Public Employees' Benefits Program

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Exclusive Provider Organization: PEBP Self-Funded Health Plan

Coverage Period: 07/01/2023 – 06/30/2024
Coverage for: Employee and Family | **Plan Type:** EPO

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 https://www.healthcare.gov/sbc-glossary/ 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: Employee only: $100 Family: $200, Individual within the Family: $100 Out-of-Network: N/A	Generally, you pay all costs up to the deductible, except preventive services and certain copayments. Individuals within the family must meet their own individual deductible until the total expenses paid by all family members meets the overall family deductible. In-network and Out-of-Network Deductibles accumulate separately. 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. In-network Preventive care services are covered before you meet your deductible.	Some items and services covered if the deductible has not been met; however, a copayment or coinsurance may apply. Example: preventive services and medications on the preventive drug list. For more additional limitations, refer to the EPO Master Plan Document (MPD). 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	The Plan does not include separate deductibles for specific services. You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: Individual: $5,000/Family $10,000, Individual within Family: $5,000. Out-of-network providers: N/A	The Out-of-pocket limit is the most an Individual or a Family will pay in a Plan Year for Eligible Medical Expenses. 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?	Penalties, premiums, balance-billing charges, excluded services, prescription drug copay assistance, non-covered services, and health	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);

	care this plan doesn't cover.	balance billing and non-covered supplies and services. Even though you pay these expenses, they don't 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 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). 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	$20 copay/visit	Not Covered	None.
	Specialist visit	$40 copay/visit	Not Covered	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	Not Covered	Routine labs covered only when performed at a free-standing lab facility.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	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/prescription 90-day/$20 copay/prescription	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 /prescription 90-day/$80 copay/prescription	Not Covered	
	Non-preferred brand	30-day/$75 copay/prescription 90-day/ $150 copay/prescription	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (ambulatory surgery center)/physician /surgeon fees	$350 copay/visit	Not Covered	Requires preauthorization. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.

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 immediate medical attention	Emergency room care	$600 copay/visit	$600 copay/visit	Emergency room care, emergency medical transportation, paid as in-network; Balance billing applies to out-of-network emergency medical transportation, subject to the Plan's Maximum Allowable Charge, except as provided by federal or state law. See the EPO MPD.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copay/visit	$50 copay/visit	Balance billing applies to out-of-network urgent care, except as provided by federal or state law.
If you have a hospital stay	Facility fee (e.g., hospital room)/physician/surgeon fees	$600 copay/admit	Not Covered	Preauthorization is required. If you do not get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you need mental health, behavioral health, or substance abuse services	Outpatient Visit	$20 copay/visit	Not Covered	None.
	Inpatient services	$600 copay/admit	Not Covered	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/visit	Not Covered	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). Cost sharing does not apply for preventive services." Depending on the type of services, a [copayment, coinsurance, or deductible] may apply.
	Childbirth/delivery professional services	Surgical: No charge Anesthesia: No charge	Not Covered	
	Childbirth/delivery facility services	$600 copay/admit	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	Preauthorization required. 60 visits/plan year.
	Rehabilitation service	$40 copay/visit $600 copay/admit	Not Covered	Preauthorization required for visits exceeding 90 combined (OT, PT, ST) per year.
	Habilitation services	$40 copay/visit $600 copay/admit	Not Covered	Preauthorization required.
	Skilled nursing care	$600 copay/admit	Not Covered	Preauthorization required. 100 visits/plan year.

	Durable medical equipment	20% coinsurance	Not Covered	Preauthorization required for equipment over $1,000.
	Hospice services	$600 copay/admit	Not Covered	Preauthorization 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
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Orthodontia expenses
- Private-duty nursing
- 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
- Dental Care (Adult)
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)
- Weight Loss Programs

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 on how 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.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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: See Attachment A

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	$100
Specialist *[copay per visit]*	$40
Hospital (facility) *[copay]*	$600
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	$100
Copayments	$640
Coinsurance	$230
What is not covered	
Estimated limits or exclusions	$0
The total Peg would pay is	**$970**

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

The plan's overall deductible	$100
Specialist *[copay per visit]*	$40
Hospital (facility) *[copay]*	$600
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	$100
Copayments	$640
Coinsurance	$900
What is not covered	
Estimated limits or exclusions	$60
The total Joe would pay is	**$1,700**

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

The plan's overall deductible	$100
Specialist *[copay per visit]*	$40
Hospital (facility) *[copay]*	$600
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation service *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$100
Copayments	$640
Coinsurance	$390
What is not covered	
Estimated limits or exclusions	$0
The total Mia would pay is	**$1,130**

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

Attachment A

Language Access Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-763- 8232 (TTY Users, Dial 7-1-1)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-763- 8232 (TTY Users, Dial 7-1-1)

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 1-888-763- 8232 (TTY Users, Dial 7-1-1)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-763- 8232 (TTY Users, Dial 7-1-1) 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-763- 8232 (TTY Users, Dial 7-1-1)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-763- 8232 (መስማት ለተሳናቸው:(TTY Users, Dial 7-1-1)

เรียน: ถ้าคุณพูดภาษา ไทยคุณสามารถ ใชบ้ รกิ ารช่วยเหลอื ทางภาษา ได้ฟรี โทร 1-888-763- 8232 (TTY Users, Dial 7-1-1)

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。1-888-763- 8232 (TTY Users, Dial 7-1-1) 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 1-1-7)رقم هاتف الصم والبكم: 1-888-763-8232.

В Н И М А Н И Е : Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-763- 8232 (телетайп: 7-1-1).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-763- 8232 (ATS: 7-1-1).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-763-8232 (TTY: 7-1-1) تماس بگیرید.

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: 1-888-763- 8232 (TTY Users, Dial 7-1-1)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-763- 8232 (TTY Users, Dial 7-1-1)

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-888-763- 8232 (TTY Users, Dial 7-1-1)