Plan Year 2025 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 2025 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)	$1,600 Individual $3,200 Family	$0	$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)	$4,000 Individual $8,000 Family $6,850 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	$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**	$49 Copay 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	20% Coinsurance	$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 2025 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 20% 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% 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-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, 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 2025 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	You pay 20% after Deductible	$10 copay Maximum benefit of $100 per annual exam*	$10 copay Maximum benefit of $100 per annual exam*	$10 copay Maximum benefit of $100 per annual exam*
Hardware (frames, lenses, contacts)	Not covered**	$10 Copay Maximum benefit of $100 every 24 months	$10 Copay Maximum benefit of $100 every 24 months	$10 Copay 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 https://pebp.nv.gov and select PEBP+ Voluntary Benefits, for additional information about the voluntary buy-up vision plan.

Plan Year 2025 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 Outpatient Visit	You pay 20% after Deductible	Plan pays 100% after Deductible	$20 Copay per visit	$25 Copay per visit
Telemedicine Visit	$79 Mental Health visit $229 Psychiatry Initial visit Doctor on Demand	$20 Mental Health 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 Register or enter anonymously using access code **FP3EAP**.
Help dial down stress, anxiety and depression – download the Sanvello® app. For community support and guided journeys (upgrade to Sanvello Premium at no cost using your insurance > UnitedHealthcare > then input your information as it appears on your PEBP insurance card)

Plan Year 2025 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 2025 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)	$1,600 Individual $3,200 Family	$500 Individual $1,000 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)	$10,600 Individual $21,200 Family	$10,600 Individual $21,200 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).

Employer Health Savings Account (HSA)/Health Reimbursement Arrangement (HRA) Contributions			(EPO)	
Base Employer Contribution HSA/HRA Funding Effective 7/1* PEBP Funded Contribution	$600	N/A	N/A	N/A
One-Time Contribution for State Active Employees** Funding Effective 7/1* Legislative Appropriated Contribution	$300 (EE) $400 (E+C, E+S) $500 (E+F)	$300 (EE) $400 (E+C, E+S) $500 (E+F)	$300 (EE) $400 (E+C, E+S) $500 (E+F)	$300 (EE) $400 (E+C, E+S) $500 (E+F)

*Prorated amount based on effective date of coverage.

** Allocation Tiers:

EE = Employee Only
E+C = Employee + Child(ren)
E+S = Employee + Spouse
E+F = Employee + Family

For more information about HSA/HRA funding please refer to the Plan Year 2025 Consumer Driven Health Plan Master Plan Document and the Plan Year 2025 Health Reimbursement Arrangement (HRA) Summary Plan Description.

HRA Frequently Asked Questions

I thought an HRA required a high deductible health plan (HDHP) like the CDHP. Do I receive the one-time HRA funds if I'm enrolled in the LD, EPO or HMO plan?

Unlike HSAs, you don't need a HDHP to use an *integrated* HRA. State active employees enrolled in the CDHP, LD, EPO and HMO plans will receive an integrated HRA for plan year 2024. In addition, CDHP participants will also receive $600 in base HSA/HRA funds.

What can I use my one-time contribution to pay for? What are considered eligible expenses under my HRA?

With an integrated HRA, you may pay for any eligible expense not fully paid for in your group health insurance policy, such as deductibles, coinsurance, prescriptions, dental and vision care, and other items listed in the IRS Publication 502. Expenses can only be incurred by you, your spouse, and eligible

dependents.

When will my funds be available and how can I use them?

All employer contributions for HSA/HRA accounts will be available in your HSA Bank account after the beginning of the new plan year on July 1st, 2023, usually within the first few weeks of the new plan year. Your HSA Bank Visa® Health Benefits Debit Card will arrive in a separate mailing within five business days of your account opening. You can use your card to pay for IRS-qualified medical expenses eligible under your State of Nevada Public Employees' Benefits Program (PEBP) plan. Remember to save your receipts so that HSA Bank can validate or substantiate the eligibility of the expense.

How to pay for IRS-qualified medical expenses with your HRA:

1. **HSA Bank Health Benefits Debit Card** – You will get your HSA Bank Visa® Health Benefits Debit Card that you may use at point of sale or after you get a medical bill from your provider. Transaction amounts automatically deduct from your account balance.
2. **Direct pay to provider** – Submit your claim to HSA Bank and include your provider's billing address. Once the claim is validated and substantiated, a check is sent to your provider to the address you specified on the claim.

Will my one-time contribution funds expire?

The one-time contribution does not have an expiration date. HRA funds rollover from one plan year to the next unless you terminate employment or transition to the Medicare Exchange with Via Benefits.

What happens to the money in my HRA if I leave my job or retire?

Because your HRA is employer-owned, the one-time contribution is only for current employees. Unused funds stay with your employer if you leave your job or retire. Employees in terminated work status may still access funds for services incurred before leaving State service and while covered under the plan, but reimbursement requests must be made manually. You are not eligible to use the funds for services incurred after your HRA terminates.

I already have an HSA or an HRA. What contributions will be used first?

HRA funds are used before HSA funds are used. So, if you have both accounts, your HRA funds will be depleted before any HSA funds will be used.

I have questions about my HSA Bank account. How can I contact HSA Bank?

HSA Bank administers HSA and HRA accounts for qualifying PEBP participants. You may log into your HSA Bank account here, or call HSA Bank Customer Service at 1-833-228-9364.

Can I have an HRA if I have Medicare, Medicaid, or Tricare?

Yes, coverage under these plans does not impact your ability to have an HRA.

When can an employee use the funds in the HRA?

The HRA funds may be spent on expenses incurred beginning on the date the HRA account is established. Incurred claims must be submitted within 365-days measured from the date of a claim.

Can I use the HRA for reimbursements for my spouse and dependents?

Reimbursements under an HRA can be made to the following individuals:

1. Employees,
2. Spouses and dependents of those employees,
3. Any person you could have claimed as a dependent on your return except that:

a. The person filed a joint return.
b. The person had a gross income of $4,400 or more; or
c. You, or your spouse if filing jointly, could be claimed as dependent on someone else's 2022 return.
d. Your child under age 27 at the end of the tax year.
e. Spouses and dependents of deceased employees.

Note: A child of parents that is divorced, separated, or living apart for the last 6 months of the calendar year is treated as the dependent of both parents whether the custodial parent releases the claim to the child's exemption. See IRS Publication 969.

What happens to the HRA funds if an employee passes away?

HRA funds are non-transferrable, meaning funds in the account cannot be transferred to a beneficiary. The only way to access funds for claims incurred prior to the date of death, is if the employee's spouse or other representative has power of attorney. The deceased employee's power of attorney representative will have 365 days to submit a request for reimbursement measured from the date of employee's death.

Do I have to be enrolled in a PEBP health plan to be eligible for the HRA?

The HRA is not offered as a stand-alone option. Instead, it is integrated with a PEBP-sponsored medical plan. This means, employees must be enrolled in a PEBP-sponsored medical plan, such as the CDHP, LD, EPO or HMO to qualify for the HRA.

Are the HRA dollars transferrable to another PEBP-sponsored medical plan?

Yes, the HRA dollars are transferrable from one PEBP medical plan to another PEBP plan. There will only be forfeiture of HRA funds if a member terminates employment or transitions to the Medicare Exchange.

Does HSA Bank offer direct deposit?

Yes, HSA Bank only offers direct deposit. There is no option for a mailed check.

What happens if I swipe my card to pay for an *ineligible* expense?

HSA Bank will reach out to ask for substantiating documentation. If you can't provide it, you will be asked to pay back the account. If neither of those things take place, you will have to pay taxes on any amount used for ineligible expenses. Additionally, you may incur a 20 percent tax penalty.

Do I have to submit reimbursement requests within a specified period?

HRA rules require claims to be submitted for reimbursement within 365 days of the date the expenses incurred.

How long with the Plan remain in effect?

PEBP expects the Plan to be offered in future years. However, PEBP has the right to modify or terminate the HRA program in any future plan year, including the amount credited to HRA accounts or to forfeit amounts currently credited to an employee HRA under certain conditions, such as: termination of employment, (except under continuation of coverage under COBRA), changing health plans (moving from one plan to another) and the death of an employee.

What happens if I have an expense higher than the HRA balance?

You may only spend or be reimbursed up to the HRA balance. If you submit a claim for more than that, the remaining amount over the balance will stay in a queue and will be reimbursed to you in the event additional funds are contributed to the HRA.

What happens to my HSA balance if I change my health plan from the CDHP with an HSA to the LD Plan or other PEBP health plan? Which account do I use first, my HSA or HRA?

If you have both an HSA, HRA or FSA, the HSA Bank will send you a "stacked" card. The stacked card allows you to pay for medical-related expenses across any combination of HSA, HRA and FSA accounts.

How does the stacked card work?

The stacked card can be used to pay for eligible purchases while a participant can use an alternative method of payment for non-eligible expenses. The stacked card technology can compare pharmacy data, retrospective data matching based on previous payments and claims matching based on previous payments, adjudicated claims, copayment matching and recurring expense logic. Using the copayment matching and recurring expense logic, once a transaction has been substantiated once, transactions for the same amount in the same setting are substantiated once and do not require another review (auto substantiated).

What if a transaction is not auto substantiated?

In the event the transaction is not auto substantiated, the employee (who uses the stacked card with an HRA or FSA) will receive a series of 3 notifications starting 5 days after the transaction. If documentation is not received, the claim is denied, and the employee is sent a letter asking for repayment. The employee can upload documentation on the HSB Bank member website, via mobile app or fax/mail. Every effort is made to avoid debit card suspension. However, debit card usage will be suspended until the transaction has been satisfied with either documentation or manual claim.

Does HSA Bank charge employees to establish an HRA account?

No. HSA Bank does not charge employees a fee to establish an HRA account.

Where can I find information regarding eligible expenses and tax information?

www.hsabank.com

What if I go out on Family Medical Leave Act ("FMLA")?

If you decline coverage while on FMLA, you have the right to reinstate the HRA upon returning from leave if you enroll in the same medical plan that you were enrolled in prior to taking leave.

What happens if my HRA claim is denied?

If a claim is denied, then you have the right to be notified of the denial and to appeal the denial. The rules for appealing denied claims can be found in the Plan Year 2024 HRA SPD available at https://pebp.nv.gov.

Can I have the HRA if I also have a Flexible Spending Account (FSA)?

An HRA can be used in tandem with a general medical flexible spending account (FSA). Typically, qualified expenses are paid from the FSA first to avoid forfeiting funds, and then funds from the HRA are used to cover any additional qualifying medical expenses.