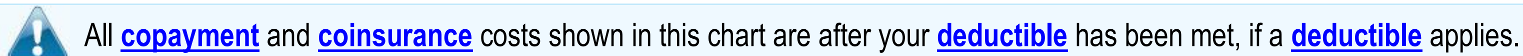
Public Employees' Benefits Program

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2017 – 06/30/2018
Coverage for: Individual | **Plan Type:** CDHP

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.pebp.state.nv.us. 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 775-684-7000 1-800-326-5496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual In Network: $1,500 Individual Out of Network: $1,500	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you have not 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 do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Individual In Network: $3,900 Individual Out of Network: $10,600	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?	Failure to obtain pre-authorization for certain services, premiums, balance-billing charges, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.pebp.state.nv.us or call 1-800-336-0123 or 1-888-763-8232** for a list of participating 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 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
		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	20% coinsurance	50% coinsurance	None.
	Specialist visit	20% coinsurance	50% coinsurance	None.
	Preventive care/screening/ immunization	No charge.	Not Covered.	You may have to pay for services that are not 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)	20% coinsurance	50% coinsurance	Covered only when ordered by a physician or health care provider.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pebp.state.nv.us	Generic drugs	20% coinsurance	Not Covered.	Non-preferred generic drugs: No deductible credit and they do not count toward your out–of–pocket limit.
	Preferred brand drugs	20% coinsurance	Not Covered.	None.
	Non-preferred brand drugs	Not Covered.	Not Covered.	Non-preferred brand drugs: No deductible credit and they do not count toward your out–of–pocket limit.
	Specialty drugs	20% coinsurance	Not Covered.	Covers up to a 30-day supply through contracted specialty pharmacy. Specialty drugs require a preauthorization by PEBP's Pharmacy Benefits Manager.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Some outpatient surgeries may require preauthorization. Please refer to the PEBP plan document for an exhaustive list of such procedures
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	20% coinsurance	50% coinsurance	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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	None.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Preauthorization required only if vaginal delivery exceeds 48 hours or cesarean section delivery exceeds 96 hours.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per person Plan Year.
	Rehabilitation services	20% coinsurance	50% coinsurance	Maintenance habilitation/rehabilitation and coma stimulation services are not covered. Speech Therapy coverage subject to certain restrictions. Preauthorization required for inpatient rehabilitation services.
	Habilitation services	20% coinsurance	50% coinsurance	Maintenance habilitation/rehabilitation and coma stimulation services are not covered. Speech Therapy coverage subject to certain restrictions. Preauthorization required for inpatient rehabilitation services.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per Plan Year for all confinements related to the same cause. Preauthorization required.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for equipment over $1,000.
	Hospice services	20% coinsurance	50% coinsurance	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)	
If your child needs dental or eye care	Children's eye exam	$25 copayment	$25 copayment	Limited to 1 routine preventive care/screening per Plan Year.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	Coverage available under separate Dental plan.

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
- Long-term care
- Non-FDA approved drugs
- Routine foot care
- Orthodontia expenses

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

- Acupuncture
- Weight loss program
- Chiropractic care
- Hearing aids
- Routine eye care (limited to one screening exam)
- Bariatric surgery

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: 1-800-326-5496 or 775-684-7000. 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 Customer Service at 1-888-763-8232, or 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.

If you do not 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 does not 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 1-888-763-8232.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-763-8232.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-763-8232.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-763-8232.

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** **$1,500**
- **Specialist *[cost sharing]*** **20%**
- **Hospital (facility) *[cost sharing]*** **20%**
- **Other *[cost sharing]*** **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	**$7,440**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$1,188
What is not covered	
Limits or exclusions	
The total Peg would pay is	**$2,688**

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

- **The plan's overall deductible** **$1,500**
- **Specialist *[cost sharing]*** **20%**
- **Hospital (facility) *[cost sharing]*** **20%**
- **Other *[cost sharing]*** **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	**$5,300**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$760
What is not covered	
Limits or exclusions	
The total Joe would pay is	**$2,260**

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

- **The plan's overall deductible** **$1,500**
- **Specialist *[cost sharing]*** **20%**
- **Hospital (facility) *[cost sharing]*** **20%**
- **Other *[cost sharing]*** **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	**$2,400**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$180
What is not covered	
Limits or exclusions	None
The total Mia would pay is	**$1,680**

*Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.pebp.state.nv.us or 775-684-7000 or 1-800-326-5496.

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