Plan Year 2019 Health Plan Comparison

Note: The information in the tables below contain general plan benefits and may not include additional provisions or exclusions. For more in-depth plan benefits, please refer to the applicable Master Plan Document.

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		HEALTH PLAN OF NEVADA (HPN – HMO)		PREMIER PLAN (EPO)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Service Areas	Global	Global	Statewide	Urgent and Emergent	Statewide	Urgent and Emergent
Annual Deductible	$1,500 Individual $3,000 Family • $2,700 Individual Family Member Deductible	$1,500 Individual $3,000 Family • $2,700 Individual Family Member Deductible	N/A		N/A	
Medical Coinsurance	20% after Deductible	20% to 50% after Deductible Subject to Usual & Customary Limits	N/A		N/A	
Out-of-Pocket Maximum	$3,900 Individual $7,800 Family • $6,850 Individual Family Max Out of Pocket	$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	No	N/A
Primary Care Office Visit	20% after Deductible	50% after Deductible Subject to Usual & Customary Limits	$25 Copay	N/A	$25 Copay	N/A
Specialist Care Office Visit	20% after Deductible	50% after Deductible Subject to Usual & Customary Limits	$45 Copay	N/A	$45 Copay	N/A

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		HEALTH PLAN OF NEVADA (HPN – HMO)		PREMIER PLAN (EPO)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Visit	20% after Deductible	50% after Deductible Subject to Usual & Customary Limits	$30 Copay	$30 Copay	$50 Copay	$50 Copay Subject to Usual & Customary Limits
Emergency Room Visit	20% after Deductible	20% after Deductible Subject to Usual & Customary Limits	$300 Copay per visit	$300 Copay per visit	$300 Copay per visit	$300 Copay Subject to Usual & Customary Limits
In-Patient Hospital	20% after Deductible	50% after Deductible Subject to Usual & Customary Limits	$500 Copay per admit	N/A	$500 Copay per admit	N/A
Outpatient Surgery	20% after Deductible Requires Pre-Authorization	50% after Deductible Subject to Usual & Customary Limits Requires Pre-Authorization	$50 Copay	N/A	$350 Copay Requires Pre-Auth	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 Dependents) **$200 Primary after completion of program requirements	N/A	N/A	N/A	N/A	N/A

** For detailed requirements regarding the additional HSA/HRA funding please refer to the Consumer Driven Health Plan section of the Plan Year 2019 Benefit Guide.

Plan Year 2019 Prescription Plan Comparison

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		HEALTH PLAN OF NEVADA (HPN – HMO)		PREMIER PLAN (EPO)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Preferred Generic	20% after Deductible*	N/A	$7 Copay	N/A	$7 Copay	N/A
Preferred Brand	20% after Deductible	N/A	$40 Copay	N/A	$40 Copay	N/A
Non-Formulary	20% after Deductible	N/A	$75 Copay	N/A	$75 Copay for Single Source	N/A
Specialty	20% after Deductible	N/A	30% Coinsurance	N/A	30% Coinsurance	N/A
ACA Preventive Medications	$0	No Benefit	$0	N/A	$0	N/A
CDHP Preventive Medications	20% Coinsurance Not subject to Deductible	No Benefit	N/A	N/A	N/A	N/A

*Preventive Drug Benefit

The Preventive Drug Benefit provides CDHP 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 if using an in-network provider. An example list can be found at www.pebp.state.nv.us. For more information on this, please contact Express Scripts at 1-855-889-7708.

Plan Year 2019 Vision Plan Comparison

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)	HEALTH PLAN OF NEVADA (HPN – HMO) EyeMed	PREMIER PLAN (EPO)
Vision Exam	$25 Copay maximum benefit of $95 per annual exam*	$10 Copay every 12 months	$10 Copay every 12 months $100 maximum benefit
Hardware (frames, lenses, contacts)	No Benefit	$10 Copay for glasses ($100 allowance) **or** $10 Copay for contacts in lieu of glasses ($115 allowance)	$10 Copay for glasses ($100 maximum benefit every 24 months)

Please note: 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 or Premier (EPO) Plan Master Plan Documents or the Health Plan of Nevada's Evidence of Coverage Certificate available at www.pebp.state.nv.us.

Plan Year 2019 Dental Plan Comparison

Dental Plan *All PPO, HMO, EPO 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, Not subject to the 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.