

<i>Active Plan B – Nevada 2021</i>	Fee-for-Service Self-funded Plan		United Healthcare Choice EPO Plan	Health Plan of Nevada Solutions Value HMO	Hometown Health HMO Plan
Plan Feature	All benefits are payable based on the allowable charges, as defined in the Summary Plan Description. Pre-authorization is recommended for all benefits indicated with an asterisk (*).				Available in Northern Nevada <u>only</u>
	PPO Provider	Non-PPO Provider			
Annual Deductible	\$300 per person; maximum of 3 deductibles per family Deductible applies to most services	\$600 per person; maximum of 3 deductibles per family Deductible applies to most services	\$500 per person; \$1,000 per family maximum Deductible applies unless otherwise noted	\$500 per person; \$1,000 per family maximum Deductible applies unless otherwise noted	\$500 per person; \$1,000 per family maximum Deductible applies unless otherwise noted
Annual Out-of-Pocket Limit	Plan pays 100% of allowable charges after you have incurred a total of \$3,900 out-of-pocket per year (\$7,800 for a family)	None Benefits do not increase from 50%	Plan pays 100% after eligible out-of-pocket costs reach \$3,000 in a year (\$6,000 for a family)	Plan pays 100% after eligible out-of-pocket costs reach \$2,000 in a year (\$6,000 for a family)	Plan pays 100% after eligible out-of-pocket costs reach \$3,000 in a year (\$6,000 per family)
In Patient Hospital Out Patient Hospital	*Plan pays 70% after deductible *Plan pays 70% after deductible	*Plan pays 50% of allowable charges *Plan pays 50% of allowable charges	Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 80% after deductible You pay \$350 per procedure after deductible	Plan pays 80% after deductible You pay \$200 per procedure after deductible
Extended Care Facility (Skilled Nursing)	Plan pays 70% of allowable charges after deductible; 60 days maximum per calendar year	Plan pays 50% of allowable charges; 60 days maximum per calendar year	Plan pays 80% after deductible; 60 days maximum per calendar year	You pay \$300 per admission after deductible, waived if admitted from an acute care facility; 100 days maximum, per calendar year;	Plan pays 80% after deductible; 100 days maximum per calendar year
Office Visits Primary Care Physician Specialist	Plan pays 70% after deductible Plan pays 70% after deductible	Plan pays 50% of allowable charges Plan pays 50% of allowable charges	Not Subject to Deductible You pay \$30 per visit You pay \$50 per visit	Not Subject to Deductible You pay \$25 per visit You pay \$50 per visit	Not Subject to Deductible You pay \$30 per visit You pay \$50 per visit
Preventative Care Routine Exam- Adults Routine Exam-Children Immunizations	Not Subject to Deductible Plan pays 100% of allowable charges, including all tests Plan pays 100% of allowable charges for at least 11 visits during 1st 30 months of age, then 1 visit every year through age 18 Plan pays 100% of allowable charges	Plan pays 50% of allowable charges, including all tests Plan pays 50% of allowable charges for at least 11 visits during 1st 30 months of age, then 1 visit every year through age 18 Plan pays 50% of allowable charges	Not Subject to Deductible Plan pays 100% Plan pays 100% Plan pays 100%	Not Subject to Deductible Plan pays 100% Plan pays 100% Plan pays 100%	Not Subject to Deductible Plan pays 100% Plan pays 100% Plan pays 100%
Diagnostic X-ray & Lab	Plan pays 70% after deductible	Plan pays 50% of allowable charges	Plan pays 100%; deductible does not apply	You pay \$15 for lab work and \$25 for x-rays; deductible does not apply	Plan pays 100% for lab work; you pay \$50 for x-rays; deductible does not apply
CAT Scans & MRI's	Plan pays 70% after deductible	Plan pays 50% of allowable charges	You pay \$100 per test after deductible	Plan pays 80% after deductible	You pay \$100 per test; deductible does not apply
Durable Medical Equipment	*Plan pays 70% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible	Plan pays 100%; deductible does not apply	Plan pays 80% after deductible
Home Health Care	*Plan pays 70% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible, up to 100 visits per calendar year	You pay \$35 per visit; deductible does not apply; <i>prior authorization required</i>	You pay \$50 per visit, up to 30 visits per calendar year, deductible does not apply
Chiropractic Care	Plan pays 100% up to a maximum of \$20 per visit		You pay \$50 per visit, up to 24 visits per calendar year; deductible does not apply	You pay \$25 per visit, <i>referral required</i> , up to 20 visits per calendar year, deductible does not apply	You pay \$50 per visit, up to 20 visits per calendar year/100 visits per lifetime; deductible does not apply

Physical Therapy	*Plan pays 70% after deductible; limit of 32 visits in 6 consecutive months	*Plan pays 50% of allowable charges; limit of 32 visits in 6 consecutive months	You pay \$50 per visit, up to 20 visits per calendar year; deductible does not apply	You pay \$25 per visit; up to 60 days/visits per calendar year; deductible does not apply	You pay \$30 per visit, up to 90 visits per calendar year for all 3 therapies; deductible does not apply
Speech Therapy	Not Covered	Not Covered	You pay \$50 per visit, up to 20 visits per calendar year; deductible does not apply	You pay \$25 per visit, up to 60 days/visits per calendar year; deductible does not apply	You pay \$30 per visit, up to 90 visits per calendar year for all 3 therapies; deductible does not apply
Maternity Care	Same as an illness, except birthing center paid at 100% up to \$1,500 with no deductible, certified nurse mid-wife paid at 100% up to \$750 with no deductible and routine prenatal visits to a PPO provider paid at 100% with no deductible		Same as an illness except no co-pay for routine prenatal visits	Same as an illness except no co-pay for routine prenatal visits	Same as an illness except no co-pay for routine prenatal visits
Mental Health and Substance Abuse Care	For substance abuse care, you may choose the Anthem Blue Cross PPO program, or the Beat It! Program		For substance abuse care, you may choose between coverage under the Beat It! Program or your HMO, or a combination of both		
Inpatient	*Plan pays 70% after deductible	*Plan pays 50% of allowable charges	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Outpatient	*Plan pays 70% after deductible	*Plan pays 50% of allowable charges	You pay \$20 per visit; deductible does not apply	You pay \$25 per visit; deductible does not apply	You pay \$30 per visit; deductible does not apply;
Prescription Drugs	Must be obtained at an ExpressScripts Network pharmacy		Must be obtained at a participating HMO pharmacy		
Annual Out-of-Pocket Limit	Not Subject to Deductible		Not Subject to Deductible		
Short Term (outpatient)	Plan pays 100% after Rx co-pays reach \$2,500 per year (\$5,000 for a family) You pay \$10 per generic, \$30 per brand name, and \$45 per non-preferred prescription, up to a 30-day supply		Included in Medical Out-of-Pocket Limit You pay \$20 per formulary generic, \$40 per formulary brand, and \$60 per non-formulary prescription, up to a 30-day supply	Included in Medical Out-of-Pocket Limit You pay \$20 per Tier I, \$40 per Tier II, and \$70 per Tier III prescription, up to a 30-day supply	Included in Medical Out-of-Pocket Limit You pay \$20 per formulary generic, \$40 per formulary brand, and \$60 per non-formulary prescription, up to a 30-day supply
Maintenance (30-day supply or more through the Mail Order)	ExpressScripts Mail Order Pharmacy - You pay \$15 per generic, \$45 per brand name and \$68 per non-preferred prescription, up to a 90-day supply		Mail Order - You pay \$50 per formulary generic, \$100 per formulary brand, and \$150 per non-formulary prescription, up to a 90-day supply	Mail Order - You pay \$50 per Tier I, \$100 per Tier II, and \$175 per Tier III prescription, up to a 90-day supply	Mail Order - You pay \$40 per formulary generic, \$80 per formulary brand, and \$120 per non-formulary prescription, up to a 90-day supply
Hearing Aids	Not Covered		Plan pays 80% after deductible, maximum benefit of \$2,500 every 3 years	Plan pays 100%; limited to a single purchase of a type of hearing aid, including repairs & replacement once every 3 years; deductible does not apply	Not Covered
Emergency Room Care	You pay a \$75 co-pay per Emergency Room visit, plus the balance due after the remaining expenses have been processed according to the regular Plan benefits, subject to the calendar year deductible and co-insurance percentages. The \$75 co-pay is waived if admitted to the hospital. Benefits will be paid only if the condition fits the Plan's definition of emergency – refer to your Summary Plan Description booklet for details		You pay \$250 per visit after deductible	You pay \$250 per visit, plus 20% of EME, (\$250 co-pay waived if admitted); deductible does not apply	You pay \$250 per visit after deductible; deductible does not apply

THIS IS ONLY A SUMMARY: The above Plan benefits show only a partial summary of benefits. Please refer to the applicable Evidence of Coverage (EOC) booklet or Summary Plan Description booklet for prior-authorization requirements and specific restrictions, exclusions, and limitations.