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 www.opcmia797benefits.org or call 1-702-415-2190. 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 http://cciio.cms.gov or call 1-702-415-2190 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**PPO: $150 per individual / $300 per family calendar year. Non PPO: $600 per individual / $1,200 per family calendar year**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$25 per individual/$75 family** for dental coverage. There are no other specific **deductibles**.	You must pay all of the costs for the services up to the specific **deductible** amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$3,500**/person, **$10,500**/family in-network per calendar year	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?	Copayments for certain services, premiums, balance billing charges, and health care this plan does not 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. For a list of preferred providers, see www.beechstreet.com or call 1-800-877-1444.	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.

Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

⚠ 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
		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	$15 copayment plus 10% coinsurance.	$15 copayment plus 25% coinsurance. No PPO available 20% coinsurance.	Must be medically necessary. See *Summary Plan Description* for Limits and Exclusions.
	Specialist visit	$15 copayment plus 10% coinsurance.	$15 copayment plus 25% coinsurance. No PPO available 20% coinsurance.	Must be medically necessary. See *Summary Plan Description* for Limits and Exclusions.
	Preventive care/screening/ immunization	No charge	20% coinsurance of allowable expenses.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance.	Lab 25% coinsurance X-ray 35% coinsurance	Must be medically necessary. Preauthorization required for claims greater than $5,000.
	Imaging (CT/PET scans, MRIs)	10% coinsurance.	35% coinsurance	Must be medically necessary. Preauthorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.opcmia797benefits.org	Generic drugs	10% copay per prescription, $5 minimum.	Not covered	----------none----------
	Preferred brand drugs	20% copay per prescription, $10 minimum.	Not covered	----------none----------
	Non-preferred brand drugs	50% copay per prescription, $10	Not covered	----------none----------

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)	
		minimum.		
	Specialty drugs	10% copay per prescription, $250 maximum.	Not covered	----------none----------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance.	25% coinsurance; if no PPO available 20% coinsurance.	Must be medically necessary. See *Summary Plan Description* for Limits and Exclusions. Requires preauthorization. Benefits reduced to 50% coinsurance if prior authorization not obtained.
	Physician/surgeon fees	Same as above.	Same as above.	Same as above.
If you need immediate medical attention	Emergency room care	$0 copayment for emergencies.	$0 copayment for emergencies.	Must be medically necessary. See *Summary Plan Description* for Limits and Exclusions. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to $0 copayment, unless you consent to the non-PPO billing rates.
	Emergency medical transportation	10% coinsurance.	20% coinsurance. 10% coinsurance for Air Ambulance.	Must be medically necessary. See *Summary Plan Description* for Limits and Exclusions.
	Urgent care	$15 copayment plus 10% coinsurance.	$15 copayment plus 25% coinsurance.	Must be medically necessary. See *Summary Plan Description* for Limits and Exclusions.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance.	25% coinsurance specialized treatment 20% coinsurance, emergency 10% coinsurance	Must be medically necessary. See *Summary Plan Description* for Limits and Exclusions. Requires preauthorization. Benefits reduced to 50% coinsurance if prior authorization not obtained.
	Physician/surgeon fees	10% coinsurance.	25% coinsurance of allowable expenses. Emergency or specialized treatment	Must be medically necessary. See *Summary Plan Description* for Limits and Exclusions. Requires preauthorization. Benefits reduced to 50% coinsurance if

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)	
			20% coinsurance.	prior authorization not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible waived	25% coinsurance	Certain services, such as intensive outpatient therapy, must be preapproved by MAP. Benefits reduced to 50% coinsurance if prior authorization not obtained for such services.
	Inpatient services	10% coinsurance	25% coinsurance	Must be preapproved by MAP. Benefits reduced to 50% coinsurance if prior authorization not obtained.
If you are pregnant	Office visits	$15 copayment 10% coinsurance	25% coinsurance	Dependent children not covered.
	Childbirth/delivery professional services	10% coinsurance	25% coinsurance	Minimum 48 hours following delivery, 96 hours for cesarean delivery. Dependent children not covered.
	Childbirth/delivery facility services	10% coinsurance	25% coinsurance	Minimum 48 hours following delivery, 96 hours for cesarean delivery. Dependent children not covered.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Must be preauthorized from a Physician and the Utilization Review Organization.
	Rehabilitation services	10% coinsurance	20% coinsurance	Maximum of 60 visits per calendar year.
	Habilitation services	10% coinsurance	20% coinsurance	Maximum of 60 visits per calendar year.
	Skilled nursing care	10% coinsurance	20% coinsurance	Limited to 100 days per year.
	Durable medical equipment	10% coinsurance	25% coinsurance	Must be preauthorized for claims greater than $500.
	Hospice services	10% coinsurance	10% coinsurance	Must be preauthorized.
If your child needs dental or eye care	Children's eye exam	$20 copay	No coverage	Must use Vision Service Plan provider. See www.vsp.com or call 1-800- 877-7195.

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)	
	Children's glasses	$20 copay	No coverage	Must use Vision Service Plan provider. See www.vsp.com or call 1-800- 877-7195.
	Children's dental check-up	$25 deductible individual/$75 deductible family. $0 copay preventive services, 20% all other services	Difference between provider charges and 100% of Non-PPO schedule	$2,500 maximum per calendar year. This maximum does not apply to pediatric dental benefits for enrollees under age 19.

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.)

- Cosmetic surgery
- Experimental services
- Foot care
- Fertility testing
- Government operated facilities
- Weight reduction

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Accident expense
- Chiropractic care
- Physical therapy
- Speech therapy
- ABA therapy
- Occupational therapy
- Transplants
- Hearing aids (up to one device per ear every five calendar years)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-702-415-2190. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, 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: www.opcmia797benefits.org or call 1-702-415-2190

* For more information about limitations and exceptions, see the plan or policy document at www.opcmia797benefits.org or call 1-702-415-2190

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? 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 1-702-415-2190.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-702-415-2190.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-702-415-2190.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-702-415-2190.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$150**
- **Specialist *[cost sharing]*** **$15 + 10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$150
Copayments	$30
Coinsurance	$1,252
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,432**

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

- **The plan's overall deductible** **$150**
- **Specialist *[cost sharing]*** **$15 + 10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$150
Copayments	$15
Coinsurance	$544
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$709**

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

- **The plan's overall deductible** **$150**
- **Specialist *[cost sharing]*** **$15 + 10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$150
Copayments	$0
Coinsurance	$265
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$415**

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

* For more information about limitations and exceptions, see the plan or policy document at www.opcmia797benefits.org or call 1-702-415-2190