


# Public Employees' Benefits Program




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

**Coverage Period:** 07/01/2018 – 06/30/2019  
**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](http://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](http://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 <a href="#">deductible</a> ?	Individual In Network: \$1,500 Individual Out of Network: \$1,500	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you have not yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You do not have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Individual In Network: \$3,900 Individual Out of Network: \$10,600	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Failure to obtain pre-authorization for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they do not count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.pebp.state.nv.us">www.pebp.state.nv.us</a> or call 1-800-336-0123 or 1-888-763-8232 for a list of participating providers.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> 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 a <a href="#">referral</a> .

**Questions:** For medical, vision, and dental benefits call HealthSCOPE Benefits at 1-888-763-8232 or visit [www.healthscopebenefits.com](http://www.healthscopebenefits.com). For prescription drug benefits call Express Scripts at 1-855-889-7708 or visit [www.Express-Scripts.com](http://www.Express-Scripts.com). For eligibility and all other questions call PEBP Member Services at 775-684-7000 or 1-800-326-5496 or [www.pebp.state.nv.us](http://www.pebp.state.nv.us).

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge.	Not Covered.	You may have to pay for services that are not <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Covered only when ordered by a physician or health care <a href="#">provider</a> .
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.pebp.state.nv.us">www.pebp.state.nv.us</a>	Generic drugs	20% <a href="#">coinsurance</a>	Not Covered.	Non-preferred generic drugs: No <a href="#">deductible</a> credit and they do not count toward your <a href="#">out-of-pocket limit</a> .
	Preferred brand drugs	20% <a href="#">coinsurance</a>	Not Covered.	None.
	Non-preferred brand drugs	Not Covered.	Not Covered.	Non-preferred brand drugs: No <a href="#">deductible</a> credit and they do not count toward your <a href="#">out-of-pocket limit</a> .
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a>	Not Covered.	Covers up to a 30-day supply through contracted specialty pharmacy. <a href="#">Specialty drugs</a> require a <a href="#">preauthorization</a> by PEBP's Pharmacy Benefits Manager.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Some outpatient surgeries may require <a href="#">preauthorization</a> . Please refer to the PEBP plan document for an exhaustive list of such procedures
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.

**Questions:** For medical, vision, and dental benefits call HealthSCOPE Benefits at 1-888-763-8232 or visit [www.healthscopebenefits.com](http://www.healthscopebenefits.com). For prescription drug benefits call Express Scripts at 1-855-889-7708 or visit [www.Express-Scripts.com](http://www.Express-Scripts.com). For eligibility and all other questions call PEBP Member Services at 775-684-7000 or 1-800-326-5496 or [www.pebp.state.nv.us](http://www.pebp.state.nv.us).

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>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
<b>If you are pregnant</b>	Office visits	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required only if vaginal delivery exceeds 48 hours or cesarean section delivery exceeds 96 hours.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 60 visits per person Plan Year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maintenance habilitation/rehabilitation and coma stimulation services are not covered. Speech therapy coverage subject to certain restrictions. <a href="#">Preauthorization</a> required for inpatient rehabilitation services.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maintenance habilitation/rehabilitation and coma stimulation services are not covered. Speech Therapy coverage subject to certain restrictions. <a href="#">Preauthorization</a> required for inpatient rehabilitation services.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 60 days per Plan Year for all confinements related to the same cause. <a href="#">Preauthorization</a> required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for equipment over \$1,000.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.

**Questions:** For medical, vision, and dental benefits call HealthSCOPE Benefits at 1-888-763-8232 or visit [www.healthscopebenefits.com](http://www.healthscopebenefits.com).

For prescription drug benefits call Express Scripts at 1-855-889-7708 or visit [www.Express-Scripts.com](http://www.Express-Scripts.com). For eligibility and all other questions call PEBP Member Services at 775-684-7000 or 1-800-326-5496 or [www.pebp.state.nv.us](http://www.pebp.state.nv.us).

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 <a href="#">copayment</a>	\$25 <a href="#">copayment</a>	Limited to 1 routine <a href="#">preventive care/screening</a> 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](#).)

- |                                                                                                       |                                                                                                      |                                                                                                       |
|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-FDA approved drugs</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Orthodontia expenses</li> </ul> |
|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|

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

- |                                                                                                |                                                                                               |                                                                                                                                   |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Weight loss program</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (limited to one screening exam)</li> <li>• Bariatric surgery</li> </ul> |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|

**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](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 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](http://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, kwijjigo holne' 1-888-763-8232.

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

**Questions:** For medical, vision, and dental benefits call HealthSCOPE Benefits at 1-888-763-8232 or visit [www.healthscopebenefits.com](http://www.healthscopebenefits.com).

For prescription drug benefits call Express Scripts at **1-855-889-7708** or visit [www.Express-Scripts.com](http://www.Express-Scripts.com). For eligibility and all other questions call PEBP Member Services at 775-684-7000 or 1-800-326-5496 or [www.pebp.state.nv.us](http://www.pebp.state.nv.us).

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*)

<b>Total Example Cost</b>	<b>\$7,440</b>
---------------------------	----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	None
Coinsurance	\$1,188
<i>What is not covered</i>	
Limits or exclusions	
<b>The total Peg would pay is</b>	<b>\$2,688</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,300</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	None
Coinsurance	\$760
<i>What is not covered</i>	
Limits or exclusions	
<b>The total Joe would pay is</b>	<b>\$2,260</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,400</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	None
Coinsurance	\$180
<i>What is not covered</i>	
Limits or exclusions	None
<b>The total Mia would pay is</b>	<b>\$1,680</b>

\*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](http://www.pebp.state.nv.us) or 775-684-7000 or 1-800-326-5496.