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 1-866-906-8966 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 https://www.healthcare.gov/sbc-glossary or call 1-866-906-8966 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$6500 per person | $13000 per group	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. Primary care, specialist visits, preventive care, diagnostic/imaging testing, generic drugs, urgent care, outpatient mental, behavioral, or substance abuse services, office visits while pregnant, child eye care, child dental care, are covered before meeting 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-carebenefits/.
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?	$10500 per person | $21000 per group	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?	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 https://www.imperialhealthplan.com/texas/hmo-exchange/provider-directory or call 1-866-906-8966 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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.

Important Questions	Answers	Why This Matters:
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.

* For more information about limitations and exceptions, see the plan or policy document at https://exchange.imperialhealthplan.com/nevada/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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	Not covered	None
	Specialist visit	$20 copay/visit	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)	$140 copay/test	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.caremarkrxplaninfo.com/imperialhealth.html	Preventive drugs (Tier 1)	No Charge	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Preauthorization is required for certain drugs.
	Generic drugs (Tier 2)	No Charge (retail & mail order)	Not covered	
	Preferred brand drugs (Tier 3)	40% coinsurance (retail & mail order)	Not covered	
	Non-preferred brand drugs (Tier 4)	50% coinsurance (retail & mail order)	Not covered	
	Specialty drugs (Tier 5)	50% coinsurance (retail & mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fees	40% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	None
	Emergency medical transportation	40% coinsurance	40% coinsurance	
	Urgent care	$60 copay/visit	$60 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units; Preauthorization is required.
	Physician/surgeon fees	40% coinsurance	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at https://exchange.imperialhealthplan.com/nevada/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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit	Not covered	None
	Inpatient services	40% coinsurance	Not covered	
If you are pregnant	Office visits	$10 copay/visit	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	40% coinsurance	Not covered	
	Childbirth/delivery facility services	40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	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	40% coinsurance	Not covered	120 visits per year. Includes chiropractic, physical therapy, speech therapy, and occupational therapy
	Habilitation services	40% coinsurance	Not covered	
	Skilled nursing care	40% coinsurance	Not covered	100 days per year
	Durable medical equipment	40% coinsurance	Not covered	Purchases are limited to a 1 purchase of a type of DME, including repair and replacement, every 3 years.
	Hospice services	40% coinsurance	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.

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

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 (limited to once per 3 years)
- 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 1-866-906-8966. 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 1-866-906-8966.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-906-8966.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-906-8966.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-906-8966.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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** **$6,500**
- **Specialist coinsurance** **$20**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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	$6,500
Copayments	$800
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,160**

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

- **The plan's overall deductible** **$6,500**
- **Specialist coinsurance** **$20**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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	$800
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

- **The plan's overall deductible** **$6,500**
- **Specialist coinsurance** **$20**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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	$2,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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: 1-866-906-8966
*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.