# Plan Year 2022 Medical Plan Comparison

# In-Network Benefits

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

***To review more in-depth plan benefits, please refer to the applicable Plan Documents.***

| MEDICAL PLAN DESIGN FEATURES | CONSUMER DRIVEN HEALTH PLAN (CDHP PPO) | LOW DEDUCTIBLE (LD PPO) | HEALTH PLAN OF NEVADA (HPN SOUTHERN HMO) | PREMIER PLAN (NORTHERN EPO) |
|---|---|---|---|---|
| | In-Network | In-Network | In-Network | In-Network |
| **Service Area** | Global | Global | Southern Nevada | Northern Nevada |
| **Annual Deductible** *(medical and prescription* combined)* | $1,750 Individual<br>$3,500 Family<br>• $2,800 Individual Family Member Deductible | $500 Individual<br>$1,000 Family<br>• $500 Individual Family Member Deductible | N/A With exception of Tier 4 prescription drug coverage, see prescription overview | $150 Individual<br>$300 Family<br>• $150 Individual Family Member Deductible |
| **Medical Coinsurance** | You pay 20% after deductible | You pay 20% after deductible | N/A | You pay 20% after deductible |
| **Out-of-Pocket Maximum** | $5,000 Individual<br>$10,000 Family<br>• $6,850 Individual Family Member Max Out-of-Pocket | $5,000 Individual<br>$10,000 Family<br>• $5,000 Individual Family Member Max Out-of-Pocket | $5,000 Individual<br>$10,000 Family<br>• $5,000 Individual Family Member Max Out-of-Pocket | $5,000 Individual<br>$10,000 Family<br>• $5,000 Individual Family Member Max Out-of-Pocket |
| **Specialist Referral Required** | No | No | No | No |
| **Primary Care Office Visit** | You pay 20% after deductible | $30 copay per visit | $25 copay per visit | $25 copay per visit |
| **Specialist Care Office Visit** | You pay 20% after deductible | $50 copay per visit | $25 copay per visit *with* a referral<br>$40 copay per visit *without* a referral | $40 copay per visit |
| **Urgent Care Visit** | You pay 20% after deductible | $80 copay per visit | $50 copay per visit | $50 copay per visit |
| **Telemedicine**** | $49 copay medical visit Dr. On Demand | $10 copay medical visit Dr. On Demand | $0 copay 24/7 Advice Nurse | $10 copay medical visit Dr. On Demand |

*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 2022 Medical Plan Comparison

# In-Network Benefits

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

***To review more in-depth plan benefits, please refer to the applicable Plan Documents.***

| MEDICAL PLAN DESIGN FEATURES | CONSUMER DRIVEN HEALTH PLAN (CDHP PPO) | LOW DEDUCTIBLE (LD PPO) | HEALTH PLAN OF NEVADA (HPN SOUTHERN HMO) | PREMIER PLAN (NORTHERN EPO) |
|---|---|---|---|---|
| | In-Network | In-Network | In-Network | In-Network |
| **Emergency Room Visit** | You pay 20% after deductible | $750 copay per visit | $750 copay per visit | $750 copay per visit |
| **In-Patient Hospital** | You pay 20% after deductible<br>*Elective hospitalization requires precertification* | You pay 20% after deductible<br>*Elective hospitalization requires precertification* | $750 copay per admit | $750 copay per admit<br>*Elective hospitalization Requires Precertification* |
| **Outpatient Surgery** | You pay 20% after deductible<br>*Elective hospitalization requires precertification* | $500 copay per visit<br>*Elective hospitalization requires precertification* | Ambulatory Facility $50 copay<br>Hospital $350 copay | $350 copay per admit<br>*Elective hospitalization requires precertification* |
| **Affordable Care Act Preventive Services** | $0 Covered at 100% | $0 Covered at 100% | $0 Covered at 100% | $0 Covered at 100% |
| **Base HSA/HRA Funding Effective 7/1*** | $600 Primary Participant | N/A | N/A | N/A |

*Prorated amount based on effective date of coverage.

-Dependents will not receive any HSA/HRA contribution for Plan Year 2022.

-For more information about HSA/HRA funding please refer to the Plan Year 2022 Consumer Driven Health Plan Master Plan Document.

# Plan Year 2022 Prescription Plan Comparison

# In-Network Benefits

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

***To review more in-depth plan benefits, please refer to the applicable Plan Documents.***

| PRESCRIPTION PLAN DESIGN FEATURES | CONSUMER DRIVEN HEALTH PLAN* (CDHP PPO) | LOW DEDUCTIBLE (LD PPO)* | HEALTH PLAN OF NEVADA* (HPN SOUTHERN HMO) | PREMIER PLAN* (NORTHERN EPO) |
|---|---|---|---|---|
| | In-Network | In-Network | In-Network | In-Network |
| **Preferred Generic** | You pay 20% after deductible | $10 copay 30-day supply | $10 copay 30-day retail supply | $10 copay 30-day supply |
| | | $20 copay 90-day retail and mail | $25 copay 90-day mail | $20 copay 90-day retail and mail |
| **Preferred Brand** | You pay 20% after deductible | $40 copay 30-day supply | $40 copay 30-day retail supply | $40 copay 30-day supply |
| | | $80 copay 90-day retail and mail | $100 copay 90-day mail | $80 copay 90-day retail and mail |
| **Non-Formulary** | You pay 100% of the cost of medication | $75 copay 30-day supply | $75 copay 30-day retail supply | $75 copay 30-day supply |
| | | $150 copay 90-day retail and mail | $187.50 copay 90-day mail | $150 copay 90-day retail and mail |
| **Specialty** | You pay 20% after deductible | You pay 30% after deductible (30-day mail only) | You pay 30% after deductible (Deductible: $150 Individual, $350 Family) | You pay 30% after deductible (30-day mail only) |
| **ACA Preventive Medications** | $0 | $0 | $0 | $0 |
| **CDHP Preventive Medications** | You pay 20%<br>Not subject to Deductible | N/A | N/A | N/A |

**Consumer Driven Health Plan Preventive Drug Benefit Program**

The Preventive Drug Benefit Program, which is only offered to members on 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 www.pebp.state.nv.us or by contacting Express Scripts Member Services at 1-855-889-7708.

**30-Day Express Advantage Network Program**

On the CDHP, LD-PPO, 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-Script 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-PPO, 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 express-scripts.com/findapharmacy or call Express-Scripts Member Services at 1-855-889-7708.

# Plan Year 2022 Vision Plan Comparison

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

***For Plan Limitations and Exclusions, refer to the applicable Plan Documents.***

| Vision Plan | | | | |
|---|---|---|---|---|
| **VISION PLAN DESIGN FEATURES** | **CONSUMER DRIVEN HEALTH PLAN (CDHP PPO)** | **LOW DEDUCTIBLE (LD PPO)** | **HEALTH PLAN OF NEVADA (HPN SOUTHERN HMO)** | **PREMIER PLAN (NORTHERN EPO)** |
| **Vision Exam** | $25 copay<br><br>Maximum benefit of $95 per annual exam* | $10 copay<br><br>Maximum benefit of $100 per annual exam* | $10 copay<br><br>Maximum benefit of $100 per annual exam | $10 copay<br><br>Maximum benefit of $100 per annual exam* |
| **Hardware (frames, lenses, contacts)** | Not Covered | $10 copay for prescription eyeglasses<br><br>Maximum benefit of $100 every 24 months | $10 copay for prescription eyeglasses<br><br>Maximum benefit of $100 every 24 months | $10 copay for prescription eyeglasses<br><br>Maximum benefit of $100 every 24 months |
| *Out-of-network providers will be paid at Usual and Customary (U&C). One annual vision exam, up to a maximum annual benefit after copayment. | | | | |

**Log in to your E-PEBP portal at www.pebp.state.nv.us and access PEBP+ Voluntary Benefits for additional information about the voluntary buy-up vision plan.**

# Plan Year 2022 Dental Plan Comparison

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

***To review more in-depth plan benefits, please refer to the applicable Plan Documents for the Self-Funded PPO Dental Plan available on your E-PEBP Portal.***

## Dental Plan

*All PPO, LD 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%<br>• Not subject to deductible<br>• 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 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 | 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 |

*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 In-Network and Out-of-Network benefit payments exceed the Plan Year maximum benefit of $1,500.

# Plan Year 2022 Medical Plan Comparison

# Out-of-Network Benefits

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

***To review more in-depth plan benefits, please refer to the applicable Plan Documents.***

| MEDICAL PLAN DESIGN FEATURES | CONSUMER DRIVEN HEALTH PLAN (CDHP PPO) | LOW DEDUCTIBLE (LD PPO) | HEALTH PLAN OF NEVADA (HPN SOUTHERN HMO) | PREMIER PLAN (NORTHERN EPO) |
|---|---|---|---|---|
| | Out-of-Network | Out-of-Network | Out-of-Network | Out-of-Network |
| **Service Areas** | Global | Global | Urgent and Emergent | Urgent and Emergent |
| **Annual Deductible** *(medical and prescription combined)* | $1,750 Individual<br>$3,500 Family<br>• $2,800 Individual Family Member Deductible | $500 Individual<br>$1,000 Family<br>• $500 Individual Family Member Deductible | N/A | N/A |
| **Medical Coinsurance** | You pay 50% after deductible | 50% of the Maximum Allowable Charge* | N/A | N/A |
| **Out-of-Pocket Maximum** | $10,600 Individual<br>$21,200 Family | $10,600 Individual<br>$21,200 Family | N/A | N/A |
| **Specialist Referral Required** | No | No | No | No |
| **Primary Care Office Visit** | You pay 50% after deductible | 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 50% after deductible | $80 copay Subject to Maximum Allowable Charge* | $50 copay | $50 copay Subject to Maximum Allowable Charge* |

*Maximum Allowable Charge for out-of-network care is 140% of the Medicare allowable charge and 250% of the Medicare allowable for air ambulance services.

# Plan Year 2022 Medical Plan Comparison

# Out-of-Network Benefits

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

***To review more in-depth plan benefits, please refer to the applicable Plan Documents.***

| MEDICAL PLAN DESIGN FEATURES | CONSUMER DRIVEN HEALTH PLAN (CDHP PPO) | LOW DEDUCTIBLE (LD PPO) | HEALTH PLAN OF NEVADA (HPN SOUTHERN HMO) | PREMIER PLAN (NORTHERN EPO) |
|---|---|---|---|---|
| | Out-of-Network | Out-of-Network | Out-of-Network | Out-of-Network |
| **Emergency Room Visit** | You pay 50% after deductible* | $750 copay per visit, Subject to Maximum Allowable Charge** | $750 copay per visit | $750 copay per visit Subject to Maximum Allowable Charge** |
| **In-Patient Hospital** | You pay 50% after deductible* | Plan pays 50% of the Maximum Allowable Charge** after Plan Year Deductible | Not Covered | Not Covered |
| **Outpatient Surgery** | You pay 50% after deductible*<br>*Requires precertification* | Plan pays 50% of the Maximum Allowable Charge** after Plan Year Deductible | Not Covered | Not Covered |
| **Affordable Care Act Preventive Services** | Not Covered | Not Covered | Not Covered | Not Covered |
| **Base HSA/HRA Funding Effective 7/1** | Please see In-Network Benefits for HSA/HRA Funding amounts | N/A | N/A | N/A |

*Subject to Usual and Customary Limits

**Maximum Allowable Charge for out-of-network care is 140% of the Medicare allowable charge and 250% of the Medicare allowable for air ambulance services.

# Plan Year 2022 Prescription Plan Comparison

# Out-of-Network Benefits

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

***To review more in-depth plan benefits, please refer to the applicable Plan Documents.***

| PRESCRIPTION PLAN DESIGN FEATURES | CONSUMER DRIVEN HEALTH PLAN (CDHP PPO) | LOW DEDUCTIBLE (LD PPO) | HEALTH PLAN OF NEVADA (HPN SOUTHERN HMO) | PREMIER PLAN (NORTHERN EPO) |
|---|---|---|---|---|
| | Out-of-Network | Out-of-Network | Out-of-Network | Out-of-Network |
| **Preferred Generic** | N/A | N/A | N/A | N/A |
| **Preferred Brand** | N/A | N/A | N/A | N/A |
| **Non-Formulary** | N/A | N/A | N/A | N/A |
| **Specialty** | N/A | N/A | N/A | N/A |
| **ACA Preventive Medications** | Not Covered | Not Covered | N/A | N/A |
| **CDHP Preventive Medications** | Not Covered | N/A | N/A | N/A |