Plan Year 2020 Medical Plan Comparison

The information in the tables below contain general plan benefits and may not include additional provisions or exclusion. ***To review more in-depth plan benefits, please refer to the applicable Master Plan Document.***

MEDICAL PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		HEALTH PLAN OF NEVADA (HPN-Southern HMO)		PREMIER PLAN (Northern 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 *(medical and prescription combined)*	$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*	N/A		N/A	
Out-of-Pocket Maximum	$3,900 Individual $7,800 Family • $6,850 Individual Family Member 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*	$20 Copay	N/A	$20 Copay	N/A
Specialist Care Office Visit	20% after deductible	50% after deductible*	$40 Copay	N/A	$40 Copay	N/A
Urgent Care Visit	20% after deductible	50% after deductible*	$30 Copay	$30 Copay	$50 Copay	$50 Copay*

*Subject to Usual & Customary Limits

Plan Year 2020 Medical Plan Comparison

The information in the tables below contain general plan benefits and may not include additional provisions or exclusion. *To review more in-depth plan benefits, please refer to the applicable Master Plan Document.*

MEDICAL PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		HEALTH PLAN OF NEVADA (HPN-Southern HMO)		PREMIER PLAN (Northern EPO)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Room Visit	20% after deductible	20% after deductible*	$500 Copay per visit	$500 Copay per visit	$500 Copay per visit	$500 Copay per visit*
In-Patient Hospital	20% after deductible	50% after deductible*	$500 Copay per admit	N/A	$500 Copay per admit	N/A
Outpatient Surgery	20% after deductible *Requires Pre-Authorization*	50% after deductible* *Requires Pre-Authorization*	$50 Copay	N/A	$350 Copay *Requires Pre-Authorization*	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
Base HSA/HRA Funding Effective 7/1**	$700 Primary Participant $200 per Dependent (max 3 Dependents)		N/A		N/A	
One-Time Additional HSA/HRA Funding	$400 Primary Participant Dependent(s) – None This one-time contribution will be deposited automatically if enrolled effective 7/1/19		N/A		N/A	

*Subject to Usual & Customary Limits

**Prorated amount based on effective date of coverage. For more information about HSA/HRA funding please refer to the Plan Year 2020 Consumer Driven Health Plan Master Plan Document.

Plan Year 2020 Prescription Plan Comparison

The information in the tables below contain general plan benefits and may not include additional provisions or exclusion. *To review more in-depth plan benefits, please refer to the applicable Master Plan Document.*

PRESCRIPTION PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		HEALTH PLAN OF NEVADA (HPN-Southern HMO)		PREMIER PLAN (Northern EPO)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preferred Generic	20% after deductible*	N/A	$10 Copay	N/A	$10 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	20% Coinsurance	N/A	20% 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

***Consumer Driven Health Plan 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.

For more information on this program, contact Express Scripts at 1-855-889-7708 or log in or register at www.express-scripts.com. A list of commonly prescribed preventive medications available under this benefit can be found under the "Benefit and account notifications" section of the home page.

Important: The Smart90 Pharmacy Network is now mandatory for CDHP Participants

This benefit allows members to save themselves and the plan money on their 90-day supply of medications. To receive a 90-day supply of maintenance (long-term) medications, members can either have their prescription filled through Express Scripts home delivery or through a Smart90 participating pharmacy (this excludes pharmacies such as CVS and Walgreens but includes most of the other chains). A 90-day supply of maintenance medications will only be available at a Smart90 participating pharmacy.

For more information on this benefit, or to locate a Smart90 participating pharmacy, please contact Express Scripts at 1-855-889-7708 or visit www.express-scripts.com/NVPEBP.

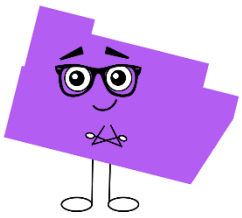
Plan Year 2020 Vision Plan Comparison

The information in the tables below contain general plan benefits and may not include additional provisions or exclusion. ***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.***

VISION PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)	HEALTH PLAN OF NEVADA (HPN-Southern HMO)	PREMIER PLAN (Northern 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

*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.

Please note: PEBP does not maintain a network specific to vision care for the CDHP or EPO plan.



Additional information about the voluntary vision benefits can be found once you have logged on to your E-PEBP Portal at www.pebp.state.nv.us.

Plan Year 2020 Dental Plan Comparison

The information in the tables below contain general plan benefits and may not include additional provisions or exclusion. ***To review more in-depth plan benefits, please refer to the Master Plan Document for the Self-Funded PPO Dental Plan and Summary of Benefits for Life and Long-Term Disability Insurance available on your PEBP Portal.***

Dental Plan *All PPO, HMO, EPO and Medicare Exchange eligible Participants*		
DENTAL PLAN DESIGN FEATURES	**In-Network**	**Out-of-Network**
Individual Plan Year Maximum (applies to basic and major services)	$1,500 per person	$1,500 per person
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* Teeth cleaning (4/plan year) Oral examination (2/plan year) Bitewing X-rays (2/plan year)	• Covered 100% • Not subject to deductible • Does not apply towards plan year max benefit	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* Full-mouth periodontal cleanings, fillings, extractions, root canals, full-mouth X-rays	You pay 20% coinsurance after deductible is met	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	You pay 50% coinsurance after deductible is met	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

*Allowable fee schedule applies

- 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.

Updated: 5/15/2019