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: 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 $1,500	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 www.pebp.state.nv.us.
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?	For network providers $3,900 for out-of-network providers $10,600	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 **www.pebp.state.nv.us 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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Specialist visit	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Preventive care/screening/ immunization	No charge.	Not Covered.	Preventive services must be provided in-network. Refer to the Plan Document for additional limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Routine labs covered only when performed at a free-standing lab (i.e. LabCorp or Quest). Balance billing applies to out-of-network claims.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	May require preauthorization. Balance billing applies to out-of-network claims.
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 and non-preferred brand drugs are not covered and do not apply to deductible and out-of-pocket maximum. Drug copay assistance does not apply to deductible and out-of-pocket maximum. Plan does not coordinate Rx benefits.
	Preferred brand drugs	20% coinsurance	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	
	Specialty drugs	20% coinsurance	Not Covered.	30-day supply through Accredo specialty pharmacy. Some Specialty drugs require preauthorization. Drug copay assistance does not apply to deductible and out-of-pocket maximum. Plan does not coordinate Rx benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies. Balance billing applies to out-of-network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Balance billing applies to out-of-network claims. See Plan Document for air ambulance benefits and limitations.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies. Balance billing applies to out-of-network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

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	Outpatient services	20% coinsurance	50% coinsurance	See Plan Document for Preauthorization requirements.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required. If preauthorization is not obtained, benefits may be reduced by 50%.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	See Plan Document for preventive prenatal services. Balance billing applies to out-of-network claims.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Preauthorization required only if vaginal delivery exceeds 48 hours or cesarean section delivery exceeds 96 hours. Balance billing applies to out-of-network provider claims.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 60 visits per person plan year. Balance billing applies to out-of-network provider claims.
	Rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization required. See Plan Document for details. Balance billing applies to out-of-network claims.
	Habilitation services	20% coinsurance	50% coinsurance	Preauthorization required. See Plan Document for details. Balance billing applies to out-of-network claims.
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 60 days per Plan Year related to the same cause.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for equipment over $1,000.
	Hospice services	20% coinsurance	50% coinsurance	Maximum lifetime benefit limited to 185 days.
If your child needs dental or eye care	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
- Infertility treatment
- Long-term care
- Non-FDA approved drugs
- Routine foot care
- Orthodontia expenses

Refer to the Consumer Driven Health Plan Master Plan Document for benefits and contact information at 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.)		
• Acupuncture	• Chiropractic care	• Vision exam (limited to one screening exam)
• Obesity Care Management Program	• Hearing aids	• 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 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	$1,500
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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$2,260
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,820**

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 *[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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$1,180
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,740**

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

The plan's overall deductible	$1,500
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)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$85
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,585**

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

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, kwiijigo 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 ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዘዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-326-5496 (መስማት ለተሳናቸው:1-800-545-8279).

เรียน: ถ้าคณุพดู ภาษา ไทยคณุสามารถ ใช้บริการชว่ ยเหลือทางภาษา 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 auaunaga fesoasoan, e fai fua e leai se totogi, 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).