Public Employees' Benefits Program

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

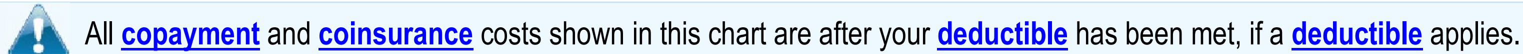
Coverage Period: 07/01/2020 – 06/30/2021

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 Individual / N/A Family	This Plan does not require deductibles.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This Plan does not require a deductible, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	This Plan does not require deductibles.
What is the out-of-pocket limit for this plan?	For network providers $7,150 individual / $14,300 Family for out-of-network providers	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, 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).
Do you need a referral to see a specialist?	No.	You can see a specialist within the Plan's exclusive provider network 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 copayment	Not Covered.	None.
	Specialist visit	$40 copayment	Not Covered.	None.
	Preventive care/screening/ immunization	$0 copayment	Not Covered.	With certain limitations. See Plan Document for details.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Depends on site of service; routine lab work: No charge	Not Covered.	*Out-of-Network labs paid in-network if no in-network provider within 50 miles/residence (balance billing applies to out-of-network provider claims); all non-pre-operative labs must be performed at a free-standing laboratory facility i.e. Labcorp, Quest
	Imaging (CT/PET scans, MRIs)	CT/MRI: $250 copay PET: $350 copay	Not Covered.	*May require preauthorization.
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	$10 copayment 30-day	Not Covered.	Plan does not coordinate prescription drug benefits.
	Preferred brand drugs	$40 copayment 30-day	Not Covered.	Plan does not coordinate prescription drug benefits.
	Non-preferred brand drugs	$75 copayment 30-day supply	Not Covered.	*Plan does not coordinate prescription drug benefits. Single-source non-preferred brand.
	Specialty drugs	20% coinsurance	Not Covered.	*Covered only when ordered from Specialty pharmacy; limited to a 30-day supply; Some Specialty drugs require preauthorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay	Not Covered.	*Some services requires preauthorization.
	Physician/surgeon fees	PCP: $0 copay Specialist: $0 copay	Not Covered.	Primary Care or Specialty Office visit copay applies when services are performed in a physician's office.
If you need immediate medical attention	Emergency room care	$500 copayment	$500 copayment	Balance billing applies to out-of-network provider claims.
	Emergency medical transportation	$200 copayment (air) (air) plus amount exceeding 250% of	$200 copayment (air) plus amount exceeding 250% of Medicare allowable.	Balance billing for amounts exceeding 250% of Medicare allowable rate.

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)	
		Medicare allowable. $150 copayment (ground)	$150 copayment (ground)	
	Urgent care	$50 copay /visit	$50 copayment	Balance billing applies to out-of-network provider claims.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission	Not Covered.	Preauthorization required.
	Physician/surgeon fees	$0 copayment	Not Covered.	*Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay /visit	Not Covered.	*See plan document for details.
	Inpatient services	$500 copay/admission	Not Covered.	*Preauthorization required.
If you are pregnant	Office visits	$0 copay /visit	Not Covered.	Routine prenatal care obtained from a Plan provider is covered at no charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. Lab)
	Childbirth/delivery professional services	$0 copay/delivery	Not Covered.	Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services.
	Childbirth/delivery facility services	$500 copay/admission	Not Covered.	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 copay /visit	Not Covered.	Preauthorization required. Limited to 60 visits per person plan year.
	Rehabilitation services	$500 copay/admission $20 copay /visit	Not Covered.	Inpatient: Preauthorization required; limited to 60 days per Plan Year. Outpatient subject to a combined maximum benefit of 90 visits for OT, ST, PT per Plan Year.
	Habilitation services	$500 copay/admission $20 copay /visit	Not Covered.	Inpatient: Preauthorization required; limited to 60 days per Plan Year. Outpatient subject to a combined maximum benefit of 90 visits for OT, ST, PT per Plan Year.
	Skilled nursing care	$500 copay/admission $20 copay /visit	Not Covered.	Inpatient: Preauthorization required and limited to 100 days per Plan Year. Outpatient: Preauthorization required; limited to 60 days per Plan Year related to the same cause.
	Durable medical equipment	$0 copay	Not Covered.	Preauthorization required for equipment over

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)	
				$1,000.
	Hospice services	$500 copay/admission $0 copay /visit	Not Covered.	Precertification required after 185 days.
If your child needs dental or eye care	Children's eye exam	$10 copayment	$10 copayment	Limited to 1 routine preventive care/screening per plan year; $100 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
- Personal/custodial care
- 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
- Obesity Care Management 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.

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** **$0**
- **Specialist *[copayment]*** **$40**
- **Hospital (facility) *[copayment]*** **$500**
- **Other *[Specialty drugs]*** ***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	$0.00
Copayments	$540
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$60
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 *[copayment]*** **$40**
- **Hospital (facility) *[copayment]*** **$500**
- **Other *[Specialty drugs]*** **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	$0.00
Copayments	$1,060
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,120**

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

- **The plan's deductible** **$0**
- **Specialist *[copayment]*** **$40**
- **Hospital (facility) *[copayment]*** **$500**
- **Other *[Specialty drugs]*** **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	$0.00
Copayments	$540
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$540**

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).

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เร◌ียน: ถาคณ◌ุพด◌ู ภาษา ไทยคณ◌ุสามารถ ใชบ◌ั ร◌ิการชว◌่ ยเหลอ◌ื ทางภาษา ได◌้ฟร◌ี 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).