

OFF EXCHANGE

Health insurance plans for individuals and their families

Health Plan of Nevada | Sierra Health and Life

2018

Choose an individual plan that's right for you

Why choose an individual plan?

Are you self-employed, between jobs or retiring early? Does your current employer not offer health care coverage? The individual mandate of the Affordable Care Act (ACA) states that everyone must have health insurance coverage or pay a penalty. Individual health plans provide individuals and families with health care coverage they can shop for and compare.

We offer Health Maintenance Organization (HMO) and Exclusive Provider Organization (EPO) individual plans. These plans are based on metallic levels – Gold, Silver and Bronze. **All include prescription drug coverage and access to a large network of contracted providers.** Adult dental and vision coverage is optional and available for an additional monthly premium.

Metal Level Plans

	Bronze	Silver	Gold
Monthly premium	$	$$	$$$
Cost per visit/ prescription	$$$$	$$$	$$
Plan pays	60%	70%	80%
You pay	40%	30%	20%
Best if you...	Rarely use medical services.	Want to balance monthly premium costs with out-of-pocket health expenses.	Want to manage monthly premium costs and reduce out-of-pocket health expenses.

KEY		
Lowest $	Low $$	Moderate $$$

We offer three types of plan designs:

- Health Maintenance Organization (HMO)
- Exclusive Provider Organization (EPO)
- Health Savings Account (HSA-EPO)

Let's take a closer look. What are the differences between HMO, EPO and HSA plans?

HPN Individual HMO

Easier on the wallet, HMO plans are designed to save members money on out-of-pocket costs. With this option, members are required to choose a primary care provider (PCP) and stay within a network of providers to receive coverage under the plan, except for emergency services and urgent care.

HMO members can see a specialist, but their PCP must give them a referral to the specialist in order to get benefit coverage.

Choose a Health Plan of Nevada PCP. For a complete list of providers, visit **myHPNonline.com**. Make sure to include your PCP on your enrollment form. If you don't select a PCP, we will match you with a doctor in your area. You can change your PCP at any time.

Your PCP will take care of most of your health care needs. Visit your PCP for routine care, yearly checkups and other general health concerns. Each member covered under your plan can select their own PCP, or you may all choose the same one. You may also pick a pediatrician for your child. Females over the age of 14 may select an OB/GYN in addition to a PCP.

SHL Individual EPO

An EPO offers the best of both worlds – lower premium than a Preferred Provider Organization (PPO) and more freedom than an HMO. EPO members can only use contracted providers, urgent care centers and hospitals. There are no out-of-network benefits, except for emergency services and urgent care.

The tradeoffs for no out-of-network benefits:

- Lower premium than a PPO
- Larger provider network than an HMO
- See a specialist without a referral

Although you aren't required to select a primary care provider (PCP), we encourage members to choose one. Your PCP becomes the leader of your health care team and is available for routine care, yearly checkups, and other general health concerns.

SHL Individual HSA-EPO

Weigh the risks of a consumer-directed high deductible EPO plan. The appeal of this plan is lower premiums compared to other plans.

This a great option for a healthy individual who only wants coverage in case you need it. Someone who has no pre-existing medical conditions, who rarely sees a doctor, and doesn't take prescription drugs regularly.

In exchange for often times lower premiums, insurance doesn't kick in until you have met your deductible. For many people, the low monthly premium is worth having a high deductible.

With this option, you must stay within a network of providers to receive coverage under the plan, except for emergency services and urgent care.

This plan is paired with a Health Savings Account (HSA), which can save you money on a tax-deferred basis for health care costs. It also includes prescription coverage in the core, making it easier for you to reach your deductible.

All of our plans are on a calendar year schedule. Calendar year deductibles reset every January 1 and end December 31.

Health Plan of Nevada Individual off Exchange plans are available in Clark, Nye and Washoe counties, only.

Sierra Health and Life Individual plans are available in Clark County only and no longer available statewide. Additionally, all enrollees in SHL Individual plans must physically reside in Clark County.

2018 HMO PLANS

	MyHPN Solutions HMO Gold 7	MyHPN Solutions HMO Silver 1.1	MyHPN Solutions HMO Silver 3.1	MyHPN Solutions HMO Silver 7	MyHPN Solutions HMO Silver 8
Calendar Year Deductible (CYD)					
Plan Provider	$3,000 of EME[1] per Member	$3,000 of EME per Member	$2,500 of EME per Member	$4,500 of EME per Member	$3,000 of EME per Member
	$6,000 of EME per Family	$6,000 of EME per Family	$5,000 of EME per Family	$9,000 of EME per Family	$6,000 of EME per Family
Coinsurance after CYD Member Pays					
Plan Provider	20% of EME	30% of EME	30% of EME	30% of EME	30% of EME
Out of Pocket Maximum (includes CYD, coinsurance and copayments)					
Plan Provider	$7,350 of EME per Member	$7,350 of EME per Member	$7,350 of EME per Member	$7,350 of EME per Member	$7,350 of EME per Member
	$14,700 of EME per Family	$14,700 of EME per Family	$14,700 of EME per Family	$14,700 of EME per Family	$14,700 of EME per Family
Medical Office Visits (In Network) Member Pays					
Preventive Care[2]	$0	$0	$0	$0	$0
Convenient Care	$5	$10	$30	$10	$15
NowClinic® (Telemedicine)	$5	$10	$10	$5	$10
Physican Extender	$5	$10	$30	$10	$15
Physician	$10	$20	$40	$10	$25
Specialist	$15	$40	$80	$30	$50
Non-preventive Routine Lab and X-ray Services (In Network) Member Pays					
Routine Laboratory	$10	$25	$25	$25	$25
Routine X-ray	$10	$25	$25	$25	$25
Emergency Services (In Network) Member Pays					
Urgent Care	$25	$40	$40	$35	$40
Hospital Emergency Room Facility	After CYD, 20% of EME	$600; waived if admitted	$500; waived if admitted	$500; waived if admitted	$500; waived if admitted
Ambulance	$100 per trip	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Hospital Facility Services (In Network) Member Pays					
Inpatient	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Outpatient	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Physician Surgical Services (In Network) Member Pays					
Inpatient Hospital Facility	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Outpatient Hospital Facility	$0 per surgery	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Ambulatory Surgical Facility	$0 per surgery	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Anesthesia	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Prescription Drugs (In Network) Member Pays					
Rx CYD	Member: $500 Family: $1,000 (Tiers 2-4)	Member: $1,000 Family: $2,000 (Tiers 2-4)	Member: $1,000 Family: $2,000 (Tiers 2-4)	Member: $1,000 Family: $2,000 (Tiers 2-4)	Member: $1,000 Family: $2,000 (Tiers 2-4)
Tier 1	$25	$25	$25	$25	$25
Tier 2	After CYD, $50	After CYD, $50	After CYD, $50	After CYD, $50	After CYD, $50
Tier 3	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Tier 4	After CYD, 50% of EME	After CYD, 50% of EME	After CYD, 50% of EME	After CYD, 50% of EME	After CYD, 50% of EME

2018 HMO PLANS

	MyHPN Solutions HMO Silver 9	MyHPN Solutions HMO Bronze 7	MyHPN Solutions HMO Bronze 10	MyHPN Solutions HMO Bronze 11	MyHPN Solutions HMO Bronze 12
Calendar Year Deductible (CYD)					
Plan Provider	$5,000 of EME[1] per Member	$6,500 of EME per Member	$6,500 of EME per Member	$6,600 of EME per Member	$6,000 of EME per Member
	$10,000 of EME per Family	$13,000 of EME per Family	$13,000 of EME per Family	$13,200 of EME per Family	$12,000 of EME per Family
Coinsurance After CYD Member Pays (coinsurance amounts may differ within the same plan)					
Plan Provider	30% of EME	0% or 20% of EME	0% or 20% of EME	0% or 20% of EME	0% or 20% of EME
Out of Pocket Maximum (includes CYD, coinsurance and copayments)					
Plan Provider	$7,350 of EME per Member	$7,350 of EME per Member	$7,350 of EME per Member	$7,350 of EME per Member	$7,350 of EME per Member
	$14,700 of EME per Family	$14,700 of EME per Family	$14,700 of EME per Family	$14,700 of EME per Family	$14,700 of EME per Family
Medical Office Visits (In Network) Member Pays					
Preventive Care[2]	$0	$0	$0	$0	$0
Convenient Care	$5	$25	$25	$35	$25
NowClinic® (Telemedicine)	$5	$10	$10	$10	$10
Physican Extender	$5	$25	$25	$35	$25
Physician	$15	$50	$45	$50	After CYD, $0 per visit
Specialist	$65	$100	$90	$100	After CYD, $0 per visit
Non-preventive Routine Lab and X-ray Services (In Network) Member Pays					
Routine Laboratory	$25	$50	$45	After CYD, 0% of EME	After CYD, 0% of EME
Routine X-ray	$25	$65	$60	After CYD, 0% of EME	After CYD, 0% of EME
Emergency Services (In Network) Member Pays					
Urgent Care	$40	$65	$60	$50	After CYD, $0 per visit
Hospital Emergency Room Facility	$500; waived if admitted	$1,000; waived if admitted	After CYD, 0% of EME	After CYD, 0% of EME	After CYD, 0% of EME
Ambulance	After CYD, 30% of EME	After CYD, 0% of EME	After CYD, 0% of EME	After CYD, 0% of EME	After CYD, 0% of EME
Hospital Facility Services (In Network) Member Pays					
Inpatient	After CYD, 30% of EME	After CYD, 0% of EME	After CYD, 0% of EME	After CYD, 0% of EME	After CYD, 0% of EME
Outpatient	After CYD, 30% of EME	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 20% of EME
Physician Surgical Services (In Network) Member Pays					
Inpatient Hospital Facility	After CYD, 30% of EME	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 20% of EME
Outpatient Hospital Facility	After CYD, 30% of EME	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 20% of EME
Ambulatory Surgical Facility	After CYD, 30% of EME	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 20% of EME
Anesthesia	After CYD, 30% of EME	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 20% of EME
Prescription Drugs (In Network) Member Pays					
Rx CYD	Member: $1,000 Family: $2,000 (Tiers 2-4)	Member: $1,500 Family: $3,000 (Tiers 2-4)	Member: $1,500 Family: $3,000 (Tiers 2-4)	Member: $1,500 Family: $3,000 (Tiers 2-4)	Member: $1,500 Family: $3,000 (Tiers 2-4)
Tier 1	$25	$25	$25	$25	$25
Tier 2	After CYD, $50	After CYD, $75	After CYD, $75	After CYD, $75	After CYD, $75
Tier 3	After CYD, 30% of EME	After CYD, 40% of EME	After CYD, 40% of EME	After CYD, 40% of EME	After CYD, 40% of EME
Tier 4	After CYD, 50% of EME	After CYD, 50% of EME	After CYD, 50% of EME	After CYD, 50% of EME	After CYD, 50% of EME

2018 2 TIER HMO PLANS

	MyHPN Solutions HMO 2 Tier Silver 1	MyHPN Solutions HMO 2 Tier Silver 2	MyHPN Solutions HMO 2 Tier Bronze 1
Calendar Year Deductible (CYD)			
Plan Provider (Tier 1)	$2,500 of EME[1] per Member	$3,000 of EME per Member	$6,500 of EME per Member
	$5,000 of EME per Family	$6,000 of EME per Family	$13,000 of EME per Family
Non - Plan Provider (Tier 2)	$7,500 of EME per Member	$9,000 of EME per Member	$19,500 of EME per Member
	$22,500 of EME per Family	$27,000 of EME per Family	$58,500 of EME per Family
Coinsurance After CYD Member Pays (coinsurance amounts may differ within the same plan)			
Plan Provider (Tier 1)	30% of EME	30% of EME	0% or 20% of EME
Non - Plan Provider (Tier 2)	50% of EME	50% of EME	50% of EME
Out of Pocket Maximum (includes CYD, coinsurance and copayments)			
Plan Provider (Tier 1)	$7,350 of EME per Member	$7,350 of EME per Member	$7,150 of EME per Member
	$14,700 of EME per Family	$14,700 of EME per Family	$14,300 of EME per Family
Non - Plan Provider (Tier 2)	Unlimited	Unlimited	Unlimited
	Unlimited	Unlimited	Unlimited
Medical Office Visits (Network Tier 1) Member Pays			
Preventive Care[2]	$0	$0	$0
Convenient Care	$20	$25	$25
NowClinic® (Telemedicine)	$10	$10	$10
Physician Extender	$20	$25	$25
Physician	$25	$30	$45
Specialist	$50	$75	$100
Non-preventive Routine Lab and X-ray Services (Network Tier 1) Member Pays			
Routine Laboratory/ X-ray	$25/$25	$30/$50	$45/$100
Emergency Services (Network Tier 1) Member Pays			
Urgent Care	$50	$50	$75
Hospital Emergency Room Facility	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, $1,000 per visit; waived if admitted
Ambulance	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 0% of EME
Hospital Facility Services (Network Tier 1) Member Pays			
Inpatient	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 0% of EME
Outpatient	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 20% of EME
Physician Surgical Services - Hospital Facility (Network Tier 1) Member Pays			
Inpatient or Outpatient	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 20% of EME
Anesthesia	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 20% of EME
Prescription Drugs (Tier 1 In Network) Member Pays			
Rx CYD	Member: $1,000 Family: $2,000 (Tier 2-4)	Member: $1,000 Family: $2,000 (Tier 2-4)	Member: $1,500 Family: $3,000 (Tier 2-4)
Tier 1	$25	$25	$25
Tier 2	After CYD, $50	After CYD, $50	After CYD, $75
Tier 3	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 40% of EME
Tier 4	After CYD, 50% of EME	After CYD, 50% of EME	After CYD, 50% of EME

2018 EPO PLANS

	MySHL Solutions EPO Gold 7	MySHL Solutions EPO Silver 1	MySHL Solutions EPO Silver 2	MySHL Solutions EPO Silver 6
Calendar Year Deductible (CYD)				
Plan Provider	$3,000 of EME[1] per Insured	$3,500 of EME per Insured	$2,500 of EME per Insured	$3,000 of EME per Insured
	$6,000 of EME per Family	$7,000 of EME per Family	$5,000 of EME per Family	$6,000 of EME per Family
Coinsurance after CYD Insured Pays				
Plan Provider	20% of EME	20% of EME	30% of EME	30% of EME
Out of Pocket Maximum (includes CYD, coinsurance and copayments)				
Plan Provider	$7,350 of EME per Insured	$7,350 of EME per Insured	$7,350 of EME per Insured	$7,350 of EME per Insured
	$14,700 of EME per Family	$14,700 of EME per Family	$14,700 of EME per Family	$14,700 of EME per Family
Medical Office Visits (In Network) Insured Pays				
Preventive Care[2]	$0	$0	$0	$0
Convenient Care	$5	$10	$20	$10
NowClinic® (Telemedicine)	$5	$10	$10	$10
Physican Extender	$5	$10	$20	$10
Physician	$10	$15	$25	$25
Specialist	$15	$30	$50	$75
Non-preventive Routine Lab and X-ray Services (In Network) Insured Pays				
Routine Laboratory	$10	$25	$25	$30
Routine X-ray	$10	$25	$25	$50
Emergency Services (In Network) Insured Pays				
Urgent Care	$25	$50	$50	$50
Hospital Emergency Room Facility	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Ambulance	$100 per trip	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Hospital Facility Services (In Network) Insured Pays				
Inpatient	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Outpatient	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Physician Surgical Services (In Network) Insured Pays				
Inpatient Hospital Facility	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Outpatient Hospital Facility	$0 per surgery	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Ambulatory Surgical Facility	$0 per surgery	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Anesthesia	After CYD, 20% of EME	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Prescription Drugs (In Network) Insured Pays				
Rx CYD	Insured: $500 Family: $1,000 (Tiers 2-4)	Insured: $1,000 Family: $2,000 (Tiers 2-4)	Insured: $1,000 Family: $2,000 (Tiers 2-4)	Insured: $1,000 Family: $2,000 (Tiers 2-4)
Tier 1	$25	$25	$25	$25
Tier 2	After CYD, $50	After CYD, $50	After CYD, $50	After CYD, $50
Tier 3	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Tier 4	After CYD, 50% of EME	After CYD, 50% of EME	After CYD, 50% of EME	After CYD, 50% of EME

2018 EPO PLANS

	MySHL Solutions EPO Silver 8.1	MySHL Solutions EPO Bronze 7	MySHL Solutions EPO Bronze 9
Calendar Year Deductible (CYD)			
Plan Provider	$5,000 of EME[1] per Insured	$6,000 of EME per Insured	$6,600 of EME per Insured
	$10,000 of EME per Family	$12,000 of EME per Family	$13,200 of EME per Family
Coinsurance after CYD Insured Pays			
Plan Provider	30% of EME	0% or 20% of EME	0% or 20% of EME
Out of Pocket Maximum (includes CYD, coinsurance and copayments)			
Plan Provider	$7,350 of EME per Insured	$7,350 of EME per Insured	$7,350 of EME per Insured
	$14,700 of EME per Family	$14,700 of EME per Family	$14,700 of EME per Family
Medical Office Visits (In Network) Insured Pays			
Preventive Care[2]	$0	$0	$0
Convenient Care	$10	$25	$35
NowClinic® (Telemedicine)	$10	$10	$10
Physican Extender	$10	$25	$35
Physician	$15	After CYD, 0% of EME	$50
Specialist	$75	After CYD, 0% of EME	$100
Non-preventive Routine Lab and X-ray Services (In Network) Insured Pays			
Routine Laboratory	$25	After CYD, 0% of EME	After CYD, 0% of EME
Routine X-ray	$50	After CYD, 0% of EME	After CYD, 0% of EME
Emergency Services (In Network) Insured Pays			
Urgent Care	$50	After CYD, 0% of EME	After CYD, $50
Hospital Emergency Room Facility	After CYD, 30% of EME	After CYD, 0% of EME	After CYD, 0% of EME
Ambulance	After CYD, 30% of EME	After CYD, 0% of EME	After CYD, 0% of EME
Hospital Facility Services (In Network) Insured Pays			
Inpatient	After CYD, 30% of EME	After CYD, 0% of EME	After CYD, 0% of EME
Outpatient	After CYD, 30% of EME	After CYD, 20% of EME	After CYD, 20% of EME
Physician Surgical Services (In Network) Insured Pays			
Inpatient Hospital Facility	After CYD, 30% of EME	After CYD, 20% of EME	After CYD, 20% of EME
Outpatient Hospital Facility	After CYD, 30% of EME	After CYD, 20% of EME	After CYD, 20% of EME
Ambulatory Surgical Facility	After CYD, 30% of EME	After CYD, 20% of EME	After CYD, 20% of EME
Anesthesia	After CYD, 30% of EME	After CYD, 20% of EME	After CYD, 20% of EME
Prescription Drugs (In Network) Insured Pays			
Rx CYD	Insured: $1,000 Family: $2,000 (Tiers 2-4)	Insured: $1,500 Family: $3,000 (Tiers 2-4)	Insured: $1,500 Family: $3,000 (Tiers 2-4)
Tier 1	$25	$25	$25
Tier 2	After CYD, $50	After CYD, $75	After CYD, $75
Tier 3	After CYD, 30% of EME	After CYD, 40% of EME	After CYD, 40% of EME
Tier 4	After CYD, 50% of EME	After CYD, 50% of EME	After CYD, 50% of EME

2018 HSA EPO PLANS

	MySHL Solutions HSA EPO Silver 1.1	MySHL Solutions HSA EPO Bronze 2.1	MySHL Solutions HSA EPO Bronze 3.1
Calendar Year Deductible (CYD)			
Plan Provider	$2,000 of EME[1] per Insured	$6,000 of EME per Insured	$6,500 of EME per Insured
	$4,000 of EME per Family	$12,000 of EME per Family	$13,000 of EME per Family
Coinsurance after CYD Insured Pays			
Plan Provider	20% of EME	30% of EME	30% of EME
Out of Pocket Maximum (includes CYD, coinsurance and copayments)			
Plan Provider	$6,650 of EME per Insured	$6,650 of EME per Insured	$6,650 of EME per Insured
	$13,300 of EME per Family	$13,300 of EME per Family	$13,300 of EME per Family
Medical Office Visits (In Network) Insured Pays			
Preventive Care[2]	$0	$0	$0
Convenient Care	After CYD, $5	After CYD, 30% of EME	After CYD, 30% of EME
NowClinic® (Telemedicine)	After CYD, $10	After CYD, 0% of EME	After CYD, 0% of EME
Physican Extender	After CYD, $5	After CYD, 30% of EME	After CYD, 30% of EME
Physician	After CYD, $15	After CYD, 30% of EME	After CYD, 30% of EME
Specialist	After CYD, $45	After CYD, 30% of EME	After CYD, 30% of EME
Non-preventive Routine Lab and X-ray Services (In Network) Insured Pays			
Routine Laboratory	After CYD, $20	After CYD, 30% of EME	After CYD, 30% of EME
Routine X-ray	After CYD, $20	After CYD, 30% of EME	After CYD, 30% of EME
Emergency Services (In Network) Insured Pays			
Urgent Care	After CYD, $50	After CYD, 30% of EME	After CYD, 30% of EME
Hospital Emergency Room Facility	After CYD, $400; waived if admitted	After CYD, 30% of EME	After CYD, 30% of EME
Ambulance	After CYD, $250 per trip	After CYD, 30% of EME	After CYD, 30% of EME
Hospital Facility Services (In Network) Insured Pays			
Inpatient	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Outpatient	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Physician Surgical Services (In Network) Insured Pays			
Inpatient Hospital Facility	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Outpatient Hospital Facility	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Ambulatory Surgical Facility	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Anesthesia	After CYD, 20% of EME	After CYD, 30% of EME	After CYD, 30% of EME
Prescription Drugs (In Network) Insured Pays			
Combined Medical/Rx CYD	Insured: $2,000 Family: $4,000 (Tiers 1-4)	Insured: $6,000 Family: $12,000 (Tiers 1-4)	Insured: $6,500 Family: $13,000 (Tiers 1-4)
Tier 1	After CYD, $25	After CYD, $25	After CYD, $25
Tier 2	After CYD, $50	After CYD, $75	After CYD, $75
Tier 3	After CYD, $100	After CYD, $150	After CYD, $150
Tier 4	After CYD, 30% of EME	After CYD, 30% of EME	After CYD, 30% of EME

ANCILLARY PRODUCTS

SHL Dental Plan

SHL Dental PPO Plan 27 Individual Adult Only Coverage (Age 19 +)		
Benefit	Plan Dentist (Insured pays)	Non-Plan Dentist (Insured pays)
Calendar Year Deductible (Type II and III)	$50 per Insured (3x family)	
Calendar Year Plan Maximum (Type II and III)	$1,500 per Insured	
Type I Services	0% of EDE*	20% of EDE
Type II Services	After CYD, 20% of EDE	After CYD, 40% of EDE
Type III Services**	After CYD, 50% of EDE	After CYD, 50% of EDE

*EDE = Eligible Dental Expenses
** Type III Services are subject to a 12 month waiting period
Provider Directory: Go to **mySHLonline.com** to find a dental provider.

Note: Refer to the Agreement of Coverage for limitations, exclusions, managed care requirements and additional information about covered services.

HPN Vision Plan

HPN HMO Adult Vision Care Services Option 6 (Age 19 +)		
Benefit	Plan Provider (Insured Pays)	Non-Plan Provider (Insured Pays)
Vision Exam (1 exam each 12 months)	$10 copay*	Not covered
Lenses (Plastic) (1 pair each 12 months)	$10 copay for one pair*	Not covered
Frames (Once each 24 months)	$100 maximum allowance*	Not covered
Contact Lenses (Once each 12 months) (in lieu of frames/lenses)	$250 max for medically necessary* $115 max for conventional or disposable*	Not covered

*Subject to limitation
Provider Directory: Go to **eyemedvisioncare.com** to find a vision provider.

Note: Refer to the Agreement of Coverage for limitations, exclusions, managed care requirements and additional information about the covered services.

SHL Vision Plan

SHL Vision Individual Adult Only (Age 19 +)		
Benefit	Plan Provider (Insured Pays)	Non-Plan Provider (Insured Pays)
Vision Exam (1 exam each 12 months)	$10 copay*	$35 maximum allowance*
Lenses (Plastic) (1 pair each 12 months)	$10 copay for one pair*	$25 maximum allowance for single vision lenses*
		$40 maximum allowance for bifocal lenses*
		$55 maximum allowance for trifocal or lenticular lenses*
Frames (Once each 24 months)	$100 maximum allowance*	$45 maximum allowance*
Contact Lenses (Once each 12 months) (in lieu of frames/lenses)	$250 max if medically necessary* $115 max for conventional or disposable*	$200 max if medically necessary* $100 max for conventional or disposable*

*Subject to limitation
Provider Directory: Go to **eyemedvisioncare.com** to find a vision provider.

Note: Refer to the Agreement of Coverage for limitations, exclusions, managed care requirements and additional information about the covered services.

Support for a hospital stay

Your doctor is your partner in health. They will help coordinate your care if you should ever need to be admitted to a hospital on a non-emergency basis.

We will stay involved in your care. Our team will help monitor your care by performing initial and ongoing reviews. This is to make sure the health care services you receive are appropriate, provided in the right setting, and medically necessary. If you're admitted to a hospital outside of our service area, we may review your medical records to evaluate the appropriateness of the medical care, services, treatments, and procedures you received.

Returning home after a long hospital stay also requires a plan. Depending on your situation, we'll arrange for any ongoing medically necessary care, services, and equipment you need after leaving the hospital. This may include in-home care or transferring you to another facility.

Understand your pharmacy benefits

You will have prescription drug coverage from network pharmacies. Your copayment is based on levels called a prescription tier. The costs are lower on tier 1 and higher on tier 4. To find what tier your medication is on, go to **myHPNonline.com** or **mySHLonline.com**.

You may be required to try step therapy. This means you must try certain drugs to treat your medical condition before we'll cover another drug for that condition. You may submit an exception request to waive step therapy requirements or quantity limit restrictions. For a list of medications requiring step therapy or to download an exception request form, go to **myHPNonline.com** or **mySHLonline.com**.

Quick lesson on prior authorization

Prior authorization is necessary to ensure benefit payment. Your provider may prescribe a health care service, treatment, equipment or medication which requires review and approval. All requests requiring a medical or clinical decision are reviewed by a licensed physician or under the supervision of one. In addition, only a physician may deny a request. To learn more, please consult your plan documents. You or your provider may file an appeal if coverage is denied. To appeal a decision, call Member Services or mail a written request within 180 days from the date of the denial to:

Member Services
Health Plan of Nevada/Sierra Health and Life
P.O. Box 15645
Las Vegas, NV 89114-5645

Know your privacy rights

We're careful to protect your privacy. This includes oral, written and electronic information. We only share protected health information (PHI) with individuals or entities responsible for coordinating your health care or administering your health benefits, unless we have your permission. And, of course, we share PHI in accordance with state and federal law. We also require our contracted providers to take similar steps to protect your PHI.

We may use your medical data to promote and improve the quality of care you receive. When we conduct research and measure quality, we use summary information whenever possible, not PHI. When we use PHI, steps are taken to help protect it. We do not allow PHI to be used for research by organizations without your consent.

You have the right to access your medical records. Contact your provider to request a copy. When you request your medical records to be shared with others, you may be required to sign an authorization form.

We may ask you for permission to use your personal data for non-routine purposes. Of course, when we ask, you have the right to refuse. If you lack the ability to authorize a release, we obtain authorization from persons recognized by state and federal laws to give such permissions.

To review our entire privacy policy, visit **myHPNonline.com** or **mySHLonline.com**.

Premium Calculator

A health plan's monthly premium may vary by age of the member, based on federal guidelines. Standard age bands are:

- Children: A single-age band for members age 0 through 14; and one-year age bands for members age 15 through 20
- Adults: One-year age bands for members age 21 through 63
- Older adults: A single age band for members age 64 and older
- If you have dependents that are 20 or younger, only the oldest three will have a premium
- If adult vision is selected, each person 19 and older will have a per person vision premium
- If SHL adult dental is selected, each person on policy 19+ is billed a dental premium

For example, to obtain total monthly premium:

- Adult age 48: medical rate + vision rate
- Adult age 45: medical rate + vision rate
- Child age 19: medical rate + vision rate
- Child age 17: medical rate
- Child age 16: medical rate
- Child age 15: no charge for medical

HPN/SHL Disclaimers

Pediatric dental and vision are embedded in all MyHPN Solutions HMO and MySHL EPO plans.

[1]EME (Eligible Medical Expenses) means the maximum amount the Plan will pay for a Covered Service in accordance with the Plan Reimbursement Schedule.

[2]Includes covered preventive exams, labs, diagnostic tests/procedures and prescription drugs as set forth by the federal government.

The Member is responsible for all charges in excess of EME. Non-Plan Provider charges are not covered (with the exception of the 2 Tier HMO plans), other than for Urgently Needed or Emergency Services. Non-Plan Provider charges may be substantial and do not accrue toward the Calendar Year Out of Pocket Maximum. These Plans include additional benefits, exclusions and limitations which are shown in the Health Plan of Nevada or Sierra Health and Life Agreement of Coverage, Attachment A Benefit Schedule, any other applicable Riders and the Summary of Benefits and Coverage. Copies of these documents are available upon request. Plan documents govern in resolving any benefit questions or payments.

HPN/SHL Form Numbers

MyHPN Solutions HMO Plans

18H_IN_HMO_G_7, 18H_IN_HMO_S_1_1, 18H_IN_HMO_S_3_1, 18H_IN_HMO_S_7, 18H_IN_HMO_S_8, 18H_IN_HMO_S_9, 18H_IN_HMO_B_7, 18H_IN_HMO_B_10, 8H_IN_HMO_B_11, 18H_IN_HMO_B_12, 18H_IN_HMO2T_S_1, 18H_IN_HMO2T_S_2, 18H_IN_HMO2T_B_1.

MySHL Solutions EPO Plans

18S_IN_EPO_G_7, 18S_IN_EPO_S_1, 18S_IN_EPO_S_2, 18S_IN_EPO_S_6, 18S_IN_EPO_S_8, 18S_IN_EPO_B_7, 18S_IN_EPO_B_9.

MySHL Solutions HSA EPO Plans

18S_IN_HSA_EPO_S_1_1,
18S_IN_HSA_EPO_B_2_1 ,
18S_IN_HSA_EPO_B_3_1

Dental and Vision Plans

17S_IN_DPPO_LAN27, HPN AdultVisionRider IND (2014).

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 toll-free member phone number listed on your health plan ID card or plan documents.

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, 1-800-537-7697 (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 toll-free phone number listed on your health plan ID card or plan documents.

English: You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card or plan documents.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card or plan documents.

Español (Spanish): Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan o los documentos de su plan.

Tagalog (Tagalog): May karapatan kang makakuha ng tulong at impormasyon sa sinasalita mong wika nang libre. Upang humiling ng interpreter, tawagan ang toll-free na numero ng telepono para sa miyembro na nakalista sa iyong ID card sa planong pangkalusugan o sa mga dokumento ng plano.

繁體中文 (Chinese):
您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡或計劃文件上的免付費會員電話號碼。

한국어(Korean): 귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드 혹은 플랜 문서에 기재된 무료 회원 전화번호로 전화하십시오.

Tiếng Việt (Vietnamese): Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID hoặc trên các tài liệu chương trình bảo hiểm y tế của quý vị.

አማርኛ (Amharic): በምትፈልጉት ቋንቋ እርዳታና መረጃ የማግኘት መብት አለዎት። አስተርጓሚ ለመጠየቅ፣ በጤና ካርድዎ ወይም የጤና ሰነዶች የተዘረዘረውን የማያስከፍል ቴሌፎን ይደውሉ። ጥያቄዎች ካሉዎት፣ አባከዎ ያስታውቁኝ። አመሰግናለሁ! አናሂ

ภาษาไทย (Thai):
คุณมีสิทธิ์ขอความช่วยเหลือหรือขอข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายใด ๆ เมื่อต้องการล่าม กรุณาโทรฟรีมาที่หมายเลขโทรศัพท์สำหรับสมาชิกที่อยู่บนบัตรแผนสุขภาพหรือเอกสารแผนสุขภาพของคุณ

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、医療プランのID
カードまたはプランの資料に記載されているメンバー用のフリーダイヤルまでお電話ください。

(Arabic) العربية:
لك الحق في الحصول على المساعدة والمعلومات مجانًا بلغتك. لطلب مترجم فوري، يرجى الاتصال برقم الهاتف المجاني الموجود على بطاقة الهوية الخاصة بك أو وثائق خطة الرعاية الصحية الخاصة بك.

Русский (Russian): Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты или документах о вашем плане.

Français (French): Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé ou dans la documentation relative à votre régime.

(Persian) فارسی:
شما حق دارید که کمک و اطلاعات رایگان به زبان خود را به صورت رایگان دریافت کنید. برای درخواست با مترجم، به شماره تلفن درج شده در کارت شناسایی سلامت خود یا اسناد طرح مراجعه کنید.

Gagana fa'a Sāmoa (Samoan): E iai lau aia tatau e maua ai faamatalaga i lau gagana e aunoa ma se totogi. Ina ia talosaga mo se tasi e faaliliu, telefoni mai le numera o le telefoni e le totogia o lisi atu i lau pepa ID o le peleni tausoifua maloloina poo pepa mo le peleni.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte oder in den Versicherungspapieren.

Ilokano (Ilocano): Addaan ka ti karbengan a maala iti daytoy nga tulong ken impormasion para ti lenguahem nga awan ti bayadna. Tapno agkiddaw iti maysa nga tagapataros, awagan iti toll-free nga numero ti telepono para kadagiti kameng nga nakalista ayan iti ID card mo para ti plano iti salun-at mo wenno ayan dagiti dokumento ti planom.

What if I have a question after I enroll in a plan?

You may call Member Services at the phone numbers below.

Health Plan of Nevada Member Services
Toll-free 1-800-777-1840

Sierra Health and Life Member Services
Toll-free 1-800-888-2264

Sales Office
Toll-free 1-800-873-0004

TTY users please call **711**.

myHPNonline.com

mySHLonline.com

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

Health plan coverage provided by Health Plan of Nevada.
Insurance coverage provided by Sierra Health and Life.

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