routine prenatal care obtained from a <u>Plan Provider</u> 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: \$25 <u>copay</u> /admission Anesthesia: \$50 <u>copay</u> /surgery	Not Covered	Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services. Member pays for cost of services if <u>prior authorization</u> is not obtained.
	Childbirth/delivery facility services	\$300 <u>copay</u> /admission	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Rehabilitation services</u>	\$10 <u>copay</u> /visit	Not Covered	Coverage is limited to 60 days/visits. Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Habilitation services</u>	\$10 <u>copay</u> /visit	Not Covered	
	<u>Skilled nursing care</u>	\$300 <u>copay</u> /admission	Not Covered	Coverage is limited to 100 days. Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Durable medical equipment</u>	No charge	Not Covered	Whichever <u>DME copayment</u> is less applies. For purchase or rental at HPN's option. Member pays for cost of services if <u>prior authorization</u> is not obtained.
	<u>Hospice services</u>	\$300 <u>copay</u> /admission	Not Covered	Member pays for cost of services if <u>prior authorization</u> is not obtained.

Common Medical Event	Services You May Need	What you will pay		Limitations, Exceptions & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$10 <u>copay</u> /visit	Not Covered	Vision exams are limited to an annual eye refraction exam. Please refer to your <u>plan</u> documents for more information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Abortion (except for rape, incest, life at risk)</li> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)</b>		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Limited infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> </ul>

**Your Rights to Continue Coverage:**

You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-877-545-7378 or visit [www.opm.gov/insure/health](http://www.opm.gov/insure/health). Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage or receive temporary continuation of coverage (TCC). 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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:**

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can request a brochure from your plan at [www.uhcfeds.com](http://www.uhcfeds.com), contact HPN's Member Services by calling 1-877-545-7378, or write to Health Plan of Nevada, P.O. Box 15645, Las Vegas, NV 89114-5645.

**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)

■ <b>The <u>plan's</u> overall <u>deductible</u></b>	\$0.00
■ <b><u>Specialist copayment</u></b>	\$25.00
■ <b><u>Hospital (facility) copayment</u></b>	\$300.00
■ <b><u>Other copayment</u></b>	\$50.00

**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*)

<b>Total Example Cost</b>	<b>\$12,700.00</b>
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$900.00
Coinsurance	\$100.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Peg would pay is</b>	<b>\$1,000.00</b>

**Managing Joe's type 2 diabetes**  
(a year of routine in-network care of a well-controlled condition)

■ <b>The <u>plan's</u> overall <u>deductible</u></b>	\$0.00
■ <b><u>Specialist copayment</u></b>	\$25.00
■ <b><u>Hospital (facility) copayment</u></b>	\$50.00
■ <b><u>Other copayment</u></b>	\$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*)

<b>Total Example Cost</b>	<b>\$7,400.00</b>
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$1,000.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Joe would pay is</b>	<b>\$1,000.00</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

■ <b>The <u>plan's</u> overall <u>deductible</u></b>	\$0.00
■ <b><u>Specialist copayment</u></b>	\$25.00
■ <b><u>Hospital (facility) copayment</u></b>	\$50.00
■ <b><u>Other copayment</u></b>	\$10.00

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$1,900.00</b>
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$300.00
Coinsurance	\$80.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Mia would pay is</b>	<b>\$380.00</b>

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](mailto: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 đãi tho (Summary of Benefits and Coverage, SBC) này.

**አማርኛ (Amharic):-** የሰዎችዎ ወጪ አርዳታና መረጃ የማግኘት መብት አለዎት። አስተርጓሚ ለመጠየቅ፣ በዚህ Summary of Benefits and Coverage/የጥቅምጥቅምችና የገደብ ማጠቃለያ (SBC) ውስጥ የተዘረዘረውን የቅጽደታ ቁጥር ይይዙ።

**ภาษาไทย (Thai):**

คุณมีสิทธิรับความช่วยเหลือและข้อมูลเป็นภาษาของตนเองได้โดยไม่เสียค่าใช้จ่ายใด ๆ

ถ้าต้องการล่ามแปล โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่ในเอกสาร

"สารบัญเกี่ยวกับผลประโยชน์และการคุ้มครอง (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せん。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 بلغة من لكافة. اطلب مترجم، اتصل برقم الهاتف المدرج في موجز المزايا والتغطية هنا (SBC).

**Русский (Russian):** Вы вправе получить помощь и информацию на родном языке без дополнительного 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 faailiū, telefoni i le numera o lisi atu i totonu o lenei Ototoga 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 lengguahem nga awan bayad na. Tapno agkidaw iti tagapataros, awagan ti numero ti telepono nga nakalista iti uneg iti Dagup dagiti Benipisyo ken Panpakasakup (SBC).