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, go to www.chftoo.org or call 702-733-9938 or 1-800-457-8512. 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 www.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-457-8512 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.00	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	Not Applicable
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?	$6,350 individual /$12,700 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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Dental copayments, expenses incurred out of network unless the Plan Administrator allows coverage at PPO rates provided an eligible person obtains prior authorization and the medical procedure is not available in the Las Vegas area, premiums, balance billing charges, and healthcare this plan doesn't 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. See www.chftoo.org or call 702-733-9938 or 1-800-457-8512.	This plan uses a provider network. You will pay less if you use a provider in the plan's PPO network. You will pay the most if you use a Non-PPO provider, and you might receive a bill from a Non-PPO provider for the difference between the Non-PPO provider's charge and what your plan pays (balance billing). Be aware, your PPO network provider might use a Non-PPO provider for some services (such as labwork). 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	$25 copay/visit	Not covered	No copay for visits at the Culinary Health Center.
	Specialist visit	$40 copay/visit	Not covered	——————none——————
	Preventive care/screening/ immunization	No charge	Not covered	Refer to www.healthcare.gov for a complete list of covered preventive health services.
If you have a test	Diagnostic test (x-ray, blood work)	**XRAY:** $20 copay/visit at freestanding facility $30 copay/visit in dr's office $45 copay/visit in hospital outpatient **BLOOD WORK:** $0 copay/visit at freestanding facility or in dr's office $15 copay/visit hospital outpatient	Not covered	Some services require prior authorization and will not be covered without such authorization. Copay for bloodwork done in an outpatient department of a hospital applies to hospital based pre-operative or diagnostic services only. No copay for X-rays or lab work done at the Culinary Health Center.
	Imaging (CT/PET scans, MRIs)	**CT/MRI/MRA:** $125 copay/visit **PET/PET CT:** $175 copay/visit at free-standing facility **PET/PET CT:** $225 copay/visit in dr's office or hospital outpatient	Not covered	Some services require prior authorization and will not be covered without such authorization. No copay for ultrasounds, bone density tests, and CT scans with contrast done at the Culinary Health Center. CT scans are only available at the Nellis Culinary Health Center.

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.chftoo.org	Generic drugs (Tier 1)	$10 copay/prescription (retail and mail order)	Not covered	No copay for prescriptions filled at the Culinary pharmacy or at the Culinary Health Center. Quantity limits, prior authorization requirements, and other cost-containment programs may apply.
	Formulary drugs (Tier 2)	$20 copay/prescription (retail and mail order)	Not covered	
	Non-Formulary drugs (Tier 3)	$35 copay/prescription (retail and mail order)	Not covered	
	Specialty drugs (Tier 4)	25% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/surgery (ambulatory surgery center); $250 copay/surgery (hospital)	Not covered	Benefits may be denied if the prior authorization program is not followed.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$350 copay/visit	$350 copay/visit	No coverage for non-emergency care in a Non-PPO emergency room in the Las Vegas geographic area.
	Emergency medical transportation	25% coinsurance (ground); $500 copay/person/incident (air)	25% coinsurance (ground); $500 copay/person/incident (air)	——————none——————
	Urgent care	$50 copay/visit	$50 copay/visit	No coverage for services at Non-PPO Urgent Care in the Las Vegas geographic area. Copay includes all covered services related to the visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	$2,000 copay/ admission + 40% coinsurance of Allowable Charges	Benefits may be denied if the prior authorization program is not followed for Non-PPO providers.
	Physician/surgeon fees	No charge	Not covered	

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	Outpatient Therapy: No copay first 5 visits/issue, then $15 copay/visit Partial Hospital Admission: $150 copay/treatment plan Intensive Outpatient Program: No charge	Not covered	Some services require prior authorization and will not be covered without such authorization. No copay for outpatient therapy at the Culinary Health Center.
	Inpatient services	$250 copay/admission	$2,000 copay/admission + 40% coinsurance of Allowable Charges	Benefits may be denied if the prior authorization program is not followed for Non-PPO providers.
If you are pregnant	Office visits	No charge	Not covered	No coverage is provided for pregnancy of a dependent child, except as required under the Affordable Care Act. Additional copay may apply for additional services. Benefits may be denied if the prior authorization program is not followed.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$250 copay/admission	$2,000 copay/admission + 40% coinsurance of Allowable Charges	

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 help recovering or have other special health needs	Home Health Care	No charge	Not covered	Coverage limited to 60 days/year. Benefits may be denied if the prior authorization program is not followed.
	Rehabilitation services	$250 copay/inpatient admission At a free-standing facility: • $20 copay/visit occupational/speech therapy, age 18 or older • $10 copay/visit occupational/ speech therapy, under the age of 18	Not covered	Inpatient coverage limited to 60 days/year. The visit limits do not apply to visits primarily for mental health or substance abuse treatment. Benefits may be denied if the prior authorization program is not followed.
	Habilitation services	At a free-standing facility: • No charge for non-surgical and post-surgical physical therapy • No copay for physical therapy received at the Culinary Health Center • $30 copay/visit for cardio rehab Hospital Outpatient after an admission: • $30 copay/visit for physical, occupational, speech therapy • $40 copay/visit for cardio rehab	Not covered	Outpatient at a hospital after an admission: Physical, occupational or speech therapy limited to 30 visits per therapy type per year. The visit limits do not apply to visits primarily for mental health or substance abuse treatment. Cardio rehab: limited to 30 visits per year at a free-standing facility or outpatient at a hospital. Benefits may be denied if the prior authorization program is not followed.
	Skilled nursing care	$250 copay/admission	Not covered	Limited to 60 days per calendar year. Benefits may be denied if the prior authorization program is not followed.
	Durable medical equipment	10% coinsurance	Not covered	The Fund pays 100% for formula and medical food for enteral nutrition services. Prior authorization required for items over $500.
	Hospice services	No charge	Not covered	————————none————————

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

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	Not covered	Not covered	Vision benefits may be provided separately.
	Children's glasses			
	Children's dental check-up	No charge	Varies depending on the cost	Coverage limited to $1,500/year for Non-PPO provider

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
- Infertility treatment
- Dental care (Adult) (may be provided separately)
- Dental care (Child) (may be provided separately)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child) (may be provided separately)
- Private-duty nursing
- Weight loss programs
- Glasses (Adult & Child) (may be provided separately)

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

- Chiropractic Care
- Hearing aids
- Acupuncture
- Bariatric surgery
- Routine foot care

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

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: U.S Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 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: US 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 1-800-457-8212.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-457-8212.
Chinese [(中文): 如果需要中文的帮助，请拨打这个号码 1-800-457-8212.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-457-8212.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-457-8212 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-457-8212.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-457-8212.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-457-8212.

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

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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 $0
- Specialist copayment $0
- Hospital (facility) copayment $250
- Other copayment $0

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	$0
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$310**

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

- The plan's overall deductible $0
- Specialist copayment $80
- Hospital (facility) copayment $0
- Other copayment $0

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	$0
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$80**

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

- The plan's overall deductible $0
- Specialist copayment $80
- Emergency Room copayment $350
- Other coinsurance $260

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	$0
Copayments	$480
Coinsurance	$260
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$740**

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