Public Employees' Benefits Program

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

Coverage Period: 07/01/2021 – 06/30/2022
Coverage for: Family | **Plan Type:** LD PPO

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 **deductible** : Family: $1,000; Individual within the Family: $500	Certain services are subject to deductible; for example: specialty drugs, inpatient hospitalization, diagnostic tests, durable medical equipment, etc. You pay out-of-pocket for these services until you meet your deductible. In-Network and Out-of-Network Deductibles accumulate separately.
Are there services covered before you meet your deductible?	Yes. In-network Preventive care services are covered before you meet your deductible.	Some items and services are not subject to the deductible, such as office visit copays and pharmacy benefit copays; other services that are not subject to deductible include preventive services.
Are there other deductibles for specific services?	No	The Plan does not include separate deductibles for specific services. In-network and an Out-of-Network Deductibles accumulate separately.
What is the out-of-pocket limit for this plan?	In-Network: Family $10,000; Individual within Family: $5,000. Out-of-network providers: Family $21,200	The In-Network Out-of-pocket limit is the most a Family ($10,000) or an individual w/in a Family ($5,000) must pay in a Plan Year for Eligible Medical Expenses. The out-of-network Out-of-pocket limit for Family is $21,200 (may be satisfied by one member or by a combination of claims for all family members. In-Network and out-of-network Out-of-pocket limits accumulate separately.
What is not included in the out-of-pocket limit?	Penalties, premiums, balance-billing charges, excluded services, prescription drug copay assistance, non-covered services	Out-of-pocket limit excludes penalties you pay for failure to obtain required preauthorization, premiums, copay surcharge for not using Express Advantage Network for short-term medications, failure to use 90-day retail/mail order for long-term medications, copay assistance dollars, failure to participate in the SaveonSP (for non-essential specialty drugs); balance billing and non-covered supplies and services.
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 more if you use an out-of-network provider, and you may receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
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	$30 copay	50% coinsurance	None.
	Specialist visit	$50 copay	50% coinsurance	None.
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
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 facility.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	May require preauthorization depending on the imaging type.
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	30-day/$10 copay 90-day/$20 copay	Not Covered	30-day supply for short-term medications must be filled at Express Advantage Network (EAN) pharmacy to avoid a copay surcharge. Penalty applies if you do not use a Smart90 retail pharmacy or home delivery for long-term medications. Some drugs require preauthorization. Penalty applies for not participating in the SaveOnSp for drugs on the Non-Essential Benefit Specialty Drug List. Copay assistance for specialty drugs do not apply to deductible or out-of-pocket limit. Must use the Plan's specialty pharmacy.
	Preferred brand	30-day/$40 copay 90-day/$80 copay	Not Covered	
	Non-preferred brand	30-day/$75 copay 90-day/ $150 copay	Not Covered	
	Specialty drugs	30% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (ambulatory surgery center); physician /surgeon fees	$500 copay	50% coinsurance	Requires preauthorization. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you need immediate medical attention	Emergency room care	$750 copay	$750 copay	Emergency room care, emergency medical transportation, paid as in-network; Balance billing applies to out-of-network emergency room and emergency medical transportation, subject to the Plan's Maximum Allowable Charge. See the LD PPO MPD.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$80 copay	50% coinsurance	Balance billing applies to out-of-network urgent care

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient Visit	$30 copay/office visit	50% coinsurance	None.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	$0 copay/office visit	50% coinsurance	Routine prenatal care obtained from Plan Provider is covered at no charge. Maternity care, including non-routine maternity care, may include tests and services subject to cost sharing as described elsewhere in this SBC. (i.e., Ultrasound, Lab).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization required. 60 visits/plan year.
	Outpatient rehabilitation services	$50 copay per visit	50% coinsurance	Preauthorization required for visits exceeding 90 combined (OT, PT, ST) per year.
	Inpatient rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization is required. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization required. 60 visits/plan year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for equipment over $1,000.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization required after 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.

Refer to the Low Deductible PPO Plan Master Plan Document for benefits and contact information 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.)		
• Cosmetic surgery	• Long-term care	• Routine foot care
• Infertility treatment	• Non-FDA approved drugs	• Orthodontia expenses

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	$500
Specialist *[copay]*	$50
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$40
Coinsurance	$1,691
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,291**

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

The plan's overall deductible	$500
Specialist *[copay]*	$50
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$89
Copayments	$1,040
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,149**

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

The plan's overall deductible	$500
Specialist *[copay]*	$50
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,075
Coinsurance	$64
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,639**

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).