**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, visit https://exchange.imperialhealthplan.com/nevada or contact us at 1-800-595-0619 or https://exchange.imperialhealthplan.com/nevada/contact-information. 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 https://exchange.imperialhealthplan.com/nevada/univeral-glossary or call 1-800-595-0619 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 per person \| $0 per group | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Yes | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| **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?** | $0 per person \| $0 per group | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, and health care this plan doesn't cover. | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Yes. See https://www.imperialhealthplan.com/texas/hmo-exchange/provider-directory or call 1-800-838-5914 for a list of network providers. | This plan does not use a provider network. You can receive covered services from any provider. |
| **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. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network 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 | No Charge | Not covered | None |
| | Specialist visit | No Charge | Not covered | |
| | Preventive care/screening/ immunization | No Charge | Not covered | 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) | No Charge | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not covered | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at https://client.formularynavigator.com/Search.aspx?siteCode=5828466201 | Generic drugs (Tier 1) | No Charge (retail & mail order) | Not covered | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Preauthorization is required for certain drugs. |
| | Preferred brand drugs (Tier 2) | No Charge (retail & mail order) | Not covered | |
| | Non-preferred brand drugs (Tier 3) | No Charge (retail & mail order) | Not covered | |
| | Specialty drugs (Tier 4) | No Charge (retail & mail order) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | No Charge | Not covered | |
| **If you need immediate medical attention** | Emergency room care | No Charge | No Charge | None |
| | Emergency medical transportation | No Charge | No Charge | |
| | Urgent care | No Charge | No Charge | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | Not covered | All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units; Preauthorization is required. |
| | Physician/surgeon fees | No Charge | Not covered | |
| **If you need mental** | Outpatient services | No Charge | Not covered | None |

* For more information about limitations and exceptions, see the plan or policy document at https://www.imperialhealthplan.com/nevada/hmo-exchange/individual-eoc

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **health, behavioral health, or substance abuse services** | Inpatient services | No Charge | Not covered | |
| **If you are pregnant** | Office visits | No Charge | Not covered | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Will cover 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section. |
| | Childbirth/delivery professional services | No Charge | Not covered | |
| | Childbirth/delivery facility services | No Charge | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Not covered | Unlimited benefit except for One (1) medical social service consultation per course of treatment; One (1) nutrition consultation by a certified registered dietitian; and health aide services are furnished only when receiving nursing services or therapy |
| | Rehabilitation services | No Charge | Not covered | 120 visits per year. Includes chiropractic, physical therapy, speech therapy, and occupational therapy |
| | Habilitation services | No Charge | Not covered | |
| | Skilled nursing care | No Charge | Not covered | 100 days per year |
| | Durable medical equipment | No Charge | Not covered | Purchases are limited to a 1 purchase of a type of DME, including repair and replacement, every 3 years. |
| | Hospice services | No Charge | Not covered | Combined maximum benefit of 5 Inpatient days or 5 Outpatient visits per Member per 90 days of Home Hospice Care and maximum benefit of 5 bereavement group therapy sessions. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | Not covered | Coverage limited to 1 exam/year. |
| | Children's glasses | No Charge | Not covered | Coverage limited to 1 pair of glasses/year. |
| | Children's dental check-up | No Charge | Not covered | Coverage limited to 2 dental check-ups & cleanings/calendar year. |

## 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 in cases of rape, incest, or when the life of the mother is endangered)
- 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 (limited to 1 procedure per lifetime)
- Chiropractic care (limited to 20 visits per year)
- Hearing aids
- Infertility treatment (limited to 6 procedures per lifetime)
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: Imperial Insurance Companies at 1-800-595-0619. You may also contact the Nevada Division of Insurance at (775) 687-0700 and 1818 E. College Pkwy., Suite 103 Carson City, NV 89706 or at (702) 486-4009 and 3300 W. Sahara Ave., Suite 275 Las Vegas, NV 89102 or the U.S. Department of Health and Human Services 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 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: Nevada Division of Insurance toll-free at (888) 872-3234 or https://doi.nv.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Nevada Division of Insurance in Northern Nevada at (775) 687-0700, in Southern Nevada at (702) 486-4009, or toll-free from anywhere in-state at (888) 872-3234.

**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 the Minimum Value Standards? Not Applicable.**

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 1-800-595-0619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-595-0619.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-595-0619.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-595-0619.

***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 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | $0 |
| Other coinsurance | $0 |

**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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$0** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | $0 |
| Other coinsurance | $0 |

**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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$0** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | $0 |
| Other coinsurance | $0 |

**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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$0** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-595-0619.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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