Plan Year 2024 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 (PPO)	LOW DEDUCTIBLE PLAN (PPO)	HEALTH PLAN OF NEVADA (HMO)	EXCLUSIVE PROVIDER ORGANIZATION (EPO)
	In-Network	In-Network	In-Network	In-Network
Service Area	Global	Global	Southern Nevada	Northern Nevada
Annual Deductible *(medical and prescription* combined)*	$1,500 Individual $3,000 Family • $2,800 Individual Family Member Deductible	$0	N/A With exception of Tier 4 prescription drug coverage, see prescription overview	$100 Individual $200 Family • $100 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	$4,000 Individual $8,000 Family • $6,850 Individual Family Member Max Out-of-Pocket	$4,000 Individual $8,000 Family • $4,000 Individual Family Member Max Out-of-Pocket	$5,000 Individual $10,000 Family • $5,000 Individual Family Member Max Out-of-Pocket	$5,000 Individual $10,000 Family • $5,000 Individual Family Member Max Out-of-Pocket
Primary Care Office Visit	You pay 20% after deductible	$30 copay per visit	$25 copay per visit	$20 copay per visit
Specialist Care Office Visit	You pay 20% after deductible	$50 copay per visit	$25 copay per visit *with* a referral $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 Doctor on Demand	$10 copay medical visit Doctor on Demand	$0 copay 24/7 Advice Nurse	$10 copay medical visit Doctor 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 2024 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 (PPO)	LOW DEDUCTIBLE PLAN (PPO)	HEALTH PLAN OF NEVADA (HMO)	EXCLUSIVE PROVIDER ORGANIZATION (EPO)
	In-Network	In-Network	In-Network	In-Network
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	Ambulatory Surgical Facility $50 copay Outpatient Hospital $350 copay	$350 copay per admit
Base Employer Contribution HSA/HRA Funding Effective 7/1*	$600	N/A	N/A	N/A
One-Time HRA Employer Contribution Funding Effective 7/1***	$600 (EE) $700 (E+C, E+S) $800 (E+F)	$600 (EE) $700 (E+C, E+S) $800 (E+F)	$600 (EE) $700 (E+C, E+S) $800 (E+F)	$600 (EE) $700 (E+C, E+S) $800 (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 2024 Consumer Driven Health Plan Master Plan Document and the Plan Year 2024 Health Reimbursement (HRA) Summary Plan Description.

Note: Some services require preauthorization, refer to the applicable Plan Document for details.

Plan Year 2024 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* (PPO)	LOW DEDUCTIBLE (PPO)*	HEALTH PLAN OF NEVADA* (HMO)	EXCLUSIVE PROVIDER ORGANIZATION* (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 20% after deductible (Deductible: $100 Individual, $200 Family)	You pay 20% after deductible (30-day mail only)
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, 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 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 express-scripts.com/findapharmacy or call Express-Scripts Member Services at 1-855-889-7708.

Plan Year 2024 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 (PPO)**	**LOW DEDUCTIBLE (PPO)**	**HEALTH PLAN OF NEVADA (HMO)**	**EXCLUSIVE PROVIDER ORGANIZATION (EPO)**
Vision Exam	Plan pays 80% 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 for prescription eyeglasses Maximum benefit of $100 every 24 months	$10 copay for prescription eyeglasses Maximum benefit of $100 every 24 months	$10 copay for prescription eyeglasses 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 2024 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 CDHP PPO, LD PPO, HMO, EPO and Medicare Exchange Eligible Participants

DENTAL PLAN DESIGN FEATURES	In-Network	Out-of-Network
Individual Plan Year Maximum No annual maximum for dependents under 19 (applies to basic and major services)	$2,000 per Person	$2,000 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 (4/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 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 $2,000.

Plan Year 2024 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 (PPO)	LOW DEDUCTIBLE (PPO)	HEALTH PLAN OF NEVADA (HMO)	EXCLUSIVE PROVIDER ORGANIZATION (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)*	$1,500 Individual $3,000 Family $2,800 Individual Family Member Deductible	$500 Individual $1,000 Family $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 $21,200 Family	$10,600 Individual $21,200 Family	N/A	N/A
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	Subject to Maximum Allowable Charge*

*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).

Plan Year 2024 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 (PPO)	LOW DEDUCTIBLE (PPO)	HEALTH PLAN OF NEVADA (HMO)	EXCLUSIVE PROVIDER ORGANIZATION (EPO)
	Out-of-Network	Out-of-Network	Out-of-Network	Out-of-Network
Emergency Room Visit	You pay 20% after deductible*	$750 copay per visit, Subject to Maximum Allowable Charge**	$600 copay per visit	$600 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*	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

*Subject to Usual and Customary Limits

**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).

Note: Some services require preauthorization, refer to the applicable Plan Document for details.

Pharmacy Benefits are not covered out-of-network.