
 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](http://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:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>PPO: \$150 per individual / \$300 per family calendar year. Non PPO: \$600 per individual / \$1,200 per family calendar year</b>	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> starts over (usually, but not always, January 1 <sup>st</sup> ). See the chart starting on page 2 for how much you pay for covered services after you meet the <b><u>deductible</u></b> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Preventive care and primary care services are covered before you meet your <b><u>deductible</u></b> .	This plan covers some items and services even if you haven't yet met the <b><u>deductible</u></b> amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your <b><u>deductible</u></b> . See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. <b>\$25 per individual/\$75 family</b> for dental coverage. There are no other specific <b><u>deductibles</u></b> .	You must pay all of the costs for the services up to the specific <b><u>deductible</u></b> amount before this plan begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$3,500/person, \$10,500/family</b> in-network per calendar year	The <b><u>out-of-pocket limit</u></b> 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 <b><u>out-of-pocket limits</u></b> until the overall family <b><u>out of pocket limit</u></b> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	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 <b><u>out-of-pocket limit</u></b> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of preferred providers, see <a href="http://www.beechstreet.com">www.beechstreet.com</a> 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 <b><u>out-of-network provider</u></b> , 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 <b><u>out-of-network provider</u></b> for some services (such as lab work). Check with your provider before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without permission from this plan.
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 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 <a href="#">provider's office</a> or <a href="#">clinic</a>	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 <i>Summary Plan Description</i> for Limits and Exclusions.
	<a href="#">Specialist</a> visit	\$15 copayment plus 10% coinsurance.	\$15 copayment plus 25% coinsurance. No PPO available 20% coinsurance.	Must be medically necessary. See <i>Summary Plan Description</i> for Limits and Exclusions.
	<a href="#">Preventive care/screening/immunization</a>	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	<a href="#">Diagnostic test</a> (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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.opcmia797benefits.org">www.opcmia797benefits.org</a>	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-----

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.opcmia797benefits.org](http://www.opcmia797benefits.org) or call 1-702-415-2190

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.		
	<a href="#">Specialty drugs</a>	10% copay per prescription, \$250 maximum.	Not covered	-----none-----
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance.	25% coinsurance; if no PPO available 20% coinsurance.	Must be medically necessary. See <i>Summary Plan Description</i> 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.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$0 copayment for emergencies, \$500 copayment for non-emergencies.	\$0 copayment for emergencies, \$500 copayment for non-emergencies.	Must be medically necessary. See <i>Summary Plan Description</i> for Limits and Exclusions.
	<a href="#">Emergency medical transportation</a>	10% coinsurance.	20% coinsurance.	Must be medically necessary. See <i>Summary Plan Description</i> for Limits and Exclusions.
	<a href="#">Urgent care</a>	\$15 copayment plus 10% coinsurance.	\$15 copayment plus 25% coinsurance.	Must be medically necessary. See <i>Summary Plan Description</i> for Limits and Exclusions.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance.	25% coinsurance specialized treatment 20% coinsurance, emergency 10% coinsurance	Must be medically necessary. See <i>Summary Plan Description</i> 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 20% coinsurance.	Must be medically necessary. See <i>Summary Plan Description</i> for Limits and Exclusions. Requires preauthorization. Benefits reduced to 50% coinsurance if prior authorization not obtained.
<b>If you need mental health, behavioral</b>	Outpatient services	No charge; deductible waived	25% coinsurance	Certain services, such as intensive outpatient therapy, must be preapproved

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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)	
<b>health, or substance abuse services</b>				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.
<b>If you are pregnant</b>	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.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% coinsurance	20% coinsurance	Must be preauthorized from a Physician and the Utilization Review Organization.
	<a href="#">Rehabilitation services</a>	10% coinsurance	20% coinsurance	Maximum of 60 visits per calendar year.
	<a href="#">Habilitation services</a>	10% coinsurance	20% coinsurance	Maximum of 60 visits per calendar year.
	<a href="#">Skilled nursing care</a>	10% coinsurance	20% coinsurance	Limited to 100 days per year.
	<a href="#">Durable medical equipment</a>	10% coinsurance	25% coinsurance	Must be preauthorized for claims greater than \$500.
	<a href="#">Hospice services</a>	10% coinsurance	10% coinsurance	Must be preauthorized.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$20 copay	No coverage	Must use Vision Service Plan provider. See www.vsp.com or call 1-800- 877-7195.
	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	Difference between provider charges and	\$2,500 maximum per calendar year. This maximum does not apply to pediatric

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)	
		deductible family. \$0 copay preventive services, 20% all other services	100% of Non-PPO schedule	dental benefits for enrollees under age 19.

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• 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 <a href="#">plan</a> document.)		
• Acupuncture	• Accident expense	• Chiropractic care
• Hearing aids (up to one device per ear every five calendar years)	• Transplants	

**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](http://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](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: [www.opcmia797benefits.org](http://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, kwijigo 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$1,252
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,432</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$15
<a href="#">Coinsurance</a>	\$544
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$709</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$265
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$415</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.