Plan Year 2027 PEBP Plan Comparison

The information provided contains general plan benefits and may not include additional provisions or exclusion.
To review in-depth plan benefits, refer to the applicable master plan document.

Plan Year 2027 Medical Plan Design Features	Consumer Driven Health Plan (PPO)	Low Deductible Plan (PPO)	Exclusive Provider Organization Plan (EPO)	Health Plan of Nevada (HMO)
	In-Network			
Service Area	Global		Northern Nevada	Southern Nevada
Annual Deductible (Medical and prescription* combined)	$1,700 Individual $3,400 Family	$300 Individual $600 Family	$100 Individual $200 Family	Tier 4 prescription drug coverage (see Prescription Overview)
Medical Coinsurance	You pay 20% after Deductible	You pay 20% after Deductible	You pay 20% after Deductible	N/A
Out-of-Pocket Maximum (OOPM)	$5,000 Individual $10,000 Family $5,000 Individual Family Member OOPM	$5,000 Individual $10,000 Family $5,000 Individual Family Member OOPM	$4,000 Individual $8,000 Family $4,000 Individual Family Member OOPM	$5,000 Individual $10,000 Family $5,000 Individual Family Member OOPM
Primary Care Office Visit	You pay 20% after Deductible	$30 Copay per visit	$20 Copay per visit	$25 Copay per visit
Specialist Care Office Visit	You pay 20% after Deductible	$50 Copay per visit	$40 Copay per visit	$25 copay per visit with a referral $40 copay per visit without a referral
Urgent Care Visit	You pay 20% after Deductible	$80 copay per visit	$50 copay per visit	$50 copay per visit
Telemedicine**	$59 medical visit Doctor on Demand	$10 Copay medical visit Doctor on Demand	$10 Copay medical visit Doctor on Demand	$0 Copay 24/7 Advice Nurse NowClinic
Emergency Room Visit	You pay 20% after Deductible	$750 Copay per visit	$600 Copay per visit	$600 Copay per visit
In-Patient Hospital	You pay 20% after Deductible	You pay 20% after Deductible	$600 Copay per admit	$600 Copay per admit
Outpatient Surgery	You pay 20% after Deductible	$500 Copay per visit	$350 Copay per visit	$350 Copay per visit Ambulatory Surgical Facility $50 Copay
Affordable Care Act Preventive Services	$0 Copay	$0 Copay	$0 Copay	$0 Copay

*Copayment assistance for specialty drugs will not apply toward your Deductible and Out-of-Pocket Maximum.
** Doctor on Demand for the CDHP is subject to the deductible. Copays apply after the deductible is met.

Plan Year 2027 Prescription Plan Design Features	Consumer Driven Health Plan (PPO)	Low Deductible Plan (PPO)	Exclusive Provider Organization Plan (EPO)	Health Plan of Nevada (HMO)
	In-Network Pharmacy Benefits are not covered Out-of-Network			
Preferred Generic	You pay 20% after Deductible	$10 Copay 30-day supply	$10 Copay 30-day supply	$10 Copay 30-day retail supply
		$20 Copay 90-day retail and mail	$20 Copay 90-day retail and mail	$25 Copay 90-day mail
Preferred Brand	You pay 20% after Deductible	$40 Copay 30-day supply	$40 Copay 30-day supply	$40 Copay 30-day retail supply
		$80 Copay 90-day retail and mail	$80 Copay 90-day retail and mail	$100 Copay 90-day mail
Non-Formulary	You pay 100% of the cost of medication	$75 Copay 30-day supply	$75 Copay 30-day supply	$75 Copay 30-day retail supply
		$150 Copay 90-day retail and mail	$150 Copay 90-day retail and mail	$187.50 Copay 90-day mail
Specialty (30-day supply)	You pay 30% after Deductible; for drugs not on the SaveOnSP program, there is $100 min/$250 max	You pay 30% after Deductible; for drugs not on the SaveOnSP program, there is $100 min/$250 max	You pay 30% after Deductible; for drugs not on the SaveOnSP program, there is $100 min/$250 max	You pay 20% Coinsurance
ACA Preventive Medications	$0	$0	$0	$0
CDHP Preventive Medications	You pay 20%, not subject to Deductible	N/A	N/A	N/A

Consumer Driven Health Plan Preventive Drug Benefit Program

The Preventive Drug Benefit Program, for those enrolled in the Consumer Driven Health Plan, provides participants access to certain preventive drugs 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 out-of-pocket maximum costs. The medications covered under this benefit are limited to those preventive drugs identified by Express Scripts. Preventive drugs include categories of prescription drugs that are used for preventive purposes for conditions such as hypertension, asthma, and high cholesterol. A list of eligible preventive drugs covered under this benefit can be found by accessing the Express Scripts website through your E-PEBP portal at https://pebp.nv.gov or by contacting Express Scripts Member Services at 1-855-889-7708.

30-Day Express Advantage Network Program

On the CDHP, LD, and EPO plan use an Express Advantage Network (EAN) retail pharmacy to fill short-term medications (up to a 30-day supply) to maximize your pharmacy benefits. You may still use a non-EAN Express Scripts preferred (network) pharmacy to fill your short-term medications, but you will pay your standard copay, plus an additional $10 for your medication.

Mandatory Smart90 Retail and Home Delivery Program

On the CDHP, LD, and EPO plan The Smart90 program is a feature of your prescription plan, managed by Express Scripts. With this program, you have two ways to get up to a 90-day supply of your long-term medications (those you take regularly for ongoing conditions). You can fill your long-term prescriptions through home delivery from the Express Scripts Home Delivery Pharmacy or at a retail pharmacy in the Smart90 network. You will need to move your long-term medications to a 90-day supply and to either a participating retail pharmacy or Express Scripts Home Delivery. If, after your second 30-day supply courtesy fill of your long-term medication, you do not make the switch you will pay a higher cost for your prescription medication and will not receive credit toward your deductible or out-of-pocket maximum. To find a preferred pharmacy near you, access Express Scripts website through your E-PEBP portal, visit http://www.express-scripts.com/findapharmacy or call Express Scripts Member Services at 1-855-889-7708.

Plan Year 2027 Vision Plan Design Features	Consumer Driven Health Plan (PPO)	Low Deductible Plan (PPO)	Exclusive Provider Organization Plan (EPO)	Health Plan of Nevada (HMO)
Vision Exam	Plan pays 80% after deductible One screening every 24 months	$10 Copay One screening every 12 months Maximum Benefit of $100	$10 Copay One screening every 12 months Maximum Benefit of $100	$10 copay Maximum benefit of $100 per annual exam
Hardware Lenses	Not covered*	$10 Copay Maximum Benefit of $100 every 24 months	$10 Copay Maximum Benefit of $100 every 24 months	$10 Copay every 12 months
Hardware Frames	Not covered*			Maximum Benefit of $100 every 24 months
Hardware Contact Lenses	Not covered*	$10 Copay Maximum Benefit of $100 every 24 months	$10 Copay Maximum Benefit of $100 every 24 months	Maximum Benefits of $250 every 12 months (subject to limitation)

For CDHP, LD, and EPO there is no limit on the number of visions screenings for children through age 18. For the LD and EPO, there are no maximums for hardware for children under age 19. When refraction is conducted in conjunction with an examination with a medical diagnosis, such as cataracts, it will be paid under the medical benefit, subject to deductible and coinsurance, or cost sharing.
Out-of-network providers will be paid at Usual and Customary (U&C).
*Log in to your E-PEBP portal at https://pebp.nv.gov and select PEBP+ Voluntary Benefits, for additional information about the voluntary buy-up vision plan.

Plan Year 2027 Mental Health Plan Design Features	Consumer Driven Health Plan (PPO)	Low Deductible Plan (PPO)	Exclusive Provider Organization Plan (EPO)	Health Plan of Nevada (HMO)
	In-Network			
Inpatient Medically Necessary Service for Mental Health Disorders	You pay 20% after Deductible	You pay 20% after Deductible	$600 Copay per admit	$600 Copay per admit
Mental Health Visit (counseling, psychotherapy)	You pay 20% after Deductible	$30 Copay per visit	$20 Copay per visit	$25 Copay per visit *with* a referral $40 Copay per visit *without* a referral
Telemedicine Visit	$88 Psychology visit (25 minutes) $245 Psychiatry Initial visit (Doctor on Demand)	$20 Psychology visit $30 Psychiatry Initial visit (Doctor on Demand)	$20 Copay per visit (Doctor on Demand)	$0 Copay (NowClinic)
The Member Assistance Program: CDHP, LD, EPO and HMO participants Mental health treatment, alcohol, and substance use support. Visit www.liveandworkwell.com.				

Plan Year 2027 Dental Plan Design Features	All Consumer Driven Health Plan, Low Deductible Plan, Exclusive Provider Organization Plan, Health Plan of Nevada, and Medicare Eligible Retirees Enrolled in Via Benefits or TRICARE for Life	
	In-Network	Out-of-Network
Individual Plan Year Maximum (applies to basic and major services) No annual maximum for dependents under 19	$2,000 per person	$2,000 per person
Plan Year Deductible	$100 per person $300 per family (3 or more)	$100 per person $300 per family (3 or more)
Preventive Services* Teeth cleaning (4/plan year) Oral examination (4/plan year) Bitewing X-ray (2/plan year)	• Covered 100% • Not subject to deductible • Does not apply towards plan year maximum 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 outside of Nevada, the plan will reimburse at the usual and customary 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 outside of Nevada, the plan will reimburse at the usual and customary rates
Major Services* Bridges, crowns, dentures, tooth implants	You pay 50% Coinsurance after Deductible is met	

*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.

Plan Year 2027 Medical Plan Design Features	Consumer Driven Health Plan (PPO)	Low Deductible Plan (PPO)	Exclusive Provider Organization Plan (EPO)	Health Plan of Nevada (HMO)
	Out-of-Network			
Service Area	Global		Northern Nevada	Southern Nevada
Annual Deductible (Medical and prescription* combined)	$1, 700 Individual $3,400 Family	$600 Individual $1,200 Family	N/A	N/A
Medical Coinsurance	You pay 50% after Deductible	50% of Allowable Maximum Charge*	N/A	N/A
Out-of-Pocket Maximum (OOPM)	$12,500 Individual $25,000 Family	$12,500 Individual $25,000 Family	N/A	N/A
Primary Care Office Visit	You pay 50% after Deductible Subject to Maximum Allowable Charge*	You pay 50% after Deductible	Not covered	Not covered
Specialist Care Office Visit	You pay 50% after Deductible	You pay 50% after Deductible	Not covered	Not covered
Urgent Care Visit	You pay 20% after Deductible Subject to Maximum Allowable Charge*	$80 Copay Subject to Maximum Allowable Charge*	$50 Copay Subject to Maximum Allowable Charge*	Subject to Maximum Allowable Charge*
Emergency Room Visit	You pay 20% after Deductible Subject to Maximum Allowable Charge*	$750 Copay per visit Subject to Maximum Allowable Charge*	$600 Copay per visit Subject to Maximum Allowable Charge*	$600 Copay per visit Subject to Maximum Allowable Charge*
In-Patient Hospital	You pay 50% after Deductible Subject to Maximum Allowable Charge*	You pay 50% after Deductible Subject to Maximum Allowable Charge*	Not covered	Not covered
Outpatient Surgery	You pay 50% after Deductible Subject to Maximum Allowable Charge*	You pay 50% after Deductible Subject to Maximum Allowable Charge*	Not covered	Not covered
Affordable Care Act Preventive Services	Not covered	Not covered	Not covered	Not covered

*Out-of-Network health care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will pay benefits based on the Maximum Allowable Charge on non-discounted medically necessary services or supplies, subject to the Plan's Copays, Deductibles, and Coinsurance. Except for services subject to the No Surprises Act, Out-of-Network health care providers can bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing).

NEVADA PEBP Public Employees' Benefits Program

Plan Year 2027 Employer Health Savings Account (HSA)/Health Reimbursement Arrangement (HRA) Contributions Funding Effective 7/1*	Consumer Driven Health Plan (PPO) HSA/HRA Account	Low Deductible Plan (PPO)	Exclusive Provider Organization Plan (EPO)	Health Plan of Nevada (HMO)
Base Employer Contribution for Participant	$700	N/A	N/A	N/A
Employer Contribution for Dependents	$200 each dependent (up to three)	N/A	N/A	N/A
Total Employer Contribution Amount	Up to $1,300	N/A	N/A	N/A

*Prorated amount based on effective date of coverage.
For more information about HSA/HRA funding please refer to the Plan Year 2027 Consumer Driven Health Plan Master Plan Document.