Plan Year 2018 Health Plan Comparison

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		STANDARD HMO PLAN (Hometown Health and Health Plan of Nevada)		ALTERNATE HMO PLAN (Hometown Health and Health Plan of Nevada)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Service Areas	Global	Global	Statewide	None	**HTH:** Washoe, Carson, Douglas, Storey, Lyon, Churchill, **HPN:** Clark, Nye, & Esmeralda Counties	None
Annual Deductible	$1,500 Individual $3,000 Family • $2,600 Individual Family Member Deductible	$1,500 Individual $3,000 Family • $2,600 Individual Family Member Deductible	N/A		N/A	
Medical Coinsurance	20% after Deductible	20% to 50% after Deductible	N/A		N/A	
Out-of-Pocket Maximum	$3,900 Individual $7,800 Family • $6,850 Individual Family Member Deductible	$10,600 Individual $21,200 Family	$7,150 Individual $14,300 Family	N/A	$7,150 Individual $14,300 Family	N/A
Specialist Referral Required	No	No	No	N/A	Yes	N/A
Primary Care Office Visit	20% after Deductible	50% after Deductible – Subject to Usual and Customary Limits	$25 Copay	N/A	$5 Copay	N/A
Specialist Care Office Visit	20% after Deductible	50% after Deductible – Subject to Usual and Customary Limits	$45 Copay (no referral required)	N/A	$25 Copay (referral required)	N/A
Urgent Care Visit	20% after Deductible	50% after Deductible – Subject to Usual and Customary Limits	$50 Copay Hometown Health $30 Copay Health Plan of Nevada	$50 Copay Hometown Health $30 Copay Health Plan Of Nevada	$25 Copay	$25 Copay

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	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Visit	20% after Deductible	20% after Deductible – Subject to U &C Limits	$300 Copay per visit	$300 Copay per visit	$1,000 Copay per visit	$1,000 Copay per visit
In-Patient Hospital	20% after Deductible	50% after Deductible – Subject to U & C Limits	$500 Copay per admit	N/A	$1,000 per day not to exceed $3,000 per admission	N/A
Outpatient Surgery	20% after Deductible Requires Pre-Authorization	50% after Deductible – Subject to U & C Limits Requires Pre-Authorization	$350 Copay Hometown Health $50 Copay Health Plan of Nevada	N/A	$1,000 Copay per visit	N/A
Affordable Care Act Preventive Services	$0 (Covered at 100%)	No Benefit	$0 (Covered at 100%)	No Benefit	$0 (Covered at 100%)	No Benefit
HSA/HRA Funding	$700 Primary $200 per Dependent (max 3) **$200 Primary after completion of PEBP's Prevention Program	N/A	N/A	N/A	N/A	N/A

**The $200 additional HSA/HRA contribution will be credited to the primary participants HSA/HRA when PEBP's Third Party Administrator, HealthScope Benefits, verifies through medical/dental claims that the participant has completed all of the following requirements:

1. Annual Preventive Exam
2. Annual Preventive Lab Work
3. Annual Dental Exam
4. One Dental cleaning (of the 4 available per year).

Primary participants have until June 30, 2018 to complete all four requirements to receive the additional $200 contribution from PEBP. Activities before July 1, 2017 will not count towards these requirements. All four requirements are covered at 100% under the preventive wellness benefits when using in network providers.

Plan Year 2018 Prescription Plan Comparison

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		STANDARD HMO PLAN Hometown Health and Health Plan of Nevada		ALTERNATE HMO PLAN Hometown Health and Health Plan Of Nevada	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUGS						
Preferred Generic	20% after Deductible*	20% after Deductible	$7 Copay	N/A	$25 Copay	N/A
Preferred Brand	20% after Deductible	20% after Deductible	$40 Copay	N/A	$50 Copay	N/A
Non-Formulary	20% after Deductible	20% after Deductible	$75 Copay	N/A	$75 Copay	N/A
Specialty	20% after Deductible	20% after Deductible	40% Coinsurance	N/A	40% Coinsurance	N/A
ACA Preventive Medications	$0	$0	$0	N/A	$0	N/A
CDHP Preventive Medications	20% Coinsurance Not subject to Deductible	20% Coinsurance after Deductible	N/A	N/A	N/A	N/A

Preventive Drug Benefit *NEW

The Preventive Drug Benefit provides plan participants access to certain preventive medications without having to meet a deductible, and will instead only be subject to coinsurance. Coinsurance paid under the benefit will not apply to the deductible, but will apply to the out-of-pocket maximum. The drugs covered under this benefit include categories of prescription drugs that are used for preventive purposes or conditions, such as hypertension, asthma or high cholesterol. This benefit only applies to if using an in-network provider. An example list can be located at www.pebp.state.nv.us. For more information on this, contact Express Scripts at (855) 889-7708.

Plan Year 2018 Vision Plan Comparison

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)	STANDARD and ALTERNATE HMO PLAN Health Plan of Nevada	STANDARD and ALTERNATE HMO PLAN Hometown Health
Vision Exam	$25 Copay with a maximum benefit of $95 per annual exam*	$10 Copayment every 12 months	$15 Copayment every 12 months
Hardware (frames, lenses, contacts)	No Benefit	$10 Copayment for glasses ($100 allowance) or contacts in lieu of glasses ($115 allowance)	• Frames: 35% off retail price • Standard plastic lenses: $50 to $135 copayment depending on lens type • Conventional contact lenses: 15% off retail

*PEBP does not maintain a network specific to vision care. Out-of-network providers will be paid at Usual and Customary (U&C). One annual vision exam, maximum annual benefit $95 per plan year after the $25 copayment.

For Plan Limitations and Exclusions, refer to the CDHP Master Plan Document or the HMO Evidence of Coverage Certificates available at www.pebp.state.nv.us.

Plan Year 2018 Dental Plan Comparison

Dental Plan *All PPO, HMO and Medicare Exchange eligible Participants*		
Benefit Category	**In-Network**	**Out-of-Network**
Individual Plan Year Maximum	$1,500 per person for Basic and Major services	$1,500 per person for Basic and Major services
Plan Year Deductible (applies to Basic and Major services only)	$100 per person or $300 per family (3 or more)	$100 per person or $300 per family (3 or more)
Preventive Services Four cleanings/plan year, exams, bitewing X-rays (2/plan year) Preventive Services are not subject to the $1,500 Individual Plan Year Maximum	100% of allowable fee schedule, no deductible	80% of allowable fee schedule for the Las Vegas area for participants using an out-of-network provider *within the in-network* service area; or For services received out-of-network, outside of Nevada, the plan will reimburse at the U&C rates
Basic Services Periodontal, fillings, extractions, root canals, full-mouth X-rays	80% of allowable fee schedule, after deductible	50% (after deductible) of allowable fee schedule for the Las Vegas area for participants using an out-of-network provider *within the in-network* service area; or For services received out-of-network, outside of Nevada, the plan will reimburse at the U&C rates
Major Services Bridges, crowns, dentures, tooth implants	50% of allowable fee schedule, after deductible	50% (after deductible) of allowable fee schedule for the Las Vegas area for participants using an out-of-network provider *within the in-network* service area; or For services received out-of-network, outside of Nevada, the plan will reimburse at the U&C rates

- **Family Deductible may be met by any combination of eligible dental expenses of three or more members of the same family coverage tier**. No one single family member will be required to contribute more than the equivalent of the individual deductible toward the family deductible.

- **Under no circumstances will the combination of PPO and Non-PPO benefit payments exceed the plan year maximum benefit of $1,500.**