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.healthscopebenefits.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.cciio.cms.gov or call 1-800-395-7069 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred-Network – University Medical Center of Southern Nevada: $0 Employee; $0 Family; In-network $250 Employee; $750 Family; Non-network: $1,500 Employee; $3,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, Preventive Care, X-rays, Physician Visit, pre-admission testing, Urgent Care, Rehabilitation Services and diabetic education 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Preferred-Network and In-network $3,750 Employee; $7,750 Family; Non-network: $11,500 Employee; $23,000 Family; Prescription: $2,000 Employee; $4,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties, amounts over Usual and Customary fees and excluded charges.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthscopebenefits.com or call 1-800-395-7069 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

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
		Preferred Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay	$20 copay	40% coinsurance after deductible	None
	Specialist visit	Not Applicable	20% coinsurance deductible waived	40% coinsurance after deductible	
	Preventive care/screening/ immunization	No Charge	No Charge	40% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance deductible waived	40% coinsurance after deductible	Interpretation of test / Reading of test 100% covered for Preferred Network
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance deductible waived	40% coinsurance after deductible	Interpretation of test / Reading of test 100% covered for Preferred Network
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.navitus.com	Tier 1	30-Day: $9 copay; 90-Day: $18 copay	30-Day: $9 copay; 90-Day: $18 copay	50% of allowable plus In-network copay	90-day available at both retail and mail.
	Tier 2	30-Day: 20% coinsurance ($30 min, $60 max) 90-Day: 20% coinsurance ($60 min, $120 max)	30-Day: 20% coinsurance ($30 min, $60 max) 90-Day: 20% coinsurance ($60 min, $120 max)	50% of allowable plus In-network copay	
	Tier 3	30-Day: 30% coinsurance ($60 min, $120 max) 90-Day: 30% coinsurance ($120 min, $240 max)	30-Day: 30% coinsurance ($60 min, $120 max) 90-Day: 30% coinsurance ($120 min, $240 max)	50% of allowable plus In-network copay	
	Specialty drugs	As stated above based upon drug class	As stated above based upon drug class	As stated above based upon drug class	None

* For more information about limitations and exceptions, see the plan or policy document at www.healthscopebenefits.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	$100 copay then 20% coinsurance after deductible	$300 copay then 40% coinsurance after deductible	Precertification may be required.
	Physician/surgeon fees	Not Applicable	20% coinsurance deductible waived	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$100 copay then 20% coinsurance	$100 copay then 20% coinsurance after deductible	$100 copay then 20% coinsurance after deductible	Deductible waived if accidental injury. Non-Emergency is not covered.
	Emergency medical transportation	Not Applicable	$100 copay then 20% coinsurance after deductible	$100 copay then 20% coinsurance after deductible	None
	Urgent care	$20 copay at UMC Quick Care	20% coinsurance	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	$100 copay then 20% coinsurance after deductible	$750 copay then 40% coinsurance after deductible	Precertification is required.
	Physician/surgeon fees	Not Applicable	20% coinsurance deductible waived	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay	PCP: $20 copay ; Specialist: 20% coinsurance deductible waived	40% coinsurance after deductible	
	Inpatient services	10% coinsurance	$100 copay then 20% coinsurance after deductible	$750 copay then 40% coinsurance after deductible	Precertification is required.
If you are pregnant	Office visits	$10 copay	$20 copay	40% coinsurance after deductible	Covered services include: All female members, complications of pregnancy for dependent children and midwife services.
	Childbirth/delivery professional services	Not Applicable	20% coinsurance after deductible	40% coinsurance after deductible	

* For more information about limitations and exceptions, see the plan or policy document at www.healthscopebenefits.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider	
	Childbirth/delivery facility services	10% coinsurance	$100 copay then 20% coinsurance after deductible	$750 copay then 40% coinsurance after deductible	None
If you need help recovering or have other special health needs	Home health care	Not Applicable	20% coinsurance after deductible	40% coinsurance after deductible	Precertification is required.
	Rehabilitation services	$10 copay	$10 copay deductible waived	40% coinsurance after deductible	Occupational, Physical, and Speech therapy limited to 30 visits per calendar year.
	Habilitation services	$10 copay	$10 copay deductible waived	40% coinsurance after deductible	
	Skilled nursing care	Not Applicable	$100 copay then 20% coinsurance after deductible	$750 copay then 40% coinsurance after deductible	Precertification is required. Limited to 120 days per calendar year.
	Durable medical equipment	Not Applicable	20% coinsurance after deductible	40% coinsurance after deductible	Precertification is required.
	Hospice services	Not Applicable	20% coinsurance after deductible	40% coinsurance after deductible	Precertification is required.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	40% coinsurance after deductible	Includes screening under the preventive benefit for children under 5.
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

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
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture (limited to 20 visits per calendar year)
- Bariatric Surgery (once per lifetime)
- Chiropractic Care (Limited to 20 visits per calendar year)
- Hearing Aids (Limited to $3,000 every 3 years)
- Private Duty Nursing

* For more information about limitations and exceptions, see the plan or policy document at www.healthscopebenefits.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272. 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 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: HealthSCOPE Benefits at 1-800-395-7069.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-395-7069.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-395-7069.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-395-7069.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-395-7069.

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

* For more information about limitations and exceptions, see the plan or policy document at www.healthscopebenefits.com.

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	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$60
Coinsurance	$1,135
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,505

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$750
Coinsurance	$400
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,455

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$140
Coinsurance	$332
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$722

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