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 and Family | **Plan Type:** EPO (Premier 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. 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?	In Network: $0 Person/ $0 Family Out of Network: N/A Person / N/A 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 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In Network: $7,150 Person/ $14,300 Family Out of Network: N/A Person / N/A 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, balance-billed charges, health care this plan doesn't cover, and services that require preauthorization when no preauthorization is given.	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 1-888-763-8232 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 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	$25 copay / visit	N/A	None.
	Specialist visit	$45 copay / visit	N/A	None.
	Preventive care/screening/ immunization	$0	N/A	None.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Depends on site of service. General lab: No charge	X-ray: N/A General lab: N/A	When ordered by a physician or health care provider. Out-of-Network labs paid in-network if no in-network provider within 50 miles/residence
	Imaging (CT/PET scans, MRIs)	CT/MRI: $250 copay/ visit PET: $350 copay visit	N/A	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	$7 copay/30 day supply	N/A	None.
	Preferred brand drugs	$40 copay/30 day supply	N/A	None.
	Non-preferred brand drugs	$75 copay/30 day supply	N/A	Single-source non-preferred brand.
	Specialty drugs	30% coinsurance	N/A	Prior authorization required. 30% coinsurance does not apply to specialty drugs obtained at the hospital or physician's office.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350	N/A	None.
	Physician/surgeon fees	PCP Office: $25 copay / visit Specialist Office: $45 copay/ visit	N/A	Copay applies when services are done in a physician's office
If you need immediate medical attention	Emergency room care	$300 copay	N/A	None.
	Emergency medical transportation	$150 copay / trip (ground) $200 copay (air)	(air) $200 plus amounts exceeding 250% of Medicare allowable rate.	None.
	Urgent care	$50 copay / visit	N/A	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500	N/A	None.
	Physician/surgeon fees	$500	N/A	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 need mental health, behavioral health, or substance abuse services	Mental/ behavioral outpatient services	$25 per visit	N/A	None.
	Mental/behavioral inpatient services	$500	N/A	None.
	Substance use disorder outpatient services	$25 per visit	N/A	None.
	Substance use disorder inpatient services	$500	N/A	None.
If you are pregnant	Office visits	$0	N/A	None.
	Childbirth/delivery professional services	$500	N/A	None.
	Childbirth/delivery facility services	$0	N/A	None.
If you need help recovering or have other special health needs	Home health care	$25 per visit	N/A	Prior authorization required; 30 visits/plan year
	Rehabilitation services	$500/per admission	N/A	Prior authorization required; Inpatient: Limited to 60 days per plan year.
	Habilitation services	$500	N/A	Prior authorization required; Inpatient: Limited to 60 days per plan year.
	Skilled nursing care	$500/per admission	N/A	Prior authorization required; Inpatient: Limited to 100 days per calendar year.
	Durable medical equipment	$0 Orthopedic & Prosthetic	N/A Orthopedic & Prosthetic	Prior authorization required. One purchase of specific item of DME every 3 years
	Hospice services	$45 for office based services	N/A	Lifetime maximum of 185 days.
If you need vision or eye care	Vision exam	$10/one per plan year	N/A	Limited to maximum benefit of $100 per plan year.
	Prescription eyeglasses	$10		Single vision, bifocal & trifocal lenses and prescription contact lenses. Limited to maximum benefit of $100 per every 24 months.

Questions: For medical, vision, and dental benefits call HealthSCOPE Benefits at 1-888-763-8232 or visit www.healthscopebenefits.com.
For prescription drug benefits call Express Scripts at **1-855-889-7708** or visit 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.

For more information about limitations and exceptions, see the plan or policy document at www.pebp.state.nv.us

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.)

- Complications of non-covered treatment
- Cosmetic surgery
- Exercise equipment
- Hearing aids
- Long-term care
- Non-emergency case when traveling outside the U.S
- Non-FDA approved drugs
- Personal comfort or convenience Items
- Private-duty nursing unless at home under home health benefit
- Orthodontia expenses
- Routine foot care

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care

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.

Questions: For medical, vision, and dental benefits call HealthSCOPE Benefits at **1-888-763-8232** or visit **www.healthscopebenefits.com**.
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For more information about limitations and exceptions, see the plan or policy document at **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	$0
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing*	$350

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	$0
Copayments	$600
Coinsurance	$0
What is not covered	
Limits or exclusions	$0
The total Peg would pay is	**$600**

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 *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	$350

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	$0
Copayments	$2,000
Coinsurance	$0
What is not covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	$350

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

*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.