



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.sierrahealthandlife.com](http://www.sierrahealthandlife.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](http://www.healthcare.gov/sbc-glossary) or call 1-800-888-2264 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | \$2,000 / Insured and \$4,000 / Family for <u>Plan Providers</u> and \$4,000 / Insured and \$8,000 / Family for <u>Non-Plan Providers</u> .                                                            | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                              |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Preventive care</u> from <u>Plan Providers</u> is covered before you meet your <u>deductible</u> .                                                                                             | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                           |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No                                                                                                                                                                                                     | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | \$6,000 / Insured and \$12,000 / Family for <u>Plan Providers</u> and \$12,000 / Insured and \$24,000 / Family for <u>Non-Plan Providers</u> .                                                         | The <u>out-of-pocket limit</u> 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.                                                                                                                                                                                                                                                                                    |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | Penalties for not complying with SHL's Managed Care Program, <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.sierrahealthandlife.com/Member/Doctor-or-Provider">www.sierrahealthandlife.com/Member/Doctor-or-Provider</a> or call 1-800-888-2264 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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | No                                                                                                                                                                                                     | You can see the <u>specialist</u> you choose without a <u>referral</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<br>(You will pay the least)                                                                                                | Non-Plan Provider<br>(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         | \$25 <u>copay</u> /visit; <u>deductible</u> does not apply                                                                               | 50% <u>coinsurance</u>                       | None                                                                                                                                                                                                               |
|                                                                                                                                                                                                                      | <u>Specialist</u> visit                                  | \$40 <u>copay</u> /visit; <u>deductible</u> does not apply                                                                               | 50% <u>coinsurance</u>                       |                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                      | <u>Preventive care</u> / <u>screening</u> / immunization | No charge                                                                                                                                | 50% <u>coinsurance</u>                       |                                                                                                                                                                                                                    |
| <b>If you have a test</b>                                                                                                                                                                                            | <u>Diagnostic test</u> (x-ray, blood work)               | X-ray: \$35 <u>copay</u> /service; <u>deductible</u> does not apply<br>Lab: \$15 <u>copay</u> /service; <u>deductible</u> does not apply | 50% <u>coinsurance</u>                       | Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.                                                                                                                                |
|                                                                                                                                                                                                                      | Imaging (CT/PET scans, MRIs)                             | 20% <u>coinsurance</u>                                                                                                                   | 50% <u>coinsurance</u>                       |                                                                                                                                                                                                                    |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.sierrahealthandlife.com">www.sierrahealthandlife.com</a> | Tier 1                                                   | \$10 <u>copay</u> /prescription (retail) \$25 <u>copay</u> /prescription (mail)                                                          | 30% <u>coinsurance</u>                       | You have a 3-Tier pharmacy <u>plan</u> . Covers up to a 30-day retail supply or up to a 90-day mail order supply. Insured pays for cost of services if <u>prior authorization</u> or step therapy is not obtained. |
|                                                                                                                                                                                                                      | Tier 2                                                   | \$50 <u>copay</u> /prescription (retail) \$125 <u>copay</u> /prescription (mail)                                                         | 30% <u>coinsurance</u>                       |                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                      | Tier 3                                                   | \$80 <u>copay</u> /prescription (retail) \$200 <u>copay</u> /prescription (mail)                                                         | 30% <u>coinsurance</u>                       |                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                      | Tier 4                                                   | Not Covered                                                                                                                              | Not Covered                                  | Not Applicable.                                                                                                                                                                                                    |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                | Facility fee (e.g., ambulatory surgery center)           | 20% <u>coinsurance</u>                                                                                                                   | 50% <u>coinsurance</u>                       | Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.                                                                                                                                |
|                                                                                                                                                                                                                      | Physician/surgeon fees                                   | 20% <u>coinsurance</u>                                                                                                                   | 50% <u>coinsurance</u>                       |                                                                                                                                                                                                                    |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                                                                                                               |                                                                                                                                                                                                                 | Limitations, Exceptions & Other Important Information                                                                                                                                                                      |
|---------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Plan Provider<br>(You will pay the least)                                                                                                                                                                       | Non-Plan Provider<br>(You will pay the most)                                                                                                                                                                    |                                                                                                                                                                                                                            |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | ER Physician: 20% <u>coinsurance</u> ; <u>deductible</u> does not apply<br>ER Facility: \$250 <u>copay/visit</u> ; <u>deductible</u> does not apply + 20% <u>coinsurance</u> ; <u>deductible</u> does not apply | ER Physician: 20% <u>coinsurance</u> ; <u>deductible</u> does not apply<br>ER Facility: \$250 <u>copay/visit</u> ; <u>deductible</u> does not apply + 20% <u>coinsurance</u> ; <u>deductible</u> does not apply | You may be <u>balance billed</u> from <u>Non-Plan Providers</u> .                                                                                                                                                          |
|                                                                           | <u>Emergency medical transportation</u>   | 20% <u>coinsurance</u>                                                                                                                                                                                          | 50% <u>coinsurance</u>                                                                                                                                                                                          |                                                                                                                                                                                                                            |
|                                                                           | <u>Urgent care</u>                        | \$25 <u>copay/visit</u> ; <u>deductible</u> does not apply                                                                                                                                                      | 50% <u>coinsurance</u>                                                                                                                                                                                          | You may be <u>balance billed</u> from <u>Non-Plan Providers</u> .                                                                                                                                                          |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                                                                                                                                                                                          | 50% <u>coinsurance</u>                                                                                                                                                                                          | Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.                                                                                                                                        |
|                                                                           | Physician/surgeon fees                    | 20% <u>coinsurance</u>                                                                                                                                                                                          | 50% <u>coinsurance</u>                                                                                                                                                                                          |                                                                                                                                                                                                                            |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$25 <u>copay/visit</u> ; <u>deductible</u> does not apply                                                                                                                                                      | 50% <u>coinsurance</u>                                                                                                                                                                                          | Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.                                                                                                                                        |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                                                                                                                                                                                          | 50% <u>coinsurance</u>                                                                                                                                                                                          |                                                                                                                                                                                                                            |
| If you are pregnant                                                       | Office visits                             | No charge                                                                                                                                                                                                       | 50% <u>coinsurance</u>                                                                                                                                                                                          | 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 | 20% <u>coinsurance</u>                                                                                                                                                                                          | 50% <u>coinsurance</u>                                                                                                                                                                                          | Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services; each service has a separate cost-share. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained. |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                                                                                                                                                                                          | 50% <u>coinsurance</u>                                                                                                                                                                                          | Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.                                                                                                                                        |

\*For more information about limitations and exceptions, see the plan or policy document at [www.sierrahealthandlife.com](http://www.sierrahealthandlife.com)

| Common Medical Event                                           | Services You May Need            | What You Will Pay                         |                                              | Limitations, Exceptions & Other Important Information                                                                                                                                                                               |
|----------------------------------------------------------------|----------------------------------|-------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | Plan Provider<br>(You will pay the least) | Non-Plan Provider<br>(You will pay the most) |                                                                                                                                                                                                                                     |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | 20% <u>coinsurance</u>                    | 50% <u>coinsurance</u>                       | Coverage is limited to a <u>Non-Plan</u> benefit of 30 visits. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.                                                                                  |
|                                                                | <u>Rehabilitation services</u>   | 20% <u>coinsurance</u>                    | 50% <u>coinsurance</u>                       | Coverage is limited to a combined Inpatient and Outpatient <u>Plan/Non-Plan</u> benefit of 120 days/visits. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.                                     |
|                                                                | <u>Habilitation services</u>     | 20% <u>coinsurance</u>                    | 50% <u>coinsurance</u>                       | Coverage is limited to a combined Inpatient and Outpatient <u>Plan/Non-Plan</u> benefit of 120 days/visits. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.                                     |
|                                                                | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                    | 50% <u>coinsurance</u>                       | Coverage is limited to 100 days. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.                                                                                                                |
|                                                                | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                    | 50% <u>coinsurance</u>                       | For purchase or rental at SHL's option. Purchases are limited to a single type of <u>DME</u> , including repair and replacement, every 3 years. Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained. |
|                                                                | <u>Hospice services</u>          | 20% <u>coinsurance</u>                    | 50% <u>coinsurance</u>                       | Insured pays a 50% benefit reduction if <u>prior authorization</u> is not obtained.                                                                                                                                                 |
| If your child needs dental or eye care                         | Children's eye exam              | Not Covered                               | Not Covered                                  | Your <u>plan</u> may include certain vision and/or dental services. 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:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |                                                                                                                                                                      |                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>                                             | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |

\*For more information about limitations and exceptions, see the plan or policy document at [www.sierrahealthandlife.com](http://www.sierrahealthandlife.com)

**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](http://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](http://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 the Nevada Department of Insurance at 888-872-3234 or [www.doi.nv.gov](http://www.doi.nv.gov) or call 1-800-888-2264

**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 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 <u>plan's</u> overall <u>deductible</u> | \$2,000.00 |
| ■ <u>Specialist copayment</u>                 | \$40.00    |
| ■ <u>Hospital (facility) coinsurance</u>      | 20%        |
| ■ <u>Other coinsurance</u>                    | 20%        |

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       |            |
|--------------------|------------|
| <u>Deductibles</u> | \$2,000.00 |
| <u>Copayments</u>  | \$200.00   |
| <u>Coinsurance</u> | \$1,900.00 |

| What isn't covered   |         |
|----------------------|---------|
| Limits or exclusions | \$80.00 |

|                            |            |
|----------------------------|------------|
| The total Peg would pay is | \$4,180.00 |
|----------------------------|------------|

### Managing Joe's type 2 diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |            |
|-----------------------------------------------|------------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000.00 |
| ■ <u>Specialist copayment</u>                 | \$40.00    |
| ■ <u>Hospital (facility) coinsurance</u>      | 20%        |
| ■ <u>Other copayment</u>                      | \$15.00    |

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 | \$5,600.00 |
|--------------------|------------|

In this example, Joe would pay:

| Cost Sharing       |          |
|--------------------|----------|
| <u>Deductibles</u> | \$0.00   |
| <u>Copayments</u>  | \$800.00 |
| <u>Coinsurance</u> | \$0.00   |

| What isn't covered   |         |
|----------------------|---------|
| Limits or exclusions | \$40.00 |

|                            |          |
|----------------------------|----------|
| The total Joe would pay is | \$840.00 |
|----------------------------|----------|

### Mia's Simple Fracture

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

|                                               |            |
|-----------------------------------------------|------------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000.00 |
| ■ <u>Specialist copayment</u>                 | \$40.00    |
| ■ <u>Hospital (facility) coinsurance</u>      | 20%        |
| ■ <u>Other copayment</u>                      | \$35.00    |

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 | \$2,800.00 |
|--------------------|------------|

In this example, Mia would pay:

| Cost Sharing       |            |
|--------------------|------------|
| <u>Deductibles</u> | \$1,700.00 |
| <u>Copayments</u>  | \$400.00   |
| <u>Coinsurance</u> | \$100.00   |

| What isn't covered   |        |
|----------------------|--------|
| Limits or exclusions | \$0.00 |

|                            |            |
|----------------------------|------------|
| The total Mia would pay is | \$2,200.00 |
|----------------------------|------------|

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

Health Plan of Nevada and Sierra Health and Life comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card or plan documents.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

[UHC Civil Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

If you need help filing a complaint, call the toll-free number on your member ID card or plan documents.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Phone: 1-800-368-1019 or 800-537-7697 (TDD)

Mail: U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F HHH Building  
Washington D.C. 20201

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>

This notice is available at:

<https://healthplanofnevada.com/content/dam/hpnv-public-sites/documents/NVStandard15Taglines.pdf>

<https://sierrahhealthandlife.com/content/dam/hpnv-public-sites/documents/NVStandard15Taglines.pdf>

**ATTENTION:** If you speak **English**, language help and communications in other formats, like large print, are available and free to you. Call the phone number included in this document.

**ATENCIÓN:** Si habla **español (Spanish)**, tiene acceso gratuito a asistencia lingüística y a materiales en otros formatos, como impresión en tamaño grande. Llame al número de teléfono que aparece en este documento.

**ATENSYON:** Kung nagsasalita ka ng **Tagalog**, ang tulong sa wika at komunikasyon sa iba pang mga format, tulad ng malalaking print, ay available at libre para sa iyo. Tawagan ang numero ng teleponong kasama sa dokumentong ito.

تنبيه: إذا كنت تتحدث اللغة العربية (Arabic)، فإن المساعدة اللغوية والواصلات بتسويات أخرى، مثل الطباعة بحروف كبيرة، متاحة لك مجاناً. يرجى الاتصال برقم الهاتف المذكور في هذا المستند.

**মনোযোগ দিন:** আপনি যদি **বাংলায় (Bengali)**, কথা বলেন, তাহলে ভাষা সহায়তা এবং বড় প্রিন্টের মতো অন্যান্য ফর্ম্যাটে যোগাযোগ আপনার জন্য বিনামূল্যে উপলভ্য। এই নথিতে দেওয়া ফোন নম্বরে কল করুন।

**ARONGGORONG:** Ngare' ukassal falawasch, eyoor aililis me' **arongorong (Carolinian)**, llon akaaw met, gnare' min tuttumogh na iisch, emween ubwe ya'ya' sin ubwe abwos. Faingii numero ye eno won documento yen.

**ATENSION:** Yanggen fumimino' **Chamorro** hao, guaha dibåtde para hagu na ayudun lengguahi yan komunikasion ni diferentes na fotmat, yan danglulo na tinigi'. Agang i numero nai gaige guini na dokumento.

**注意:** 如果您說中文(**Chinese**), 您可以免費獲得語言協助和其他格式 (例如大字版) 的通訊。請撥打本文件內的電話號碼。

توجہ: اگر یہ فارسی (Farsi)، صحبت میکنید، خدمات کمک زبان و مطالب در قالبهای دیگر، مانند پرینت درشت، بصورت رایگان برای شما فراهم است. با این سند ذکر شده، تماس بگیرید.

**ATTENTION:** si vous parlez **français (French)**, une assistance linguistique et des communications dans d'autres formats, tels que du texte en gros caractères, sont gratuitement mis à votre disposition. Appelez le numéro de téléphone inclus dans ce document.

**HINWEIS:** Wenn Sie **Deutsch (German)**, sprechen, stehen Ihnen Sprachdienste und Mitteilungen in anderen Formaten, wie z. B. in Großdruck, kostenlos zur Verfügung. Rufen Sie die in dieser Mitteilung angegebene Telefonnummer an.

**ધ્યાન આપો:** જો તમે ગુજરાતી (**Gujarati**), બોલો છો, તો ભાષા સહાય અને સંદેશાલ્પવાદર અન્ય ફોર્મેટમાં, જેમ કે મોટી પ્રિન્ટમાં, તમારા માટે નિ:શુલ્ક અને ઉપલબ્ધ છે. આ દસ્તાવેજમાં આપેલા ફોન નંબર પર કોલ કરો.

**ATANSYON:** Si w pale **Kreyòl Ayisyen (Haitian Creole)**, genyen ed pou lang ou a disponib gratis pou ou ansann ak komunikasyon nan lòt fòm, pa egzanp gwo lèt. Rele nan nimewo telefòn ki nan dokiman sa a.

**ध्यान दें:** यदि आप **हिन्दी (Hindi)**, बोलते हैं, तो भाषा संबंधी मदद और अन्य प्रारूपों, जैसे बड़े प्रिंट, में संचार, आपके लिए उपलब्ध और निःशुल्क है। इस दस्तावेज़ में शामिल किए गए फ़ोन नंबर पर कॉल करें।

**ATTENZIONE:** se parla **italiano (Italian)**, può usufruire gratuitamente di assistenza linguistica e comunicazioni in altri formati, come la stampa a caratteri grandi. Chiama il numero di telefono riportato in questo documento.

**注意:** 日本語(**Japanese**),を話される場合は、言語サポートや大きな活字などの他の形式でのコミュニケーションを無料でご利用いただけます。本書に記載されている電話番号までお電話ください。

**참고:** 한국어를 (**Korean**) 구사하신다면 언어 지원 및 의사소통을 큰 인쇄물과 같은 형식으로도 무료로 이용하실 수 있습니다. 본 문서에 있는 전화번호로 전화하십시오.

**BAĀ' ĀKONÍNÍZIN:** Diné (Navajo), bizaad bee yáńíł'igo, saad bee áka'aná'awo' dóó bee ahít dahane'í nááńá'ahgo át'éego bee hada'dilyaígíí, díí nitsaa bee ak'eda'ashchíní t'áá jik'eh ná dahóó. Díí naaltsoos bee éé'dahóziní bąąh námboo biká'ígíí bee hodilílníh.

**WICHDICH:** Wann du **Deutsch (Pennsylvania Dutch)**, schwetscht, kenne mer dich Schprooch-Hilf griege, wann du's brauchsch, un Information in differnti Wege, so wie gross Schreibes (large print). All sell zellt dich nix koschde. Call der Toll-Free-Number as do debei is.

**UWAGA:** jeśli mówisz po **polsku (Polish)**, oferujemy bezpłatną pomoc językową i materiały w innych formatach, w tym napisane dużym drukiem. Zadzwoń pod numer telefonu wskazany w tym dokumencie.

**ATENÇÃO:** se você fala **português (Portuguese)**, a ajuda com o idioma e as comunicações em outros formatos, como letras grandes, por exemplo, estão disponíveis e são gratuitas. Ligue para o número de telefone incluído neste documento.

**ВНИМАНИЕ:** Если Вы говорите по-русски (**Russian**), Вы можете бесплатно воспользоваться помощью переводчика и информационными материалами в альтернативных форматах, например, крупным шрифтом. Позвоните по номеру телефона, указанному в этом документе.

**MO LE SILAFIA:** Pe afai e te tautala i le faa-**Samoa (Samoa)**, o le fesoasoani tau gagana ma feso'ota'iga i isi auala, e pei o lomiga e laporo'a mata'itusi, o loo avanoa mo oe aunoa ma se totofi. Valaau le numera o le telefoni o loo aofia ai i lenei pepa.

توجہ فرمائیں: اگر آپ اردو (**Urdu**), بولتے ہیں تو بڑے پرنٹ جیسی دوسری شکلوں میں لسانی امداد اور مواصلات آپ کے لیے مفت میں دستیاب ہوتی ہیں۔ اس دستاویز میں شامل فون نمبر پر کال کریں۔

**LƯU Ý:** Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được hỗ trợ ngôn ngữ miễn phí và các định dạng thông tin miễn phí khác như bản in khổ lớn. Hãy gọi số điện thoại có trong tài liệu này.