

# Public Employees' Benefits Program



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

Coverage Period: 07/01/2019 – 06/30/2020

Coverage for: Family | 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 deductible?	Family \$3,000 / Individual \$2,700	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 in the CDHP Master Plan Document at <a href="http://www.pebp.state.nv.us">www.pebp.state.nv.us</a> .
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?	Network providers: Individual \$6,850 / Family \$7,800; out-of-network Individual \$10,600 / Family \$21,200	Out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalty for failure to obtain pre-authorization for certain services, premiums, balance-billing charges, excluded services and prescription drug copay assistance.	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 <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.	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).
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)	
<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>	<a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims.
	<a href="#">Preventive care/screening/immunization</a>	No charge.	Not Covered.	Preventive services must be provided in-network. Refer to the Plan Document for additional limitations.
<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>	Routine labs covered only when performed at a free-standing lab (i.e. LabCorp or Quest). <a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	May require preauthorization. <a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims.
<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 and non-preferred brand drugs are not covered and do not apply to <a href="#">deductible</a> and <a href="#">out-of-pocket maximum</a> . Drug copay assistance does not apply to <a href="#">deductible</a> and <a href="#">out-of-pocket maximum</a> . Plan does not coordinate Rx benefits.
	Preferred brand drugs	20% <a href="#">coinsurance</a>	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	30-day supply through Accreddo specialty pharmacy. Some <a href="#">Specialty drugs</a> require preauthorization. Drug copay assistance does not apply to <a href="#">deductible</a> and <a href="#">out-of-pocket maximum</a> . Plan does not coordinate Rx benefits.
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a>	Not Covered.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Requires <a href="#">preauthorization</a> or 50% penalty applies. <a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims. See Plan Document for air ambulance benefits and limitations.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Requires <a href="#">preauthorization</a> or 50% penalty applies. <a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

Refer to the Consumer Driven Health Plan Master Plan Document for benefits and contact information at [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 need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% coinsurance	50% coinsurance	See Plan Document for <a href="#">Preauthorization</a> requirements.
	Inpatient services	20% coinsurance	50% coinsurance	<a href="#">Preauthorization</a> required. If preauthorization is not obtained, benefits may be reduced by 50%.
<b>If you are pregnant</b>	Office visits	20% coinsurance	50% coinsurance	<a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	See Plan Document for preventive prenatal services. <a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	<a href="#">Preauthorization</a> required only if vaginal delivery exceeds 48 hours or cesarean section delivery exceeds 96 hours. <a href="#">Balance billing</a> applies to out-of-network provider claims.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% coinsurance	50% coinsurance	<a href="#">Preauthorization</a> required. Limited to 60 visits per person plan year. <a href="#">Balance billing</a> applies to out-of-network provider claims.
	<a href="#">Rehabilitation services</a>	20% coinsurance	50% coinsurance	<a href="#">Preauthorization</a> required. See Plan Document for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims.
	<a href="#">Habilitation services</a>	20% coinsurance	50% coinsurance	<a href="#">Preauthorization</a> required. See Plan Document for details. <a href="#">Balance billing</a> applies to <a href="#">out-of-network</a> claims.
	<a href="#">Skilled nursing care</a>	20% coinsurance	50% coinsurance	<a href="#">Preauthorization</a> required. Limited to 60 days per Plan Year related to the same cause.
	<a href="#">Durable medical equipment</a>	20% coinsurance	50% coinsurance	<a href="#">Preauthorization</a> required for equipment over \$1,000.
	<a href="#">Hospice services</a>	20% coinsurance	50% coinsurance	Maximum lifetime benefit limited to 185 days.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$25 copayment	\$25 copayment	Limited to 1 routine vision exam plan year. \$95 maximum benefit.
	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      | • Long-term care         | • Routine foot care    |
| • Infertility treatment | • Non-FDA approved drugs | • Orthodontia expenses |

Refer to the Consumer Driven Health Plan Master Plan Document for benefits and contact information at [www.pebp.state.nv.us](http://www.pebp.state.nv.us).

**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>• Obesity Care Management 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>• Vision exam (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 benefits, contact HealthSCOPE Benefits Customer Service at 1-888-763-8232

**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](#).

*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](#) \$3,000
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 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>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,700
Copayments	\$0.00
Coinsurance	\$2,020
<i>What is not covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,780</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 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>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,700
Copayments	\$0.00
Coinsurance	\$940
<i>What is not covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,700</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist \[coinsurance\]](#) 20%
- [Hospital \(facility\) \[coinsurance\]](#) 20%
- [Other \[coinsurance\]](#) 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>\$1,925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,700
Copayments	\$0.00
Coinsurance	\$0.00
<i>What is not covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Refer to the Consumer Driven Health Plan Master Plan Document for benefits and contact information at [www.pebp.state.nv.us](http://www.pebp.state.nv.us).

# Attachment A

## Language Access Services

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-763-8232.

[Spanish (Español): Para obtener asistencia en Español, llame al 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, kwijijigo holne' 1-888-763-8232.

[PAUNAWA]: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-326-5496 (TTY: 1-800-545-8279).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-326-5496 (TTY: 1-800-545-8279).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오. 1-800-326-5496 (TTY: 1-800-545-8279).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-326-5496 (TTY: 1-800-545-8279). (TTY: 1-800-545-8279).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-326-5496 (መስማት ለተሳናቸው: 1-800-545-8279).

เรียน: ถ้าคุณพูด ภาษา ไทยคุณสามารถ ใช้บริการช่วยเหลือทางภาษา ได้ฟรี โทร 1-800-326-5496 (TTY: 1-800-545-8279)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-326-5496 (TTY: 1-800-545-8279) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم): 1-800-326-5496 (TTY: 1-800-545-8279)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-326-5496 (телетайп: 1-800-545-8279).

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-326-5496 (1-800-545-8279).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. بتماس بگیرید. 1

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auunaga fesoasoan, e fai fua e leai se totoi, mo oe, Telefoni mai: 1-800-326-5496 (TTY: 1-800-545-8279).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-326-5496 (TTY: 1-800-545-8279).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-326-5496 (TTY: 1-800-545-8279).