

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 <u>deductible</u> ? | <u>In-Network</u> : Employee only: \$100 Family: \$200, Individual within the Family: \$100 <u>Out-of-Network</u> : N/A | Generally, you pay all costs up to the <u>deductible</u> , except <u>preventive services</u> and certain <u>copayments</u> . Individuals within the family must meet their own individual <u>deductible</u> until the total expenses paid by all family members meets the overall family <u>deductible</u> . <u>In-network</u> and <u>Out-of-Network Deductibles</u> accumulate separately. Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>In-network Preventive care</u> services are covered before you meet your <u>deductible</u> . | Some items and services covered if the <u>deductible</u> has not been met; however, a <u>copayment</u> or <u>coinsurance</u> may apply. Example: <u>preventive services</u> and medications on the preventive drug list. For more additional limitations, refer to the EPO Master <u>Plan</u> Document (MPD). For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| Are there other <u>deductibles</u> for specific services? | No | The <u>Plan</u> does not include separate <u>deductibles</u> for specific services. You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | <u>In-network</u> : Individual: \$5,000/Family \$10,000, Individual within Family: \$5,000. <u>Out-of-network providers</u> : N/A | The <u>Out-of-pocket limit</u> is the most an Individual or a Family will pay in a <u>Plan</u> Year for Eligible Medical Expenses. The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u> ? | Penalties, <u>premiums</u> , <u>balance-billing</u> charges, <u>excluded services</u> , <u>prescription drug copay</u> assistance, non-covered services, and health | <u>Out-of-pocket limit</u> excludes penalties you pay for failure to obtain required <u>preauthorization</u> , <u>premiums</u> , <u>copay</u> surcharge for not using Express Advantage <u>Network</u> for short-term medications, failure to use 90-day retail/mail order for long-term medications, <u>copay</u> assistance dollars, failure to participate in the SaveonSP (for non-essential <u>specialty drugs</u>); |

| | | |
|--|--|---|
| | care this <u>plan</u> doesn't cover. | <u>balance billing</u> and non-covered supplies and services. Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.pebp.state.nv.us or 1-888-763-8232 for a list of participating <u>providers</u> . | <p>You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay more if you use an <u>out-of-network provider</u>, and you may receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>).</p> <p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>).</p> <p>Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p> |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

 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 |
|--|--|--|---|--|
| | | <u>Network provider</u> (You will pay the least) | <u>Out-of-Network provider</u> (You will pay the most) | |
| If you visit a health care provider's office or clinic | <u>Primary care</u> visit to treat an injury or illness | \$20 <u>copay</u> /visit | Not Covered | None. |
| | <u>Specialist</u> visit | \$40 <u>copay</u> /visit | Not Covered | None. |
| | <u>Preventive care/screening/immunization</u> | No charge | Not Covered | You may have to pay for services that are not <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | Not Covered | Routine labs covered only when performed at a free-standing lab facility. |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | Not Covered | May require <u>preauthorization</u> depending on the imaging type. |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.pebp.state.nv.us | Generic | 30-day/\$10 <u>copay</u> /prescription 90-day/\$20 <u>copay</u> /prescription | Not Covered | 30-day supply for short-term medications must be filled at Express Advantage <u>Network</u> (EAN) pharmacy to avoid a <u>copay</u> surcharge. Penalty applies if you do not use a Smart90 retail pharmacy or home delivery for long-term medications. Some <u>drugs</u> require <u>preauthorization</u> . Penalty applies for not participating in the SaveOnSp for drugs on the Non-Essential Benefit <u>Specialty drug</u> List. <u>Copay</u> assistance for <u>specialty drugs</u> do not apply to <u>deductible</u> or <u>out-of-pocket limit</u> . Must use the <u>Plan's</u> specialty pharmacy. |
| | Preferred brand | 30-day/\$40 <u>copay</u> /prescription 90-day/\$80 <u>copay</u> /prescription | Not Covered | |
| | Non-preferred brand | 30-day/\$75 <u>copay</u> /prescription 90-day/ \$150 <u>copay</u> /prescription | Not Covered | |
| | <u>Specialty drugs</u> | 20% <u>coinsurance</u> | Not Covered | |
| If you have outpatient surgery | Facility fee (ambulatory surgery center)/physician /surgeon fees | \$350 <u>copay</u> /visit | Not Covered | Requires <u>preauthorization</u> . If you do not get <u>preauthorization</u> , 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 |
|---|---|---|---|--|
| | | <u>Network provider</u> (You will pay the least) | <u>Out-of-Network provider</u> (You will pay the most) | |
| If you need immediate medical attention | <u>Emergency room care</u> | \$600 <u>copay</u> /visit | \$600 <u>copay</u> /visit | <u>Emergency room care</u> , <u>emergency medical transportation</u> , paid as <u>in-network</u> ; <u>Balance billing</u> applies to <u>out-of-network emergency medical transportation</u> , subject to the Plan's Maximum Allowable Charge, except as provided by federal or state law. See the EPO MPD. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | |
| | <u>Urgent care</u> | \$50 <u>copay</u> /visit | \$50 <u>copay</u> /visit | <u>Balance billing</u> applies to <u>out-of-network urgent care</u> , except as provided by federal or state law. |
| If you have a hospital stay | Facility fee (e.g., hospital room)/physician/surgeon fees | \$600 <u>copay</u> /admit | Not Covered | <u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> , 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 <u>copay</u> /visit | Not Covered | None. |
| | Inpatient services | \$600 <u>copay</u> /admit | Not Covered | <u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service. |
| If you are pregnant | Office visits | \$0 <u>copay</u> /visit | Not Covered | Routine prenatal care obtained from <u>Plan Provider</u> is covered at no charge. Maternity care, including non-routine maternity care, may include tests and services subject to <u>cost sharing</u> as described elsewhere in this SBC. (i.e., Ultrasound, Lab). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a [<u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u>] may apply. |
| | Childbirth/delivery professional services | Surgical: No charge Anesthesia: No charge | Not Covered | |
| | Childbirth/delivery facility services | \$600 <u>copay</u> /admit | Not Covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | Not Covered | <u>Preauthorization</u> required. 60 visits/ <u>plan</u> year. |
| | <u>Rehabilitation service</u> | \$40 <u>copay</u> /visit \$600 <u>copay</u> /admit | Not Covered | <u>Preauthorization</u> required for visits exceeding 90 combined (OT, PT, ST) per year. |
| | <u>Habilitation services</u> | \$40 <u>copay</u> /visit \$600 <u>copay</u> /admit | Not Covered | <u>Preauthorization</u> required. |
| | <u>Skilled nursing care</u> | \$600 <u>copay</u> /admit | Not Covered | <u>Preauthorization</u> required. 100 visits/ <u>plan</u> year. |

| | | | | |
|---|----------------------------------|---------------------------|-----------------------|--|
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | Not Covered | <u>Preauthorization</u> required for equipment over \$1,000. |
| | <u>Hospice services</u> | \$600 <u>copay</u> /admit | Not Covered | <u>Preauthorization</u> required after 185 days. |
| If your child needs dental or eye care | Children's eye exam | \$10 <u>copayment</u> | \$10 <u>copayment</u> | Limited to 1 routine <u>preventive care/screening</u> per <u>plan</u> 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 <u>plan</u> . |

Excluded Services & Other Covered Services:

| <u>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</u> | | | |
|--|--|---|--|
| <ul style="list-style-type: none"> • Cosmetic surgery • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Orthodontia expenses • Private-duty nursing • Routine foot care | |
| <u>Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)</u> | | | |
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic care • Dental Care (Adult) • Hearing aids | <ul style="list-style-type: none"> • 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 <u>deductible</u> | \$100 |
| ■ <u>Specialist</u> [<u>copay per visit</u>] | \$40 |
| ■ Hospital (facility) [<u>copay</u>] | \$600 |
| ■ Other [<u>coinsurance</u>] | 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:

| <u>Cost sharing</u> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$100 |
| <u>Copayments</u> | \$640 |
| <u>Coinsurance</u> | \$230 |
| <u>What is not covered</u> | |
| 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 <u>deductible</u> | \$100 |
| ■ <u>Specialist</u> [<u>copay per visit</u>] | \$40 |
| ■ Hospital (facility) [<u>copay</u>] | \$600 |
| ■ Other [<u>coinsurance</u>] | 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:

| <u>Cost sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$100 |
| <u>Copayments</u> | \$640 |
| <u>Coinsurance</u> | \$900 |
| <u>What is not covered</u> | |
| 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 <u>deductible</u> | \$100 |
| ■ <u>Specialist</u> [<u>copay per visit</u>] | \$40 |
| ■ Hospital (facility) [<u>copay</u>] | \$600 |
| ■ Other [<u>coinsurance</u>] | 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:

| <u>Cost sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$100 |
| <u>Copayments</u> | \$640 |
| <u>Coinsurance</u> | \$390 |
| <u>What is not covered</u> | |
| 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፣ በገጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-763- 8232 (መስማት ለተሳናቸው፡(TTY Users, Dial 7-1-1)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถ ใช้นี้ รกิ ารช่วยเหลือ 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: 8232-763-888-1)

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).

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

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)