N. Nevada Operating Engineers H&W Trust Fund: PPO Plan

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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-826-5053. 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.dol.gov/ebsa/healthreform or call **1-877-826-5053** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO and Non-PPO Providers: **$250**/individual; **$750**/family. The deductible is accumulated during the 12-month calendar year.	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. Outpatient prescription drugs 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.
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?	PPO providers: $5,500/individual. Non-PPO providers: $13,000/individual. Payments to PPO providers also accumulate to the Non-PPO provider out-of-pocket limit. The out-of-pocket limit is accumulated during the 12-month calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain precertification, deductible, charges in excess of benefit maximums and allowed charges, outpatient prescription drugs and health care this plan doesn't cover.	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.
Will you pay less if you use a network provider?	Yes. See http://nevada.oe3health.org/docs/ppodir.pdf or call 1-877-826-5053 for a list of PPO providers for medical services. For a list of PPO providers for chemical dependency, call 1-800-562-3277.	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 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
		PPO Provider (You will pay the least)	Non-PPO 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	10% coinsurance	40% coinsurance, plus any amount above the Plan's Allowed Amount.	Telemedicine with a Renown healthcare provider or specialist via telemedicine (rather than having the you travel to that provider) is covered subject to normal benefits when initiated through a Renown Telehealth location.
	Specialist visit	10% coinsurance	See Primary care visit row (above)	
	Preventive care/screening/ Immunization	Physical exam for employee and spouse: No charge for routine physical exam, resting ECG, chest x-ray, coronary calcium scoring CT scan & many lab tests. All other services (including well child care and immunizations, pelvic exam, pap smear, mammogram, colonoscopy): 10% coinsurance	See Primary care visit row (above)	Preventive benefit covers mammogram for those over age 35, and one colonoscopy every 10 years. Well child care is covered including routine diagnostic tests and vaccinations in accordance with recommendations by the American Academy of Pediatrics up to age 19. The Fund will pay up to $33 for a flu shot, up to $344 for the shingles vaccination ($172 per shot) and up to $224 for a pneumonia vaccine with a PPO or Non-PPO provider or pharmacy.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	See Primary care visit row (above)	For a-Non-PPO Provider performing only the professional component, you will pay 60% coinsurance, plus any amount above the Plan's Allowed Amount.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	See Primary care visit row (above)	Requires precertification prior to testing.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$15 copayment/script retail, $5 copayment/script mail order.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	• Deductible does not apply. • Covers up to 34-day supply if purchased at retail, 90-day supply for mail order prescription drugs. • Contact OptumRx for information on prescription drugs subject to preauthorization, step therapy, or quantity limits. • If you purchase a brand drug when generic drug is available, you may pay a higher copayment (or payment may be denied if you are taking a brand drug that is excluded from the formulary, or a drug for which there is a preferred alternative). • If the cost of the drug is less than the copayment, you pay just the drug cost.
	Preferred brand drugs (if no generic is available or generic is medically inappropriate)	$25 copayment/script retail, $45 copayment/script mail order.		
	Non-preferred brand drugs (if generic is available)	$30 copayment/script retail, $55 copayment/script mail order.		
	Specialty drugs	Subject to retail copayments above.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	See Primary care visit row (above)	Outpatient surgery requires precertification.
	Physician/surgeon fees	10% coinsurance	See Primary care visit row (above)	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance.	Physician charges may be billed separately.
	Emergency medical transportation	10% coinsurance	10% coinsurance, plus any amount above the Plan's Allowed Amount.	You pay 10% coinsurance for covered Non-PPO air ambulance services and there will be no balance billing from the Non-PPO provider.
	Urgent care	10% coinsurance	See Primary care visit row (above)	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	See Primary care visit row (above)	Elective hospital admission requires precertification. Emergency hospital admission requires certification as soon as possible. Private room covered up to cost of semi-private room at same facility.
	Physician/surgeon fees	10% coinsurance	See Primary care visit row (above)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	See Primary care visit row (above)	None.
	Inpatient services	10% coinsurance	See Primary care visit row (above)	Elective hospital or residential treatment facility admission requires precertification. Call (775) 826-7200 or (877) 826-5053 for inpatient precertification of mental health. Call ARP for inpatient precertification of substance abuse at (800) 562-3277.
If you are pregnant	Office visits	10% coinsurance	See Primary care visit row (above)	• Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). • You pay 100% of maternity services for dependent children (even with PPO providers)
	Childbirth/delivery professional services	10% coinsurance	See Primary care visit row (above)	Precertification is required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section. You must pay 100% of delivery expenses for a dependent child (even with PPO providers).
	Childbirth/delivery facility services	10% coinsurance	See Primary care visit row (above)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	See Primary care visit row (above)	Precertification is required.
	Rehabilitation services	10% coinsurance	See Primary care visit row (above)	Precertification is required.
	Habilitation services	10% coinsurance	See Primary care visit row (above)	Precertification is required.
	Skilled nursing care	10% coinsurance	See Primary care visit row (above)	Precertification is required. Private room covered up to cost of semi-private room at same facility.
	Durable medical equipment	10% coinsurance	See Primary care visit row (above)	Requires a doctor's written order.
	Hospice services	10% coinsurance	See Primary care visit row (above)	Covered if terminally ill up to a lifetime maximum of 30 days. Precertification required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	0% coinsurance	• Vision benefits are available through a separate vision plan. • Non-PPO lens allowance may be higher for certain types of lenses. • Non-PPO scheduled allowances are not applied to dependent children under age 19.
	Children's glasses	No charge on select frames and lenses	0% coinsurance	
	Children's dental check-up	10% coinsurance	20% coinsurance, plus any amount above the Plan's Allowed Amount.	Dental benefits are available through a separate dental plan. Non-PPO dental allowances are based on a fee schedule.

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.)

- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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 (up to 15 visits/calendar year)
- Chiropractic care (up to 15 visits/calendar year).
- Dental care (Adult & Child) under separate dental plan
- Hearing aids
- Routine eye care (Adult-& Child) under separate vision plan

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the Administrative Office at 1-877-826-5053. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-877-826-5053.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-826-5053.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-826-5053.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-826-5053.

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** **$250**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance]** **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	$250
Copayments	$10
Coinsurance	$1,240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **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	$250
Copayments	$460
Coinsurance	$160
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$890**

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

- **The plan's overall deductible** **$250**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **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	$250
Copayments	$10
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$510**

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