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CONSUMER DRIVEN HEALTH PLAN MASTER PLAN DOCUMENT

PLAN YEAR 20245

(EFFECTIVE JULY 1, 20234 – JUNE 30, 20254)



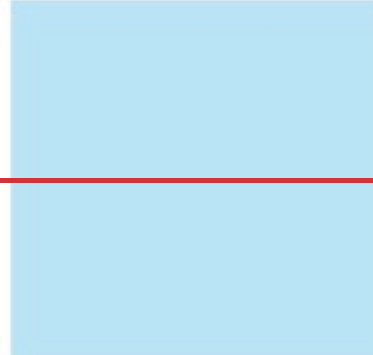
NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

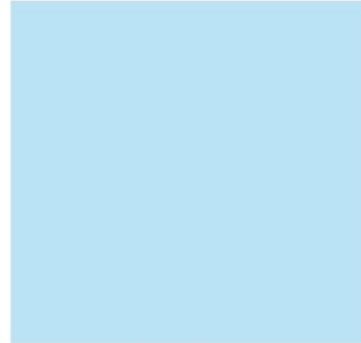
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Public Employees' Benefits Program
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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

~~“One-Time HSA or HRA Funding for Active State Employees” — Add language that clarifies “Legislatively approved enhancements, such as HSA/HRA funding and enhanced basic life insurance amounts may be subject to change in subsequent plan years.”~~

~~Health Savings Account~~

~~Health Savings Account contribution limit updated for 2024 per IRS Revenue Procedure (Rev. Proc. 2023-23)~~

~~Utilization Management~~

~~“Inpatient Admissions” — Remove “All” and “Same-day surgeries.” Refer to the Outpatient and Physician Surgery category for outpatient and same-day surgery prior authorization requirements.~~

~~Schedule of Medical Benefits~~Schedule of Benefits

~~“Preventative Services”~~

- ~~• Remove references to Skin Cancer Screenings: This was downgraded by the USPSTF to code “I” prior to the start of the plan year.~~
- ~~• Update age for Pap Smear to 21 through 65 to align with USPSTF guidelines and comply with IRS guidelines for HSA qualifying high-deductible health plans.~~
- ~~• Update mammogram by removing specification to 2-D or 3-D for mammograms.~~
- ~~• Clarify the Prostate Cancer Screening to coincide with NRS 695G.177. Add “Limited to 1 preventative per plan year and offered in accordance with NRS 695G.177 which includes reference to the American Cancer Society guidelines.”~~

~~“Durable Medical Equipment” — Remove limitation on electric wheelchairs “for paralysis.” Clarified the listed examples “include, but are not limited to[....].”~~

~~“Continuity of Coverage” which is within the “No Surprises Act” — Add the clarifying statement “Per NRS 695G.164, the Plan provides coverage for continued medical treatment for a medical condition from a provider of health care whose contract with the insurer is terminated during active medically necessary treatment. Unless excepted, this is until the later of:~~

- ~~• The 120th day after the date the contract is terminated; or~~
- ~~• If the medical condition is pregnancy, the 45th day after:~~
 - ~~○ The date of delivery; or~~
 - ~~○ If the pregnancy does not end in delivery, the date of the end of the pregnancy.”~~

~~Schedule of Prescription Drug Benefits~~

~~The Pharmacy Benefit Manager, Express Scripts, has offered a benefit for our members not expressly noted in the plan documents. Add “Diabetes Care Value: Express Scripts offers a program that supports members with diabetes (type 1 and 2) pre-diabetes, and even common comorbidities like obesity. ESI’s digital diabetes prevention and obesity solution offers a personalized coaching and weight loss program to help patients avoid type 2 diabetes. The~~

~~Diabetes Care Value is administered by Express Scripts and qualifying participants will receive a personal invitation, with instructions, to join the program."~~

~~Benefit Limitations and Exclusions~~

~~"Abortion" — Add "This plan provides abortion benefits in accordance with NRS 422.250."~~

~~"Corrective Appliance" — Update limitation language for motorized modes of transportation to include "determined to be not medically necessary."~~

~~Appeals~~

~~Update contact information for Office of Consumer Health Assistance.~~

~~Coordination of Benefits~~

~~Add information from the Health and Welfare Wrap Document for member benefit.~~

~~Key Terms and Definitions~~

~~"Medically Necessary" — Update the definition for Medically Necessary to include "Has the meaning ascribed to it in accordance with NRS 695G.055."~~

~~"Step Therapy" — Add to the definition to include "see also "Medical Management technique" and "The Plan also complies with step therapy per NRS 695G.1675."~~

~~Add "Medical management technique: Has the meaning ascribed to it within NRS 695G which means a practice which is used to control the cost or use/utilization of health care services, prescription drugs, or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration."~~

Outcomes from the 82nd Legislative Session 2023

Utilization Management

~~“Outpatient and Physician Diagnostic Services” — Update to clarify that Genetic Testing includes Biomarker Testing as this is generally used interchangeably. This is related to Assembly Bill 155.~~

~~“Gender Dysphoria” — Update to remove “Coverage for procedures is based on the UM company’s clinical policy for medical necessity.” Added “In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.”~~

Schedule of Medical Benefits~~*Schedule of Benefits*~~

~~“Genetic Testing” — Add “Biomarker testing: In accordance with Assembly Bill 155 from the 82nd Legislative Session in 2023, the Plan provides benefits for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.”~~

~~“Preventative Care/Wellness Benefits” — Add plan language “In accordance with Senate Bill 280 from the 82nd Legislative Session in 2023, the Plan provides benefits for contraceptive injection or the insertion of a device at a hospital immediately after an insured gives birth.”~~

~~“Gender Dysphoria” — Remove limitations and add to plan language:~~

~~“In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.~~

~~This plan does not discriminate on the basis of gender identity or expression. Claim or coverage appeal shall include a consult with a provider of health care who has experience in prescribing or delivering gender affirming treatment. The plan does not provide coverage cosmetic benefits as defined by Senate Bill 163.~~

~~Cosmetic Surgery means:~~

- ~~● Means a surgical procedure that:~~
 - ~~○ Does not meaningfully promote the proper function of the body~~
 - ~~○ Does not prevent or treat illness or disease; and~~
 - ~~○ Is primarily directed at improving the appearance of a person.~~
- ~~● This includes, without limitation, cosmetic surgery directed at preserving beauty.”~~

*Prescription Drug Benefits**Add to plan language:*

~~“In accordance with Assembly Bill 156 from the 82nd Legislative Session in 2023, the Plan provides benefits for substance use disorder including coverage for all drugs approved by the United States Food and Drug Administration to provide medication assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.”~~

~~“In accordance with Senate Bill 167 from the 82nd Legislative Session in 2023, the Plan provides prescription benefits for psychiatric conditions for drugs that are approved by the Food and Drug Administration or the use of a drug to treat a psychiatric condition that is supported by medical or scientific evidence when prescribed by a Provider acting within the scope of their license. These prescription drugs are not subject to medical management techniques, such as step therapy.”~~

Benefit Limitations and Exclusions

~~“Cosmetic Services and Surgery” — Remove language and clarified: “Breast augmentation/augmentation mammoplasty excluded, except as otherwise covered and described above.” This is related to Senate Bill 163 from the 82nd Legislative Session in 2023.~~

~~“Gender Dysphoria and/or Gender Services” — Related to Senate Bill 163 from the 82nd Legislative Session in 2023:~~

~~Remove “No more than one genital surgery in the individual’s lifetime when covered under any current or previous PEBP health plan.” And “A surgery to reverse a surgery to treat gender dysphoria will not be covered.”~~

~~Add “The Plan provides benefits to individuals seeking services for the treatment of gender dysphoria and gender incongruence in accordance with Senate Bill 163 from the 82nd Legislative Session in 2023.”~~

Key Terms and Definitions

~~“Gender Dysphoria” — Change definition: “In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023: “Gender dysphoria” means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:~~

- ~~(1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.~~
- ~~(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.~~
- ~~(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.~~

- ~~(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.~~
- ~~(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.~~
- ~~(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth."~~

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP offers medical, vision, dental, and life insurance, in addition to flexible spending accounts, and other voluntary benefits for eligible state and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may access whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and plan requirements. These plans include the Consumer Driven Health Plan (CDHP), Exclusive Provider Organization Plan (EPO), Low Deductible PPO Plan, and the Health Plan of Nevada HMO Plan. You are also encouraged to research plan provider access and quality of care in your service area.

PEBP participants choosing this Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the Active Employee Health and Welfare Wrap Plan, Retiree Health and Welfare Wrap Plan, Section 125 Document, Health Reimbursement Arrangement Summary Plan Document, and the PEBP Enrollment and Eligibility Master Plan Document. These documents are available at <https://pebp.nv.gov/> ~~www.pebp.state.nv.us~~ or by calling PEBP.

Master Plan Documents are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted in the Active Employee Health and Welfare Plan Document and Retiree Health and Welfare Wrap Plan Document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the Participant Contact Guide.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,

Public Employees' Benefits Program

Introduction

This Master Plan Document describes the Consumer Driven Health Plan (herein after referred to the “Plan” or “CDHP”) benefits. This Plan offers In-Network and Out-of-Network benefits and is a self-funded plan administered by PEBP and governed by the State of Nevada. The Plan is available to eligible employees, retirees, and their eligible dependents participating in the Public Employees’ Benefits Program (PEBP).

The benefits offered with the CDHP include medically necessary medical, behavioral health, prescription drug, vision, and dental coverage. Additional benefits include basic life insurance for active employees and eligible retirees. The medical, behavioral health, prescription drug, and vision benefits are described in this document. For information regarding the dental and life insurance benefits, refer to the PEBP ~~PPO~~ Dental Plan and Summary of Benefits for Life Insurance Master Plan Document. The CDHP provides a Health Savings Account (HSA) for eligible employees or a Health Reimbursement Arrangement (HRA) for eligible retirees and active employees who are ineligible for the HSA.

An independent ~~Third-~~~~Party~~ Claims Administrator pays the claims for the medical, dental and vision benefits. An independent pharmacy benefit manager pays the claims for prescription drug benefits.

~~The Plan and T~~his document ~~is-are~~ intended to comply with ~~the Chapter 287 of the Nevada Revised Statutes (NRS) Chapter 287, Chapter 287 and of the Nevada Administrative Code (NAC) 287, as amended and certain provisions of NRS 695G and NRS 689B~~ and all other applicable provisions of Nevada ~~l~~aw. Additionally, ~~T~~PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the ~~the~~ Health Insurance Portability and Accountability Act (HIPAA)~~he Plan Sponsor certifies that this Article incorporates the provisions set forth in 45 CFR Section 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii).~~

The Plan described in this document is effective **July 1, 2023**~~34~~, and unless stated differently, replaces other CDHP medical and prescription drug benefit plan documents/summary plan descriptions previously provided to you.

The provisions of this document contain important information. It will help you understand and use the benefits provided by this Plan. You should review it and show it to members of your family who are or will be covered by the Plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan. Be sure to read the *Benefit Limitations and Explanations*, and *Benefit Limitations and Exclusions*, and *Key Terms and Definitions* sections. Remember, not every expense you incur for health care is covered by this Plan.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. Members should keep informed of this document as the Plan is amended periodically. If those later notices describe a benefit or

procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Per NRS 287.0485 no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.

Suggestions for Using this Document

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The *Table of Contents* provides you with an outline of the sections.
- The *Participant Contact Guide* helps you become familiar with PEBP vendors and the services they provide.
- The ~~Participant—Rights~~Participant Rights section describes your rights and responsibilities as a participant of this Plan.
- The ~~Key Terms and Definitions~~Key Terms and Definitions section explains many technical, medical, and legal terms that appear in the text.
- The *Eligible Medical Expenses and Non-Eligible Medical Expenses, Summary of the CDHP Components, ~~Schedule of Medical Benefits~~Schedule of Benefits, Schedule of Prescription Drug Benefits, Key Terms and Definitions, and ~~Exclusions~~Benefit Limitations and Exclusions* sections describe your benefits in more detail.
- The ~~Preventive Care/Wellness Services~~Preventive Care/Wellness Services section provides wellness information that can help you proactively manage your health.
- The *Utilization Management* section provides information on what health care services require prior authorization and the process to request prior authorization.
- The *Claims Administration* section describes how benefits are paid and how to file a claim.
- The ~~Appeals Procedure~~Appeals section describes how to request a review (appeal) if you are dissatisfied with a claim decision.
- The *Coordination of Benefits* section describes situations where you have coverage under more than one health care plan, including Medicare.

Accessing Other Benefit Information:

You will also want to access the following documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, Consolidated Omnibus Budget Reconciliation Act (COBRA), third-party liability and subrogation, Health Insurance Portability and Accountability Act (HIPAA) and Privacy and Security and mandatory notices. These documents are available at <https://pebp.nv.gov/www.pebp.state.nv.us>.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan (CDHP) Master Plan Document
- CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO Plan Master Plan Document

- Low Deductible PPO Plan Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- Exclusive Provider Organization Plan Master Plan Document
- Exclusive Provider Organization Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description
- Health Reimbursement Arrangement Summary Plan Document

Participant Rights

You have the right to:

- Participate with your health care professionals in your health care decisions and have your health care professionals give you information about your condition and your treatment options.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with State and Federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and providers and your rights.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's participants' rights and responsibilities policies.
- Express, respectfully and professionally, any concerns you may have about PEBP or any benefit or coverage decisions the Plan, or the Plan's designated administrator, makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing future treatment and be informed by your physician(s) of the medical consequences.

Summary of the CDHP Components

Highlights of the Plan

The CDHP is a PEBP administered Preferred Provider Organization (PPO) High Deductible Health Plan which provides In-Network and Out-of-Network benefits. As a member, you receive coverage for many medically necessary services and supplies, subject to any Benefit Limitations and Explanations and ~~Exclusions~~Benefit Limitations and Exclusions. This is an open access PPO Plan and does not require a referral to see a specialist.

The Plan includes:

- Coverage for participants residing nationwide (in- and outside of Nevada).
- In- and Out-of-Network benefits.
- Reimbursement for *Eligible Medical Expenses* described in this document (and as determined by the Plan Administrator) for participants residing permanently, part time, or while traveling outside of the United States. Refer to the *Out-of-Country Medical, Prescription, and Vision Purchases* section.
- Coverage for eligible preventive care services at 100% when using In-Network providers. Refer to the *Preventive Care/Wellness Services* section for more information.
- Health care resources and tools to assist you in making informed decisions about your and your family's health care services. For more information log in to your E-PEBP member portal account at <https://pebp.nv.gov/www.pebp.state.nv.us>.

The CDHP is coupled with either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA).

Plan Year Deductibles and Out-of-Pocket Maximums				
	In-Network Deductible	In-Network Out-of-Pocket Maximum	Out-of-Network Deductible	Out-of-Network Out-of-Pocket Maximum
Individual (self-only coverage)	\$1, ~~6~~ 500	\$4,000	\$1, ~~5~~ 600	\$10,600
Family	Family: \$3, ~~2~~ 900 Individual family member: \$2,800	Family: \$8,000 Individual family member: \$6,850	Family: \$3, ~~2~~ 900 Individual family member: \$2,800	\$21,200
In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums are not interchangeable.				
The Deductibles and Out-of-Pocket Maximums accumulate separately for In-Network and Out-of-Network provider expenses. See Family Deductible explanation below.				

Deductibles

The Plan Year Deductibles (combined medical and prescription drug) includes two tiers:

- **Individual Deductible:** Applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible:** Applies when two or more individuals are covered on the same Plan (e.g., Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductible may be met through a combination of *Eligible Medical Expenses* from covered family members. The In-Network Family Deductible includes an “Individual Family Member” embedded Deductible. This means one single member of the family is only required to meet the Individual Family Member Deductible before the Plan starts to pay Coinsurance for that member.

The Individual and Family Deductibles start July 1st (the first day of the Plan Year) and reset the following Plan Year on July 1st. This Plan does not include a Deductible carryover or rollover provision.

During the Plan Year, you are responsible for paying for your eligible medical and prescription drug expenses (except eligible Preventive Services provided In-Network)–, including amounts exceeding the Plan’s reference-based pricing for hip and knee replacement, preauthorization penalties, and other out of pocket costs.

In-Network Individual Deductible

The In-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible is **\$1,5600**. Participants are responsible for paying Out-of-Pocket for eligible medical and prescription drug expenses that are subject to the Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Out-of-Network Individual Deductible

The Out-of-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible for Eligible Medical Expenses received Out-of-Network is **\$1,6500**. Participants are responsible for paying Out-of-Pocket for eligible medical (prescription drugs are not covered Out-of-Network) expenses up to the Plan Year Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

In-Network Family Deductible

The In-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **\$3,2900** and includes a **\$2,800** embedded “Individual Family Member” Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible In-Network medical and prescription drug expenses for the entire family after the **\$3,0200** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **\$2,800** “Individual Family Member” Deductible (under no circumstances will one single family member be required to pay more than **\$2,800** toward the **\$3,0200** Family Deductible). The **\$3,2900** In-Network Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including “Individual Family Member” Deductible) accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Out-of-Network Family Deductible

The Out-of-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **\$3,2900** and includes a **\$2,800** “Individual Family Member” Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible Out-of-Network medical and vision (prescription drugs are not covered Out-of-Network) expenses for the entire family after the **\$3,0200** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **\$2,800** “Individual Family Member” Deductible (under no circumstances will one single family member be required to pay more than **\$2,800** toward the **\$3,0200** Out-of-Network Family Deductible). The **\$3,2900** Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including “Individual Family Member” Deductible) accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Coinsurance

Coinsurance is the percentage of costs that generally you and the Plan pay for Eligible Medical Expenses after your Deductible is met. If you receive covered health care services using a health care provider who is a participating provider of this Plan’s PPO network, you will be paying less money out of your pocket. This Plan generally pays **80%** of the In-Network provider’s contract rate and you are responsible for paying the remaining **20%**. If you use an Out-of-Network provider (a non-participating provider, meaning the provider is not contracted with the PPO network), the Plan benefit may be reduced to **50%** of the Maximum Allowable Charge, and you are responsible for paying the remaining **50%**. Out-of-Network providers can also bill you directly for any difference between their billed charges and the Maximum Allowable Charge allowed by this Plan, except when prohibited by law.

Out-of-Pocket Maximums

In-Network Out-of-Pocket Maximums

The In-Network Out-of-Pocket Maximum (OOP~~M-Maximum~~) is the maximum amount you will pay for In-Network eligible medical and prescription drug expenses during the Plan Year. The Out-of-Pocket costs you pay toward your Deductible and Coinsurance for Eligible Medical Expenses accumulate toward your OOP-M~~aximum~~. The OOP-M~~aximum~~ for:

- An Individual (covered as self-only) is **\$4,000**
- Family coverage (participant plus one or more covered dependents) is **\$8,000**
 - The Family OOP Maximum includes a **\$6,850** embedded “Individual Family Member” OOP Maximum. An Individual Family Member OOP Maximum means one single family member will not pay more than **\$6,850** in the Plan Year for Eligible Medical Expenses.

Once an Individual or Family satisfies the OOP Maximum, the Plan will pay 100% of eligible medical and prescription drug expenses for the remainder of the Plan Year. The OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year. The accumulation of Eligible Medical Expenses toward the OOP Maximum is based on the date the medical or prescription drug expense is received by the Plan and not on the date of services.

Only Eligible Medical Expenses that are subject to cost-sharing (Deductible, Copayments, and Coinsurance) will apply to the OOP~~M-Maximum~~. The OOP-M~~aximum~~ does not include premiums, cost-sharing for non-covered supplies and services, penalties for failure to get preauthorization, amounts exceeding the Plan’s allowable charge for hip and knee replacement, expenses associated with denied claims, ancillary charges and amounts that Out-of-Network providers bill and are payable that are greater than this Plan’s Maximum Allowable Charge. This list is not all-inclusive and may not include certain services and supplies that are not listed here.

For this section only, references to the OOP-M~~aximum~~, Eligible Medical Expenses, Deductible and Coinsurance are specific to In-Network benefits.

Out-of-Network Out-of-Pocket Maximum

The Out-of-Network Out-of-Pocket Maximum (OOP~~M-Maximum~~) is the maximum amount you will pay for Eligible Medical Expenses (excluding prescription drugs) during the Plan Year. The Out-of-Pocket costs you pay toward your Deductible and Coinsurance for Eligible Medical Expenses accumulate toward your OOP-M~~aximum~~. The OOP-M~~aximum~~-M for:

- Individual (covered as self-only) is **\$10,600**.
- Family coverage (participant plus one or more covered dependents) is **\$21,200**.
(The Family coverage tier does not include an embedded Individual Family Member OOP Maximum.)

Once the OOP Maximum is met, the Plan will pay 100% of Eligible Medical Expenses (excluding Out-of-Network prescription drug expenses) for the remainder of the Plan Year. The OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year.

The accumulation of Eligible Medical Expenses toward the OOP ~~M~~ ~~Maximum~~ is based on the date the medical expense is received by the plan and not on the date of services.

The Family OOP Maximum (for Out-of-Network services only) can be met by one person or by a combination of Out-of-Pocket Eligible Medical Expenses from covered family members.

Only Eligible Medical Expenses that are subject to cost-sharing (Deductible, Copayments, and Coinsurance) will apply to the OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, penalties for failure to obtain preauthorization, amounts exceeding the Plan's allowable charge for hip and knee replacement, expenses associated with denied claims, ancillary charges, and any amount that Out-of-Network providers bill and are payable that are greater than this Plan's Maximum Allowable Charge. This list is not all-inclusive and may not include certain services and supplies that are not listed here.

References to the Out-of-Network, OOP Maximum, Eligible Medical Expenses, Deductible and Coinsurance in this section are specific to Out-of-Network benefits.

In- and Out-of-Network Maximums are not interchangeable and cannot be combined to reach your Plan Year OOP-~~Maximum~~.

Description of In-Network and Out-of-Network

Provider Network

PEBP leases a network of preferred providers (PPO) through a contract with a vendor who maintains such a network.~~The Plan or its designee arranges for providers to participate in a PPO network.~~ For more information, see the Participant Contact Guide section of this document. In-Network providers are hospitals, physicians, medical laboratories, and other health care providers located within a “service area” who have agreed to provide health care services and supplies at negotiated discount fees. Network providers are not the Plan’s employees or employees of any Plan designee.

The contracted PPO Network is responsible for credentialing providers by confirming public information about the providers’ licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the network status of a provider. A provider’s status may change.~~You are responsible for verifying a provider’s network status prior to receiving services, even when you are referred by another In-Network provider.~~ You can verify the provider’s status by calling the third-party administrator or on the PEBP website in the Find a Provider section. The provider listing is maintained and updated by the contracted network.

The provider network is subject to change. It is possible that you might not be able to obtain specific services from an In-Network provider.~~The provider network is subject to change.~~ Or you might find that an In-Network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available, you must choose another In-Network provider to get In-Network benefits.

Do not assume that an In-Network provider’s agreement includes all Eligible Medical Expenses. Some In-Network providers agree to provide only certain covered expenses, but not all covered expenses. Some In-Network providers choose to be an In-Network provider for only some products and services. You may contact the third-party administrator for assistance in choosing a provider or with questions about a provider’s network participation.

Pursuant to NRS 695G.164, if a member is receiving medical treatment from a provider whose In-Network status changes during the course of treatment, the member may continue to receive treatment with that provider at In-Network rates under certain circumstances. See more detailed explanation in PPO Network Health Care Provider Services section.~~This plan also adheres to for required provision in certain plans concerning coverage for continued medical treatment~~

In-Network Provider Benefits

The Plan provides In-Network benefits when the services are provided by an In-Network provider and generally pays at a higher amount than Out-of-Network benefits. In-Network benefits are payable for covered Eligible Medical Expenses.

When a participant uses the services of a PPO network (In-Network) health care provider, the participant is responsible for paying the applicable cost-share (Deductible, Copay, and/or Coinsurance) on the discounted fees for medically necessary services or supplies, subject to the Plan's coverage, limitations, and exclusions.

If you receive medically necessary services or supplies from an In-Network provider, you will pay a lower ~~Coinsurance-cost~~ than if you received those services or supplies from a health care provider who is not in the PPO network (Out-of-Network). In-Network providers have agreed to accept the Plan's payment (plus any applicable ~~Coinsurance-cost-share~~ you are responsible for paying) as payment in full. The In-Network health care provider generally deals with the Plan or its designee directly for any additional amount due.

Out-of-Network Provider Benefits

Out-of-Network, Eligible Medical Expenses are subject to applicable Deductibles and a Coinsurance rate of 50% of eligible billed charges and subject to the Plan's Maximum Allowable Charge, except when prohibited by law.

Out-of-Network (~~non-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 Plan's Maximum Allowable Charge (as defined in the *Key Terms and Definitions*) on non-discounted medically necessary services or supplies, subject to the Plan's cost-share (Deductibles, Copay, and/or Coinsurance). With exception of services subject to the No Surprises Act, Out-of-Network health care providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing). Balance billing for Eligible Medical Expenses can be avoided by using In-Network Providers.

Other Providers

If you have a medical condition that the third-party administrator or the utilization management company believes needs special services, they may direct you to a provider identified by them. If you require certain complex covered services for which expertise is limited, the third-party administrator or the utilization management company may direct you to an Out-of-Network provider. In both cases, benefits will only be paid at the In-Network benefit level (subject to the Maximum Allowable Charge) if your covered expenses for that condition are provided by or arranged by the other provider as chosen by third-party claims administrator or the utilization management company.

Participants may obtain health care services from In-Network or Out-of-Network health care providers. Because providers are added and dropped from the PPO network periodically throughout the year, it is the participant's responsibility to verify provider participation before receiving services by contacting the third-party claims administrator at the telephone number or by visiting the provider network's website located at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Out-of-Network Benefit Exceptions

If there is no In-Network provider within 50- miles of your home, you may be eligible to receive benefits for certain Eligible Medical Expenses paid at the In-Network level, subject to the Plan's Maximum Allowable Charge (with exception of services subject to the No Surprises Act). Benefits that fall under this category must be approved prior to receipt of the care and are subject to any Plan ~~Benefit Limitations and Exclusions~~~~limitations or Exclusions~~ set forth in this MPD.

If you are traveling outside your network and you need medical care, you should contact the third-party administrator at the telephone number appearing on your medical identification card for assistance in locating the nearest In-Network provider. There is an exception for emergency care. ~~If you need emergency care, however, go ahead and get the care you need. The Plan will pay your claim for Eligible Medical Expenses at the In-Network provider level.~~

Emergency Care

The Plan provides benefits for emergency care when required for stabilization and initiation of treatment as provided by or under the direction of a health care provider. Eligible Medical Expenses that are provided as a result of Emergent care provided by In-Network providers are paid at the -In-Network benefit level. Out-of-Network -Emergent care for Eligible Medical Expenses are paid at the In-Network benefit level.

Confinement in an Out-of-Network Hospital Following an Emergency

If you are confined in an Out-of-Network hospital after you receive emergency services, the utilization management company must be notified within two business days or on the same day of admission if reasonably possible. The UM company may elect to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the utilization management company decides a transfer is medically appropriate, and the provider obtains informed consent and you receive the required notice as required under the No Surprises Act, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service.

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the *Eligible Medical Expenses* at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge. Services subject to the No Surprises Act are subject to the Recognized Amount.

When Out-of-Network Providers May be Paid as In-Network Providers

When a participant uses the services of an Out-of-Network provider for *Eligible Medical Expenses* in the circumstances defined below, charges by the Out-of-Network provider will be subject to the Plan's Maximum Allowable Charge (as defined in the *Key Terms and Definitions* section). Out-of-Network providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing).

- If a participant traveling to an area serviced by an In-Network provider experiences an urgent but not life-threatening situation and cannot access an In-Network provider, benefits may be paid at the In-Network benefit level for use of an Out-of-Network urgent care facility.
- In the event of a life-threatening emergency in which a participant uses an Out-of-Network urgent care.
- For medically necessary services or supplies when such services or supplies are not available from an In-Network provider within 50 driving miles of the participant's residence. This includes services provided for wellness/preventive, or a second opinion.
- Participant travels to an area not serviced by an In-Network provider within 50 miles.
- If a participant travels to an area serviced by an In-Network provider, the participant must use an In-Network provider to receive benefits at the In-Network benefit level.
- If there is a specialty not available inside the participant's eligible PPO network, benefits may be paid as In-Network.

Preferred Provider Organizations (PPO Network)

A preferred provider organization (PPO) network is a list of the doctors, other health care providers, and hospitals that the Plan has a contract with to provide medical care for Plan members. These providers are called "network providers" or "In-Network providers."

This Plan includes a PPO network for members residing in-and outside-of Nevada. To locate an In-Network provider visit the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) or contact the third-party claims administrator. Information regarding the PPO network is also available in the *Participant Contact Guide* section of this document.

Service Area

A "Service Area" is a geographic area serviced by In-Network health care providers. If you and or your covered dependent(s) live more than 50 driving miles from the nearest In-Network health care provider whose services or supplies are determined by the Plan Administrator or its designee as being appropriate for the condition being treated, the Plan will consider that you live outside the service area. In that case, your claim for medically necessary services or supplies from an Out-of-Network health care provider will be treated as if the services or supplies were provided In-Network, subject to the Maximum Allowable Charge.

Directories of Network Providers

Participants are encouraged to confirm the In-Network participation status of a provider prior to receiving services.

A list of PPO providers is available to you without charge by visiting [your member website from the Third-Party Administrator's website](#) or by calling the phone number on your ID card. The

network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

The online provider directory updates are made seven (7) days a week for Sierra HealthCare Options (SHO) and Behavioral Healthcare Options (BHO) networks. UHC Choice Plus providers are available in the Find Care and Cost tool available 24/7 yearly updates. The list of PPO providers is maintained and updated by the contracted network based on information supplied by Providers.

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services, and supplies. The expenses for which you are covered are called *Eligible Medical Expenses*. Eligible medical expenses are limited to the covered benefits specified in the ~~Schedule of Medical Benefits~~Schedule of Benefits and are:

- Determined by the Plan Administrator or its designee to be medically necessary (unless otherwise stated in this Plan), but only to the extent that the charges are usual and customary (U&C), provided in-network, and/or do not exceed this Plan's Maximum Allowable Charge (as those terms are defined in the *Key Terms and Definitions* section).
- Not services or supplies that are excluded from coverage (as provided in the *Exclusions* section).
- Charges for services or supplies that do not exceed the Plan Year maximum benefits as shown in the ~~Schedule of Medical Benefits~~Schedule of Benefits.

Generally, the Plan will not reimburse you for all *Eligible Medical Expenses*. Usually, you will have to pay some portion of costs, known as cost-sharing such as Coinsurance toward the amounts you incur for *Eligible Medical Expenses*. However, once you have incurred the Plan Year Out-of-Pocket Maximum cost for *Eligible Medical Expenses*, no further Coinsurance will apply for the balance of the Plan Year. There are also maximum benefits applicable to each participant.

The above is not all-inclusive. For more information regarding eligible medical expenses, see the ~~Schedule of Medical Benefits~~Schedule of Benefits, Key Terms and Definitions, Benefit Limitations and Exclusions sections.

A Person Whose Status Changes from Employee/Retiree to Dependent or from Dependent to Employee

A person who is continuously covered on this Plan before, during, and after a change in status, will be given credit for portions of the medical, prescription drug and dental Deductibles previously met in the same Plan Year, including the benefit maximum accumulators (e.g., medical Out-of-Pocket Maximums, dental frequency maximums and annual benefit maximum) will continue without interruption.

Non-Eligible Medical Expenses

Non-eligible medical expenses are expenses that are excluded from the Plan and do not accumulate towards your Deductible and Out-of-Pocket Maximum.

This Plan does not pay benefits equal to all the medical expenses you may incur. You are responsible for paying the full cost of all expenses that are not *Eligible Medical Expenses*, including expenses that are:

- Not determined to be medically necessary (unless otherwise stated in this Plan).
- Determined to exceed this Plan's Maximum Allowable Charge.
- Expenses for medical services or supplies that are not covered by the Plan, including, but not limited to, expenses that exceed the PPO provider contract rate, services listed in the *Exclusions* section of this document and dental expenses.
- Benefits exceeding those services or supplies subject to limited overall maximums for each covered individual for certain *Eligible Medical Expenses*.
- Additional amounts you are required to pay because of a penalty for failure to comply with the Plan's utilization management requirements described in the *Utilization Management* section of this document. If you fail to follow certain requirements of the Plan's utilization management program, the Plan may pay a smaller percentage of the cost of those services, and you may have to pay a greater percentage of those costs. The additional amount you may have to pay is in addition to your Deductibles or Out-of-Pocket Maximums described in the tables.
- *Preventive Care/Wellness Services* that are paid by the Plan at 100% do not accumulate towards the Out-of-Pocket Maximum.

This list is not all-inclusive and may include certain services and supplies that are not listed above.

Non-Eligible Medical Expenses do not accumulate toward the Plan Year Deductible or Out-of-Pocket Maximum as determined by the Plan Administrator for your specific coverage tier. You are responsible for paying these expenses out of your own pocket.

For more information regarding *Non-Eligible Medical Expenses*, see the *Benefit Limitations and Exclusions* section.

PPO Network Health Care Provider Services

If you receive medical services or supplies from an In-Network PPO provider, you will be responsible for paying less money out-of-pocket. Health care providers who are participating providers of the PPO network have agreed to accept the PPO network negotiated amounts in place of their standard charges for covered services. You are responsible for any applicable Plan Deductible and Coinsurance requirements as outlined in this document and are described in more detail in the ~~*Schedule of Medical Benefits*~~ *Schedule of Benefits*.

With exception of services subject to the No Surprises Act, Out-of-Network providers may bill the participant their standard charges and any balance that may be due after the Plan payment. It is the participant's responsibility to verify the In-Network status of a chosen provider.

NOTE: In accordance with [NRS 695G.164](#), if you are seeing a provider that is In-Network and that provider leaves the network, and you are actively undergoing a medically necessary course of treatment, and you and your provider agree that a disruption to your current care may not be in your best interest or if continuity of care is not possible immediately with another In-Network provider, PEBP will pay that provider at the same level they were being paid while contracted with PEBP's PPO network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- The 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 90th day after:
 - The date of delivery; or
 - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Out-of-Country Medical, Prescription and Vision Purchases

This Plan provides you with coverage worldwide. Whether you reside in the United States and travel to a foreign country, or if you reside outside of the United States permanently or on a part-time basis, and require medical, prescription drug, or vision care services, you may be eligible for reimbursement of the cost.

Please contact this Plan's third-party claims administrator and pharmacy benefit manager before traveling or moving to another country to discuss any criteria that may apply to a medical, prescription drug, or vision service reimbursement request.

Typically, foreign countries do not accept payment directly from the Plan. You may be required to pay for medical and vision care services and submit your receipts to this Plan's third-party claims administrator for possible reimbursement. Medical and vision services received outside of the United States are subject to Plan provisions, coverage, limitations, exclusions, clinical review if necessary, and determination of medical necessity. The review may include application of pertinent Food and Drug Administration (FDA) regulations~~The review may include regulations determined by the FDA.~~ Out-of-country medication purchases are only eligible for reimbursement while traveling outside of the United States.

The third-party claims administrator may require a written notice from you or your designated representative explaining why you received the medical services from an out of country provider and why you were unable to travel to the United States for these services. This provision applies to elective and emergency services.

Prior to submitting receipts from a foreign country to this Plan's third-party claims administrator, you must complete the following:

- Proof of payment from you to the provider of service (typically your credit card invoice).

- Itemized bill to include complete description of the services rendered and admitting diagnosis(es).
- Itemized bill must be translated to English.
- Reimbursement request converted to United States dollars.
- Foreign purchases of medical care and services are subject to Plan limitations such as:
 - Benefit coverage
 - Coinsurance and deductibles
 - Frequency maximums
 - Annual benefit maximums
 - Medical necessity
 - FDA approval
 - the Plan's Maximum Allowable Charge

The Plan administrator and the third-party claims administrator reserve the right to request additional information. If the provider will accept payment directly from the claim's administrator, you must also provide the following:

- Assignment of benefits signed by you or an individual with the authority to sign on your behalf such as a legal guardian or Power of Attorney (POA).

Once payment is made to you or to the out-of-country provider, the Plan administrator and its vendors are released from any further liability for the out-of-country claim. The Plan administrator has the exclusive authority to determine the eligibility of all medical services rendered by an out-of-country provider. The Plan administrator may or may not authorize payment to you or to the out-of-country provider if all requirements of these provisions are not satisfied.

This Plan may provide certain benefits for travel assistance back to the United States.

This Plan may provide benefits for the purposes of emergency medical transportation only. For more information, contact this Plan's third-party claims administrator listed in the *Participant Contact Guide*.

Health Savings Accounts (HSA)

Active Employees Only

The Consumer Driven Health Plan (CDHP) is an IRS qualified High Deductible Health Plan. This means the CDHP complies with federal requirements regarding Deductibles, Out-of-Pocket Maximums, and certain other features. As a qualified High Deductible Health Plan, the CDHP is coupled with a Health Savings Account (HSA). A Health Savings Account is a tax-exempt account that you can use to pay or reimburse yourself for certain medical expenses you incur. For further information on Health Savings Account's, see IRS Publication 969.

HSAs are employee-owned accounts, meaning the funds in the HSA remain with the employee and carry over from one year to the next (i.e., will not be forfeited ~~unless there is no account activity for a 3-year period then the funds will be considered abandoned per NRS 120A.500~~). Contributions to the HSA grow tax free and are portable. When an employee retires or terminates employment, the employee retains the funds in the HSA. The employee can continue to use the funds in the HSA for health care and other qualified medical expenses after employment ends.

There are limits on the amount an eligible individual can contribute to an HSA based on the employee's coverage tier. For example, "self-only" or "Family" coverage:

- Self-only coverage means an eligible individual (employee).
- Family coverage means an eligible employee covering at least one dependent (whether that dependent is an eligible individual (for example, if the dependent has Medicare) if that other person is claimed on your tax return and not claimed as a tax dependent on someone else's return.

You must be an eligible individual to qualify for an HSA. Employees may not establish or contribute to a Health Savings Account if any of the following apply:

- The employee is covered under other medical insurance coverage unless that medical insurance coverage: (1) is also a High Deductible Health Plan as defined by the IRS; (2) covers a specific disease state (such as cancer insurance); or (3) only reimburses expenses after the Deductible is met.
- The employee is enrolled in Medicare.
- The employee is enrolled in Tricare.
- The employee is enrolled in Tribal coverage.
- The employee can be claimed as a dependent on someone else's tax return unless the employee is Married Filing Jointly.
- The employee or the employee's spouse has a Medical Flexible Spending Account (excludes Dependent Care or Limited Use Flexible Spending Accounts) that can reimburse the employee's medical expenses.
- The employee's spouse has an HRA that can be used to pay for the medical expenses of the employee.

- The employee is on COBRA; or
- The employee is retired.

If an employee loses eligibility to contribute to a Health Savings Account (HSA) for any reason, the Plan reserves the right to cease processing employee contributions to the HSA for the remainder of the Plan Year. If an HSA ineligible employee elects to continue coverage in the Plan for the subsequent Plan Year, the employee will only be eligible to enroll in the Health Reimbursement Arrangement (HRA) to receive PEBP contributions as described below. The HSA third-party claims administrator reserves the right to verify Medicare eligibility with the Centers for Medicare and Medicaid Services (CMS).

Employees who wish to establish or contribute to an HSA should contact the HSA third-party claims administrator regarding eligibility requirements, consult with a tax professional or read the provisions described in IRS Publication 969.

Current CDHP participants who are eligible for the HSA will receive PEBP contributions during the first month of the new Plan Year. New hires receive a prorated contribution based on the coverage effective date and the number of months remaining in the Plan Year. HSA funds may not be used for a person who does not meet the IRS definition of dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether the dependent is covered under this Plan. In general, HSA funds may not be used to pay premiums. There are certain exceptions for retirees or former employees enrolled in a Plan offered under COBRA provisions.

HSA funds may only be used to pay, or reimburse expenses incurred after the HSA is established and can only be reimbursed if there are available HSA funds in the account.

HSA Bank, a division of Webster Bank, N.A., is the third-party claims administrator and custodian for the HSA. PEBP does not (i) endorse HSA Bank, a division of Webster Bank, N.A. as an HSA provider; (ii) limit an employee's ability to move funds to other HSA providers, (iii) impose conditions on how HSA funds are spent, (iv) make or influence investment decisions regarding HSA funds, or (v) receive any payment or compensation in connection with an HSA. PEBP HSA contributions and employee voluntary pre-tax payroll deductions will only be deposited to an HSA at HSA Bank, a division of Webster Bank, N.A. Employees may choose to establish an HSA with any HSA trustee or custodian and may transfer funds deposited into HSA Bank, a division of Webster Bank, N.A. account to another HSA account held by another trustee or custodian. However, PEBP will not pay any fees associated with any other HSA account including transfer fees.

The IRS requires any person with an HSA to submit form 8889 with their annual income tax return.

Health Savings Account Owner Identity Verification

Section 326 of the USA PATRIOT Act requires financial institutions to verify the identity of each employee who opens a Health Savings Account (HSA). If an employee's identity cannot be verified, the employee will be required to provide additional documentation to establish their identity. If additional verification is not provided within 90 days of the employee's HSA opening date, the HSA will be closed. Failure to comply with the identity verification requirement within the stated timeframe will result in the conversion from an HSA to a Health Reimbursement Arrangement (HRA) for the remainder of the Plan Year. The next opportunity to establish an HSA will be during the Open Enrollment Period for the subsequent Plan Year.

HSA Contributions for Eligible Active Employees	
Tier	Contribution
Active Participant (Employee/Retiree) Only	*\$600

*HSA contribution provided to HSA eligible active employees enrolled in the CDHP on **July 1, 2023**. New hires with benefits effective **August 1, 2023**, and later receive a pro-rated contribution based on their CDHP coverage effective date. For **Plan Year 2025**, dependents are not eligible for a PEBP HSA contribution. Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing from the CDHP with an HSA to the CDHP with a HRA or vice versa.

Calendar Year 2023 HSA Contribution Limits	
Individual	Family (two or more HSA eligible family members)
\$3,850	\$7,500
Total contributions (combined employee/employer) cannot exceed the 2023 calendar year limit, as determined by the IRS (Revenue Procedure, 2023-23) . To contribute the family maximum, the employee and at least one tax dependent must be covered on the CDHP Plan. The Family maximum applies regardless of whether two employees are married and enrolled in the CDHP and eligible for the HSA. Employees aged 55 years and older at the end of the tax year may contribute an additional \$1,000 to the HSA.	
Calendar Year 2025 HSA Contribution Limits	
Individual	Family (two or more HSA eligible family members)
\$4,150	\$8,300
Total contributions (combined employee/employer) cannot exceed the 2025 calendar year limit, as determined by the IRS (Revenue Procedure pending, 2023-23) . To contribute the family maximum, the employee and at least one tax dependent must be covered on the CDHP Plan. The Family maximum applies regardless of whether two employees are married and enrolled in the CDHP and eligible for the HSA. Employees aged 55 years and older at the end of the tax year may contribute an	

additional ***\$1,000*** to the HSA.

Health Reimbursement Arrangement (HRA)

PEBP and its vendor require direct deposit for HRA reimbursements. PEBP's HRA benefits are subject to the provisions explained in IRS Publication 969. Also see PEBP HRA Summary Plan Document on PEBP's website.

Active Employees and Retirees

This section provides summary information only. For more detailed information regarding this important benefit, see Internal Revenue Service (IRS) Publication 502 or contact the HRA third-party claims administrator listed in the *Participant Contact Guide*.

The CDHP with an HRA is available to active employees who are not eligible for an HSA, or who fail to establish an HSA. An HRA, ~~it~~ is also available to eligible retirees enrolled in the CDHP.

Each Plan Year, PEBP contributions will be available for use through a CDHP HRA account established in the employee's or retiree's name. Funds in the CDHP HRA account may be used, tax-free, to pay for qualified medical expenses as defined by the IRS (see [IRS Publication 502](#)), other than premiums, including payment of Deductibles, Coinsurance, and other Out-of-Pocket qualifying healthcare expenses not covered by this Plan.

The CDHP's HRA may only be used to pay or reimburse qualified Out-of-Pocket health care expenses incurred by:

- the participant; or
- the participant's spouse; or
- participant's dependent(s) who could be claimed on the participant's annual tax return;

CDHP HRA funds may not be used for a person who does not meet the IRS definition of a qualified tax dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether PEBP provides coverage for the dependent.

The entire annual PEBP base contribution for **Plan Year 2024~~5~~** will be available for use at the beginning of the Plan Year on or about **July 1, 202~~34~~** (subject to certain limitations). Participants who initially elect for PEBP coverage after **July 1, 202~~34~~**, will receive a pro-rated base contribution for the participant based upon the coverage effective date and the months remaining in the Plan Year. Participants cannot contribute to a CDHP HRA. If the annual funds in the CDHP HRA are exhausted, neither PEBP nor the participant will contribute any additional funds.

Participants are allowed the option annually, and at termination in the plan, to permanently opt-out of the HRA, and thereby forfeit any unused balance.

Any funds remaining in the CDHP HRA at the end of the Plan Year will carryover (i.e., will not be forfeited) and will be available for use in the following Plan Year. Unlike a Flexible Spending Account (FSA), participants cannot be reimbursed from funds that are not yet available in the CDHP HRA. Any reimbursement from the CDHP HRA will be the lesser of the available CDHP HRA balance or the claim amount paid to the provider.

Participants enrolled in the CDHP HRA who change plans during the Open Enrollment period to a plan without a HRA and retirees who transition coverage to the Via Benefits Medicare exchange will forfeit any remaining funds in their CDHP HRA account.

Active employees who retire and who are not Medicare age (typically at age 65 years) can maintain the balance of their CDHP HRA account at retirement if:

- They are eligible to enroll in and continue coverage under the CDHP plan; or
- Continue CDHP coverage under COBRA.
 - If a participant elects COBRA coverage, the CDHP HRA account will remain in place until COBRA coverage is terminated.

In the case of a retroactive coverage termination, any funds used from the CDHP HRA for expenses that are incurred after the date of coverage termination will be recovered by PEBP through the collection process.

Retirees who have a CDHP HRA balance and who transition to the Medicare Exchange will forfeit any remaining funds in the HRA on the last day of coverage under the Plan.

The death of an active employee or retiree will cause any remaining funds in the HRA to be forfeited on the first day following the date of death.

Timely Filing of HRA Claims

In accordance with [NAC 287.610](#), claim requests must be submitted to the third-party claims administrator within one year (12 months) from the date of service that the claim is incurred. No plan benefits will be paid for any claim requests submitted after this period.

When your HRA-eligible coverage ends, you will have one year (12 months) from the date your coverage ends to file a claim for reimbursement from your HRA for eligible claims incurred during your coverage period in accordance with [NAC 287.610](#), dependent on the date of service. CDHP HRA funds may not be used to pay premiums.

HRA Contributions for Eligible Active Employees and Retirees	
Employee/Retiree	Contribution
Participant Only	*\$600

*HRA contribution provided to eligible active employees and retirees enrolled in this Plan on **July 1, 2023~~4~~**. For **Plan Year 2024~~5~~**, dependents are not eligible for PEBP HRA contributions. New hires effective **August 1, 2024~~3~~**, and later receive a pro-rated contribution based on their CDHP coverage effective date.

Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing from the CDHP with an HSA to the CDHP with a HRA or vice versa.

Reinstated employees who return to active employment within the same Plan Year and who re-enroll in the CDHP HRA shall have their remaining HRA fund balance reinstated. Reinstated employees who re-enroll in the CDHP HRA more than one year after termination are not eligible for reinstatement of HRA balance reinstatement. No additional prorating of HRA funds is available to reinstatements unless the reinstated employee is eligible for additional prorated funding due [to](#) adding new dependent(s).

One-Time HSA or HRA Funding for Active State Employees

There is additional funding for the HSA or HRA for active, state employees enrolled in a PEBP plan on July 1, 202~~34~~.*

The entire one-time contribution for **Plan Year 202~~45~~** will be available for use at the beginning of the Plan Year on or about **July 1, 202~~34~~** (subject to certain limitations, above).

HSA/HRA Contributions for Eligible State Active Employees	
Tier	One-Time Contribution
~~PEBP Funded Contribution~~	
~~State Active Employee Only~~	~~\$300~~
~~State Active Employee + Spouse/Domestic Partner~~	~~\$300~~
~~State Active Employee + Child(ren)~~	~~\$300~~
~~State Active Employee + Family~~	~~\$300~~
Legislature Appropriated One-Time Contribution	
State Active Employee Only	\$300
State Active Employee + Spouse/Domestic Partner	\$400
State Active Employee + Child(ren)	\$400
State Active Employee + Family	\$500

*One-time contribution provided to eligible active, State employees enrolled in a Plan on **July 1, 202~~34~~**. State employees who initially elect PEBP coverage after **July 1, 202~~34~~**, will receive a pro-rated base contribution based on the tier and the coverage effective date and the months remaining in the Plan Year.

Legislatively approved enhancements, such as HSA/HRA funding and enhanced basic life insurance amounts may be subject to change in subsequent plan years.

Utilization Management

The Plan is designed to provide you and your eligible dependents with financial protection from significant health care expenses. To enable the Plan to provide coverage in a cost-effective way, it has a Utilization Management (UM) program designed to help control increasing health care costs by avoiding unnecessary services, directing participants to more cost-effective treatments capable of achieving the same or better results and managing new medical technology and procedures. If you follow the procedures of the Plan's UM program, you may avoid some Out-of-Pocket costs. However, if you do not follow these procedures, Plan benefits may be reduced, and you will be responsible for paying more out of pocket.

The Plan's UM program is administered by an independent professional UM company operating under a contract with the Plan. The name, address and telephone number of the UM company appears in the *Participant Contact Guide* section. The health care professionals at the UM company focus their review on the medical necessity of hospital stays and the medical necessity, appropriateness, and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM company has been given discretionary authority by the Plan administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of the Plan.

The UM program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document, PEBP's *Employee Health and Welfare Wrap Plan*, and *Retiree Health and Welfare Wrap Plan* documents. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered, either in whole or in part, by an exclusion in the Plan.

~~Regardless of whether~~ Even if your physician recommends surgery, hospitalization, confinement in a skilled nursing or sub-acute facility, or your physician or other provider proposes or provides any medical service or supply, ~~does not mean~~ the recommended services or supplies are not automatically considered medically necessary for purposes of ~~will be considered medically necessary for~~ determining coverage under the Plan.

Benefits payable by the Plan may be affected by the determination of the UM company if:

- The UM company does not authorize a proposed surgery or other proposed medical treatment as medically necessary; or
- The Plan will not pay regular benefits for a hospitalization or confinement in a skilled nursing or sub-acute facility because the UM company does not authorize a proposed confinement.

PEBP, the third-party claim administrator, and the UM company are not engaged in the practice of medicine and are not responsible for the outcomes of health care services rendered (even if the health care services have been authorized by the UM company as medically necessary), or

for the outcomes if the patient chooses not to receive health care services that have not been authorized by the UM company as medically necessary.

When reviewing services for appropriateness of care and medical necessity, the UM company uses guidelines and criteria published by nationally recognized organizations, along with medical judgement of licensed health care professionals.

Delivery of Services

You are entitled to receive medically necessary medical care and services as specified in this Plan's ~~Schedule of Medical Benefits~~Schedule of Benefits. These include medical, mental health, behavioral health, surgical, diagnostic, therapeutic, and preventive services. If a precertification is required and you do not obtain the required precertification, the service may not be covered, even if the service is medically necessary. These services, although not an all-inclusive are those that generally:

- Are provided In-Network and Out-of-Network,
- Are performed or ordered by a participating provider,
- Require a precertification according to the utilization management and quality assurance protocols, if applicable.

Concurrent Review

Concurrent Review (continued stay) is the ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or skilled nursing or sub-acute facility. When you are receiving medical services in a hospital or other inpatient facility, the UM company monitors your stay by contacting your physician or other providers to assure that continuation of medical services in the facility is medically necessary. The UM company will also help coordinate your medical care with other healthcare benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services, and or advising your physician or other providers of various options and alternatives for your medical care available under this Plan.

If at any point, your stay is found not to be medically necessary and care could be safely and effectively delivered in another environment (such as through home health care or in another type of health care facility), you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, expenses incurred after the notification will be your responsibility. If your hospital stay is determined not to be medically necessary, no benefits will be paid on any related hospital, medical or surgical expense. You may also appeal the determination (refer to the *Appealing a ~~UM~~Utilization Management* determination section).

Retrospective Review

Retrospective Review is the review of health care services after they have been provided to determine if those services were medically necessary. The Plan will pay benefits only for those

days or treatment that would have been authorized under the utilization management program; and case management: The process whereby the patient, the patient's family, physician, or other providers work together with the Plan Administrator or its designee under the guidance of the UM company to coordinate a quality, timely and cost-effective treatment plan.

Case Management

Case management is a voluntary process administered by the UM company. Its ~~medical~~ professionals work with the patient, the patient's family, caregivers, providers, the third-party claims administrator, and the Plan Administrator or its designee to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly and/or high-technology services, or when assistance is needed to guide the patient through a maze of potential providers. Case management is available for sickle cell disease and its variants, among other conditions (see NRS 695G.174, among other conditions). Case management is also available for a disability resulting from a mental health or substance use disorder diagnosis.

The case manager will work directly with your physician, hospital, and/or other provider to review proposed treatment plans and to assist in coordinating services and obtaining discounts from providers as needed. From time to time, the case manager may confer with your physician or other providers and may contact you or your family to assist in making plans for continued health care services or obtaining information to facilitate those services.

You, your family, or your physician may call the case manager at any time to ask questions, make suggestions or offer information. The case manager can be reached by calling the UM company at the telephone number shown in the *Participant Contact Guide* section or on the PEBP website at <https://pebp.nv.gov/www.pebp.state.nv.us>.

Precertification (Prior Authorization) Process

Precertification prior authorization review is a procedure administered by the UM company to assure health care services meet or exceed accepted standards of care. In certain cases, as set forth below, for a benefit to be covered, the UM company must approve and/or pre-certify the service. **If a precertification is required and you do not obtain the required precertification, the benefits may be reduced, even if the service is medically necessary.** The UM company uses nationally recognized guidelines and criteria as standard measurement tools to determine whether benefits are approved and/or pre-certified.

Precertification also includes the determination of whether the admission and length of stay in a hospital or skilled nursing or sub-acute facility, surgery or other health care services are medically necessary and if the location of service is high quality and lowest cost.

A precertification is required for referrals to physicians and providers for certain services. Benefits listed in this Plan may be subject to precertification requirements and concurrent or retrospective review depending upon the circumstances associated with the services. Refer to the Services Requiring Precertification section below for more information.

Failure to obtain precertification may result in your benefits being reduced or denied (see the *Failure to Follow Required Utilization Management Procedures* in this section).

Services Requiring Precertification (Prior Authorization)

Inpatient Admissions

- Acute inpatient or observation
- Long-Term Acute Care
- Rehabilitation
- Behavioral Health
- Transplant including ~~all~~ pre-transplant related expenses
- Skilled Nursing facility and sub-acute facility
- Residential Treatment Facility, ~~including outpatient partial hospitalization programs,~~ and partial residential treatment programs
- Hospice (inpatient/outpatient) exceeding six (6) months.
- Obstetric – (precertification only required if days exceed 48 hours for vaginal delivery or 96 hours for a C-section)
- Intraoperative Neuro Monitoring
- Surgeries to treat Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery

Outpatient and Physician – Surgery

When outpatient and physician surgery is performed at an In-Network, contracted ambulatory surgical center (ASC) by an In-Network, contracted physician, prior authorizations is not required.

However, when services are not performed at an In-Network, contracted ASC, procedures will require prior authorization. This is commonly referred to as Site of Service. Examples of services that require prior authorization include, but are not limited to:

- Back Surgeries and hardware related to surgery
- Total and remaining Hip and Knee Surgeries
- Biopsies (excluding skin, colonoscopy and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Frenectomy
- Oophorectomy, unilateral and bilateral
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Surgeries to treat Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery

- Sleep apnea related surgeries, limited to:
 - Radiofrequency ablation (Coblation, Somnoplasty)
 - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic) and reconstruction surgery
- Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Varicose vein surgery/sclerotherapy
- Any procedure deemed to be Experimental and/or Investigational (provider must indicate on the pre-certification request that the service/procedure is Experimental and/or Investigational and/or part of a clinical trial).
- Intraoperative Neuro Monitoring
- Prophylactic surgery

Outpatient and Physician – Diagnostic Services

- Advanced high-tech imaging services
 - Including, but not limited to, CT, PET, SPEC, ~~and~~ MRI, etc.
- Capsule endoscopy
- Genetic Testing including:
 - BRCA
 - Biomarker Testing (Assembly Bill 155 from the 82nd Legislative Session in 2023)

Outpatient and Physician – Continuing Care Services

- Applied Behavior Analysis (ABA) Therapy for Medical, Mental Health, and Substance Use Disorder
- ~~Dialysis~~
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Chemotherapy
 - Oral Chemotherapy to be reviewed by Pharmacy Benefit Manager
- Radiation Therapy
- Oncology and transplant related injections, infusions, and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric Oxygen
- Home Health Care
- Durable Medical Equipment exceeding \$1,000
 - prior authorization is based on overall cost to the plan and/or purchase price, not the amount billed for monthly rental. DME rental to purchase in accordance with Medicare guidelines.
- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables and infusions excluding services reviewed by the PBM

- ~~Behavioral Health~~ Intensive Outpatient Programs, including partial hospitalization programs
- Sickle Cell Disease
- Vein Therapy
- Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a combined-visit limit of 90 visits between the types of therapy per Plan Year.
 - Visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder.

Services Not Requiring Precertification (Prior Authorization)

Prior authorization is not required for medically necessary emergency services when a medical condition that manifests itself by symptoms of such severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the participant.
- Serious jeopardy to the health of an unborn child.
- Serious impairment of a bodily function; or
- Serious dysfunction of any bodily organ or part.

The UM company must be notified of an emergency hospital admission within one business day so the UM company can conduct a *concurrent review*. Your physician or the hospital should call the UM company to initiate the concurrent review. Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding UM, such as concurrent review.

How to Request Precertification (Prior Authorization)

It is your responsibility to ensure that precertification occurs when it is required by the Plan. Any penalty or denial of benefits for failure to obtain precertification is your responsibility, not the provider's. ~~You or your~~ Your physician must call the UM company at the telephone number shown in the *Participant Contact Guide* to request precertification. Calls for elective services should be made at least 15 calendar days before the expected date of service or may be subject to the benefit reduction listed in the *Utilization Management* section. The UM company will require the following information:

- The employer's name.
- Employee's name.
- Patient's name, address, phone number and Social Security Number or PEBP unique ID.
- Physician's name, phone number or address.
- The name of any hospital or outpatient facility or any other provider that will be providing services.
- The reason for the health care services or supplies; and
- The proposed date for performing the services or providing the supplies.

The UM company will review the information and provide a determination to you, your physician, the hospital or other provider, and the third-party claims administrator as to whether the proposed health care services have been determined to be medically necessary. Additionally, the UM company may approve medical necessity but not site of care. In these circumstances, the UM company will provide approved alternate locations to the caller. While industry and accreditation standards require a preauthorization determination within 15 calendar days for a non-urgent case, the UM company will usually respond to your physician or other provider by telephone within (5) five business days of receipt of the request. The determination will then be confirmed in writing.

If your hospital admission or medical service is determined not to be medically necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal (refer to the *Appealing a UM Determination* section).

Second Opinion

The utilization management company may authorize a second opinion upon your request in accordance with this Plan. Examples of instances where a second opinion may be appropriate include:

- Your physician has recommended a procedure and you are unsure whether the procedure is necessary or reasonable.
- You have questions about a diagnosis or plan or care for a condition that threatens substantial impairment or loss of life, or bodily functions.
- You are unclear about the clinical indications about your condition.
- A diagnosis is in doubt due to conflicting test results.
- Your physician is unable to diagnose your condition; and a treatment plan in progress is not improving your medical condition within a reasonable period.

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in Services Requiring Precertification (Prior Authorization).

2nd.MD

2nd.MD is PEBP's preferred second opinion Service. See benefits in the Schedule of Benefits, below, for additional information.

Hospital Admission

You are responsible for ensuring the UM company is notified at least 5 (five) business days before an inpatient admission to obtain pre-certification.

Your physician or other provider may notify the UM company, but it is ultimately your responsibility to make sure they are notified. The UM company will review the physician/provider's recommendation and treatment plan to determine the level of care and place of service. If the UM company denies the precertification for hospital admission as not covered or they determine that the services do not meet the UM company's medical necessity

criteria, the Plan's third-party administrator will only pay benefits for inpatient that has been pre-certified.

You are required to obtain a precertification before you obtain services for inpatient elective surgeries. If you do not follow the required UM process, benefits for the elective surgeries may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network surgery expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum, if applicable.

Emergency and Urgent Hospital Admission

This Emergency and Urgent Hospital Admissions includes complications of pregnancy.

You are not required to obtain a precertification before you obtain services for a medical emergency. However, the UM company must still be notified within 24 hours, the next business day, or as soon as reasonable after admission so the UM company can conduct a concurrent review. If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times, they must receive notification as soon as reasonably possible after the admission or you may be subject to reduction or denial of benefits as provided by the Plan.

- **Emergency Hospital Admission:** Admission for hospital confinement that results from a sudden and unexpected onset of a condition that requires medical or surgical care. In the absence of such care, you could reasonably be expected to suffer serious bodily injury or death. Examples of emergency hospital admission include, but are not limited to, admissions, for heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal injuries, and other acute conditions.
- **An urgent hospital admission** means an admission for a medical condition resulting from injury or serious illness that is less severe than an emergency hospital admission but requires care within a short time, including complications of pregnancy.

Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding utilization management, such as concurrent review.

If you do not follow the required UM process, benefits payable for the services may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network medical expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum.

Confinement in an Out-of-Network Hospital Following an Emergency Admission

Please refer to the No Surprises Act section of this document for claims subject to that Act. For all other confinements, if you are confined in an Out-of-Network hospital after you receive emergency services, the UM company must be notified within 24 hours, the next business day, or as soon as reasonable after admission. The UM company may determine it is appropriate to

transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the UM company decides a transfer is medically appropriate, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service.

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the Eligible Medical Expenses at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge.

Elective Knee and Hip Joint Replacement – Nevada Exclusive Hospitals and Outpatient Surgery Centers

Precertification is required; the UM company will review the request based on surgery type, medical necessity, covered benefits, provider quality, cost, and provider location.

Due to cost variations for elective knee and hip joint replacement performed in Nevada, the third-party claims administrator has identified exclusive providers who meet the Plan's cost threshold for routine knee and hip replacement procedures. The exclusive provider list can be found on the PEBP website.

If you choose a provider on the exclusive list, you will potentially reduce your out-of-pocket costs in accordance with the standard plan benefits.

However, if you choose to use a non-exclusive provider, the Plan will pay benefits in accordance with its cost threshold or Maximum Allowable Charge. You may be subject to balance billing for any amount exceeding this Plan's cost threshold. Amounts exceeding the Plan's established threshold will not apply to your Deductible (if applicable) or Out-of-Pocket Maximum.

Inpatient or Outpatient Surgery

You are responsible for ensuring that the UM company is notified at least 5 (five) business days before elective inpatient or outpatient surgery is performed to ensure that it is covered.

Your physician or other provider may notify the UM company, but it is your responsibility to make sure they are notified. The UM company will review the physician's recommended course of treatment to ensure the requested treatment meets established medical necessity criteria and protocols.

The claims administrator will only pay benefits for inpatient or outpatient surgery that is pre-certified, and the services/supplies are a covered benefit.

Outpatient Infusion Services

Precertification is required for outpatient infusion services. The UM company will review the request based on covered benefits, medical necessity, provider quality, cost, and location. If you choose to receive your infusion at a non-exclusive hospital or infusion center, you will be responsible for any amount that exceeds this Plan's Maximum Allowable Charge. Amounts exceeding this Plan's established cost threshold will not apply to your annual Deductible or Out-of-Pocket Maximum.

Air Ambulance Services

This Plan provides coverage for emergency air ambulance and inter-facility patient air transport if there is a life-threatening situation, or the service is deemed medically necessary by the UM company. The air ambulance services are subject to cost-share (Deductible, Copay, or Coinsurance) if applicable, then the Plan will pay the lower of the PPO allowable for In-Network air ambulance providers, or for Out-of-Network providers, the Plan will pay up to the Recognized Amount.

See the Utilization Management section for air ambulance precertification requirements.

Air/Flight Schedule Inter-Facility Transfer

All inter-facility transport services require precertification. The UM company may discuss with the physician and/or hospital/facility the diagnosis and the need for inter-facility patient transport versus alternatives. Failure to obtain a precertification may result in a reduction or denial of benefits for charges arising from or related to flight-based inter-facility transfers. Non-compliance penalties imposed for failure to obtain a precertification will not be included as part of the annual out-of-pocket maximum.

Inter-facility transport may occur if there is a life-threatening situation, or if the transport is deemed medically necessary. The following conditions apply:

- Services via any form of air/flight for inter-facility transfers must be pre-certified before transport of the participant to another hospital or facility, and the participant is in a hospital or other health care facility under the care or supervision of a licensed health care provider; and
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

Emergency Air Ambulance

This Plan provides coverage for emergency air ambulance transportation for participants whose medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness/injury. Air ambulance transportation must meet the following criteria:

- Services via any form of air/flight for emergency air ambulance; and

- The patient's destination is an acute care hospital; and
- The patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health; or
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

See *Air Ambulance Services* and the No Surprises Act for details on plan benefits and coverage.

Gender Dysphoria

The participant or their physician must contact the UM company to begin the process toward surgical intervention ~~of~~ to treat gender dysphoria. The initial contact will include:

- Notification to the participant that the precertification process begins with the initial contact to the UM company.
- Advising participants of providers who specialize in this type of treatment.

This service is provided by the UM company and will be initiated upon the first call for a precertification. Case management services are particularly helpful for a participant or their covered dependent who is receiving complex medical services for medical conditions such as gender dysphoria. Your assigned case manager nurse will provide you with assistance addressing any concerns you may have about issues such as continuity of care or finding providers or a provider who specializes in gender dysphoria.

In accordance with [Senate Bill 163](#) from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include [consideration of the most](#) recent ~~Standards of Care~~ published by the World Professional Association for Transgender Health, or its successor organization.

Health Care Services and Supplies Review

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in *Services Requiring Precertification (Prior Authorization)*.

Non-participating providers may not know the UM company to obtain precertification for services. In such a case, you must confirm that the UM company pre-certified the service to assure that it is covered.

The Plan will pay for covered health care services and supplies only if authorized as outlined above. The Plan will not pay for any health care services or supplies that are not covered services or do not meet medically necessary criteria and protocols.

Failure to Follow Required UM Procedures

If you do not follow the required precertification review process described in this section, benefits payable for the services you failed to receive a precertification may be reduced by 50% of the Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network *Eligible Medical Expenses*. Expenses related to the penalty will not apply to your Plan Year Deductible or Out-of-Pocket Maximum. If you wish to appeal a decision made by the UM company, refer to the *Appealing a UM Determination* section.

~~Schedule of Medical Benefits~~ Schedule of Benefits

The ~~Schedule of Medical Benefits~~ Schedule of Benefits provides a description of benefits, including certain limitations under this Plan. Covered services must be medically necessary and are subject to exclusions and limitations as described herein. Precertification is required for many services. ~~P~~Plan benefit limitations apply to certain benefit categories, and out-of-network charges are not covered unless otherwise specified in this document.

When the Plan Administrator determines that two or more courses of treatment are substantially equivalent, the Plan Administrator reserves the right to substitute less costly services or benefits for those that this Plan would otherwise cover.

Example: If both inpatient care in a skilled nursing facility and intermittent, part-time nursing care in the home would be medically appropriate, and if inpatient nursing care would be less costly, this Plan could limit coverage to the inpatient care. This Plan could limit coverage to inpatient care even if this means extending the inpatient benefit beyond the quantity provided in the ~~Schedule of Medical Benefits~~ Schedule of Benefits.

The fact that a participating provider prescribed, ordered, recommended, or approved a service, treatment, or supply does not necessarily make it a covered service or medically necessary.

The ~~Schedule of Medical Benefits~~ Schedule of Benefits should be read in conjunction with the *Benefit Limitations and Exclusions* and *Key Definitions Terms and Definitions*. ~~†~~†The Explanations and Limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any precertification requirements), *Exclusions*, *Key Terms and Definitions* and other sections that may apply to a specific benefit.

All claims must be submitted within twelve (12) months of the date of service to be considered for payment.

The following services are covered services when provided by a professional.

Benefit Description	In-Network	Out-of-Network
Acupuncture and Acupressure	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Acupuncture and Acupressure - Covered if performed by a licensed provider acting within the scope of their license. - Supporting documentation establishing medical necessity will be required after 20 visits in a Plan Year. - Maintenance services are not a covered benefit.		
Allergy Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible, or 110% of the Medi-Span Average Wholesale Price (AWP) after Plan Year Deductible
Explanations and Limitations Allergy Services - Allergy services are covered only when ordered by a physician. - Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast; Desensitization and hypo-sensitization (allergy shots given at periodic intervals); Allergy antigen solution.		

Benefit Description	In-Network	Out-of-Network
Ambulance		
Ground Ambulance	Plan pays 80% after Plan Year Deductible	Plan pays 80% of Maximum Allowable Charge after Plan Year Deductible
Air Ambulance	Plan pays 80% after Deductible	Plan pays 80%, subject to the No Surprises Act.
Explanations and Limitations Ground and Air Ambulance Services		

Benefit Description	In-Network	Out-of-Network
Ambulance Ground Ambulance Services: In the event of a life-threatening emergency in which a participant uses an Out-of-Network provider, benefits will be paid at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge. Out-of-Network providers do not have a contract with this Plan's provider network and may balance bill the member for any amounts exceeding the Plan's Maximum Allowable Charge as defined in the section. Air Ambulance Services: In the event of a life-threatening emergency in which a participant uses an Out-of-Network provider, benefits will be paid at the In-Network benefit level. Out-of-Network providers do not have a contract with this Plan's provider network and may not balance bill the member. Transportation by a professional ground ambulance to a local hospital or transfer to the nearest facility having the capability to treat the condition. Air Ambulance (fixed wing/rotary) Inter-Facility Transfer • Inter-facility patient air transport, for participants if there is a life-threatening situation or it is deemed to be medically necessary. • Air ambulance for scheduled inter-facility transfers must be prior authorized before transport via any form of flight (fixed wing/rotary) to another hospital or facility. ○ Failure to obtain a precertification may, at the discretion of the Plan Administrator or its designee, result in a reduction or denial of benefits for charges arising from or related to inter-facility patient transport via any form of flight. ○ Non-compliance penalties imposed for failure to obtain precertification will not apply to the Plan Year Deductible or Out-of-Pocket Maximum. ○ As part of the precertification review, the Plan Administrator retains the discretionary authority to limit benefit availability to alternative providers of flight-based inter-facility patient transport if a provider fails to comply with the terms of the Plan, or the proposed charges exceed the maximum allowable charge in accordance with the terms of this Plan. Air Ambulance (fixed wing/rotary) Emergency • Includes coverage for emergency air ambulance transportation when a medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness/injury. • Emergency air ambulance services must meet the following criteria: ○ The patient's destination is an acute care hospital, and ○ The Patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health, or ○ Inaccessibility to ground transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient. • The Plan Administrator retains the discretionary authority to limit benefit availability for air emergency ambulance and/or inter-facility patient transfer when a provider fails to comply with the terms of this Plan, except where provided by the No Surprises Act. See the <i>Utilization Management</i> section for air ambulance precertification requirements.		

Benefit Description	In-Network	Out-of-Network
Autism Spectrum Disorders Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Autism Spectrum Disorders Services		
The Plan provides benefits for autism spectrum disorders in accordance with NRS 695G.1645, including coverage of screening for and diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders for covered individuals. ~~Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription drug care, psychiatric care, psychological care, behavioral therapy, or therapeutic care that is:~~ ~~Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and~~ ~~Provided for a person diagnosed with an autism spectrum disorder by a licensed psychologist, licensed behavior analyst or other provider that is acting within the scope of their license.~~ -Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services. ~~Terms in the Autism Spectrum Disorders section of NRS have the definitions assigned to them in NRS 695G.1645 and not necessarily the definitions in this MPD.~~		

Benefit Description	In-Network	Out-of-Network
Bariatric/Weight Loss Surgery	Plan pays 80% after Plan Year Deductible	Not Covered
Explanation and Limitations Bariatric/Weight Loss Surgery		
Bariatric weight loss surgery benefits, pre-and post-surgery, are available only when performed at an In-Network Bariatric Surgery Center of Excellence facility, by an In-Network surgeon and ancillary providers. The third-party claims administrator will determine the In-Network Bariatric Surgery Center of Excellence facility. It is the participant's responsibility to ensure that bariatric surgery services providers are In-Network and facilities chosen to provide services are In-Network. Participants can verify the		

Benefit Description	In-Network	Out-of-Network
Bariatric/Weight Loss Surgery	Plan pays 80% after Plan Year Deductible	Not Covered
Explanation and Limitations Bariatric/Weight Loss Surgery network status of any provider, including a facility, by calling the third-party claims administrator. For more information regarding Bariatric Surgery Centers of Excellence, see the <i>Key Terms and Definitions</i>. Participants are limited to one obesity related surgical procedure of any type in an individual's lifetime while covered under any PEBP-sponsored self-funded plan. For example, a participant cannot have lap band surgery on a PEBP-sponsored self-funded plan and then subsequently seek benefits for gastric bypass on this Plan. If a participant has started any type of program to meet the pre-surgery criteria outlined below with an Out-of-Network provider (including a facility), those services will not meet the Plan's mandatory precertification requirements. For the Plan to consider your bariatric surgery at the In-Network benefit level; you will have to begin the precertification process again with the appropriate In-Network providers. For lap band adjustments, the Plan will consider any adjustments made in the immediate 12 months following surgery if the participant remains compliant with their post-surgical support group meetings as verified by the UM company. Any adjustments to the lap band after the first 12 months post-surgery will be subject to precertification. Clinical criteria for weight loss surgeries is managed by the UM Company Travel Expenses: This Plan provides reimbursement of certain costs associated with travel and ~~hotel~~ <u>lodging</u> accommodations for the member and one additional person (spouse/domestic partner, family member or friend) when associated with bariatric/weight loss surgery and performed at a Center of Excellence that is located 50 or more miles from the member's residence. For travel expense benefits, refer to the <i>Travel Expenses</i> benefit section. Expenses incurred for travel and <u>lodging</u> ~~hotel~~ accommodations for bariatric/weight loss surgery not performed at a Center of Excellence are not covered.		

Benefit Description	In-Network	Out-of-Network
<i>Behavioral Health Services</i> Mental Health and Substance Abuse	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Behavioral Health Services Precertification is required for inpatient admissions, including residential treatment facilities, outpatient partial hospitalization programs, and partial residential treatment programs. Services and supplies for treatment of alcoholism, chemical dependency or drug addiction are covered. ~~Treatment must have a physician's order, include a treatment, and discharge plan.~~ Care must be provided by licensed/credentialed providers—such as hospitals or residential treatment programs for inpatient care, and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care. Behavioral health services payable by this Plan include: • Outpatient visits • Acute inpatient admission • Partial day treatment • Partial hospitalization • Intensive outpatient program • Day treatment • Psychological testing • Detoxification The following behavioral health practitioners are payable under the Plan: psychiatrist (MD or DO), psychologist (Ph.D.), Masters' prepared counselors (e.g., MSW), licensed associate in social work, social worker, independent social worker, or clinical social worker, as well as any licensed provider providing covered services and acting within the scope of their license. The Plan provides benefits for intermediate levels of care for behavioral health disorders and/or chemical dependency disorders in parity with medical or surgical care of the same level. If the Plan provides benefits for a skilled nursing facility for medical or surgical treatment, the Plan will provide equal behavioral health disorder and/or chemical dependency disorder benefits for intensive outpatient therapy, partial hospitalization, residential treatment, inpatient treatment. The provider must be licensed or approved by the state in which the services are provided. Care must be provided by licensed, eligible providers—such as hospitals or residential treatment programs for inpatient care and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care. Precertification is required for inpatient and outpatient care in a facility.		

Benefit Description	In-Network	Out-of-Network
<i>Behavioral Health Services</i> Mental Health and Substance Abuse	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Behavioral Health Services Outpatient prescription drugs for behavioral health <u>are</u> payable under the prescription drug benefits. For information regarding precertification requirements, benefits, and exclusions, refer to the <i>Utilization Management, Key Terms and Definitions, and Exclusions</i> sections.		

Benefit Description	In-Network	Out-of-Network
<i>Blood Services for Surgery</i>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Blood Transfusions • Blood transfusions, blood products and equipment for its administration. • Services are covered only when ordered by a physician. • Expenses related to autologous blood donation (patient's own blood) are covered.		

Benefit Description	In-Network	Out-of-Network
<i>Chemotherapy</i>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge or 110% of the Medi Span AWP, after Plan Year Deductible
Explanations and Limitations Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a physician in a hospital, health care facility, physician's office or at home. Covered when ordered by a physician; chemotherapy must be pre-certified by the UM company. • See prescription benefits for orally administered chemotherapy drugs: • Patients undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year (excluding sales tax).		

Benefit Description	In-Network	Out-of-Network
Chiropractic Services Office visit and spinal manipulation services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Chiropractic Services • Services are covered if performed by a licensed provider acting within the scope of their license. • Limited to a maximum of 20 visits per Plan Year. • Maintenance services are not a covered benefit. X-rays performed in conjunction with chiropractic services are payable under the Radiology Services section of this ~~Schedule of Medical Benefits~~<u>Schedule of Benefits</u>.		

Benefit Description	In-Network	Out-of-Network
Clinical Trials	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Clinical Trials A clinical trial is the process for testing new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases. • <u>Coverage for certain treatment received as part of a clinical trial or study for treatment of cancer or chronic fatigue syndrome will be provided subject to the requirements and limitations set forth in NRS 695G.173.</u>~~The routine medical treatment costs, including items and services that are otherwise generally available to Plan participants, received as part of a clinical trial or study, may be covered under NRS 695G.173.~~ • Precertification must be obtained from the UM company.		

Benefit Description	In-Network	Out-of-Network
Corrective Appliances		
Prosthetic & Orthotic Devices, other than dental	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
*Hearing Aids	~~Plan pays 80% after Plan Year Deductible (maximum benefit \$1,500 per device, per each ear)~~	~~Plan pays 50% after Plan Year Deductible (maximum benefit \$1,500 per device, per each ear)~~
Explanations and Limitations Corrective Appliances and Hearing Aids - Coverage is provided for certain corrective appliances that are medically necessary and FDA approved. This Plan pays for the purchase of standard models at the option of the Plan. <u>There is coverage for</u> ~~R~~repair, adjustment, or servicing of the device or, replacement of the device due to a change in the covered person's physical condition that makes the original device no longer functional or if the device cannot be satisfactorily repaired. - Prosthetics such as limbs and ocular; orthotics such as casts, splints and other orthotic devices used in the reduction of fractures and dislocations; colostomy or ostomy (Orthotic) supplies, hearing aid* (with limitations). - Plan allows up to \$120 for one set of lenses (contacts or frame-type) for the treatment of glaucoma or when required following cataract surgery. <u>This includes</u> ~~S~~soft lenses or sclera shells intended as corneal bandages for patients without the lens of the eye (aphakic). Corrective appliances are covered only when ordered by a physician or health care practitioner. Orthopedic shoes and foot orthotics are not a covered benefit unless the shoe or foot orthotic is permanently attached to a brace. *Hearing aids: ~~Air conduction hearing aids are considered medically necessary when one or more of the following hearing loss criteria are met in either or both ears:~~ ~~Hearing thresholds 40 dB HL or greater at two or more of these frequencies: 500, 1000, 2000, 3000, 4000 Hz; or~~ ~~Hearing thresholds 26 dB HL or greater at three of these frequencies; or~~ ~~For high frequency hearing loss, defined as loss occurring only above 2000 Hz: a. Hearing thresholds of 26 dB HL or greater at three or more of these frequencies: 2000, 3000, 4000, 6000 or 8000 Hz~~ ~~Speech recognition is less than 80 percent in either or both ears regardless of hearing threshold level.~~ ~~Participants who meet the above hearing loss criteria: Each air conduction hearing aid is subject to Deductible, then the Plan pays 80% up to a maximum benefit of \$1,500 per device, per device, per each ear, every three years.~~		

Benefit Description	In-Network	Out-of-Network
Corrective Appliances		
Prosthetic & Orthotic Devices, other than dental	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
*Hearing Aids	~~Plan pays 80% after Plan Year Deductible (maximum benefit \$1,500 per device, per each ear)~~	~~Plan pays 50% after Plan Year Deductible (maximum benefit \$1,500 per device, per each ear)~~
Explanations and Limitations Corrective Appliances and Hearing Aids ~~Participants may submit a copy of their hearing aid payment receipt from the hearing aid provider to the third party claims administrator to request reimbursement for the hearing aid benefit, less applicable copayment(s), and to receive credit towards the Out of Pocket Maximum.~~ To help determine what prosthetic or orthotic appliances are covered, see the definitions of “Prosthetics” and “Orthotics” in the <i>Key Terms and Definitions</i> section. ~~Over the Counter hearing aids are excluded from plan benefits.~~		

Benefit Description	In-Network		Out-of-Network
Diabetes Care Management Disease Program (DCM) (Enhanced Benefits)*			
Office Visits	Two office visits covered at 100% per Plan Year, not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Laboratory Test (must be performed using a free-standing non-hospital-based laboratory)	Two routine lab tests covered at 100% per Plan Year, not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
	Preferred Retail Network Retail 30-Day Supply	Smart90 Retail or ESI Home Delivery 90-Day Supply	
Preferred Generic	\$5 Copay	\$15 Copay	Not covered
Preferred Brand	\$25 Copay	\$75 Copay	Not covered
Non-Preferred Brand	100% copay		Not covered
Diabetic Supplies (test strips, insulin syringes, alcohol pads, and lancets)	ESI Home Delivery Pharmacy: 90-Day Supply \$50 Copay per supply item or the lessor of actual cost		Not covered
Blood Glucose Monitor	ESI Home Delivery: \$0 Copay (limited to one per Plan Year)		Not covered
Explanations and Limitations			
Diabetes Care Management Disease program (enhanced benefits)			
The Diabetes Care Management (DCM) program is a voluntary opt-in disease management program that provides enhanced benefits to participants diagnosed with diabetes, and who are enrolled in and actively engaged in the program. Benefits provided under the DCM program are not subject to deductible if determined to be preventive under the ACA and IRS guidelines. To enroll:			
- Obtain the DCM form by logging into the E-PEBP Portal at www.pebp.state.nv.ushttps://pebp.nv.gov/, or contact the third-party claims administrator to request the DCM enrollment form. Complete the required information and have your physician sign the form. Send the form to the third-party claims administrator for processing. - The effective date of the DCM program will begin on the first day of the month following the third-party claims administrator's receipt and processing of the DCM enrollment request. - Annually, To continue receiving the DCM enhanced benefits for the next plan year, a new DCM form must be completed annually, at the start of, or prior to, the new plan year. This form must			

Benefit Description	In-Network	Out-of-Network
Diabetes Care Management Disease Program (DCM) (Enhanced Benefits)* be—signed by both you and your physician, and submitted to the third-party claims' administrator for processing. Enrolled DCM participants must comply with the following requirements to receive the enhanced benefits: • Complete two office visits each Plan Year for a primary diagnosis of diabetes with your primary care physician or endocrinologist. • Comply with the diabetes medications as prescribed by your physician. • Complete the appropriate laboratory testing as ordered by your physician. • Must remain compliant with your physician's prescribed treatment plan in the Diabetes Care Management program. Enhanced In-Network benefits in the DCM Program include: • Two physician office visits per Plan Year are paid at the 100% benefit level when billed with a primary diagnosis of diabetes (additional office visits are subject to deductible and coinsurance). • Two routine laboratory hemoglobin (A1c) blood tests are paid at the 100% benefit level per Plan Year (additional lab services are subject to deductible and coinsurance). • Diabetes-related medications, such as insulin and Metformin, are eligible for copayments listed in the DCM Pharmacy Benefits and not be subject to the Plan Year Deductible. • One glucose monitor, per Plan Year at \$0 copayment available through the Pharmacy Benefit Manager. • Diabetic supplies including test strips, lancets, insulin syringes and alcohol pads are eligible for purchase for the lessor of a \$50 copay per 90-day supply item, or the cost of the item, when coordinated through the Pharmacy Benefit Manager's Home Delivery program. • Copayments for Tier 1 (Generic) and Tier 2 (Preferred Brand) drugs apply to the Plan Year Deductible and Out-of-Pocket Maximum. • Copayments made while enrolled in the DCM program apply to the Plan Year Deductible and Out of Pocket Maximum.  Laboratory services must be performed at an independent (non-hospital-based laboratory) to be covered by this Plan. Refer to the Laboratories services in the ~~Schedule of Medical Benefits~~<u>Schedule of Benefits</u>. Other limitations: • Diabetes Medications: Preferred Retail Network Pharmacies, Smart90 Retail, and Express Scripts Home Delivery Program requirements apply. Refer to the <i>Schedule of Prescription Drug Benefits</i> for coverage limitations, cost implications and details regarding these programs. • Participants who are not enrolled or non-compliant in the DCM Program receive the standard CDHP benefits. The effective date of the return to the standard CDHP benefits will be the first day of the month following the non-compliance determination by the third-party claims administrator.		

Benefit Description	In-Network	Out-of-Network
Diabetes Care Management Disease Program (DCM) (Enhanced Benefits)*		
- Specialty medications are not eligible for enhanced benefits under this program and are subject to the standard CDHP benefits. - This Plan does not coordinate prescription drug benefits. - Medications purchased at Out-of-Network pharmacies are not covered under this Plan.		
Diabetes Education Services	This Plan pays 80% after Plan Year Deductible	Not Covered
Explanations and Limitations Diabetes Education Services - Diabetes training and education services are payable when requested by a physician and are medically necessary for the self-care and self-management of a person with diabetes. Services must be provided by a certified diabetes educator or a health care practitioner. Included in this benefit is retraining due to new techniques for the treatment of diabetes or when there has been a significant change in the person's clinical condition or symptoms that requires modification of self-management techniques. - Some diabetic supplies are payable under the <i>Prescription Drug</i> section of this document. Please contact the prescription drug Plan Administrator for more information. - This Plan pays enhanced benefits for participants enrolled in and actively engaged in the Diabetes Care Management (DCM). For information regarding the DCM program and the enhanced benefits, refer to the Disease Management section and to the ~~Schedule of Medical Benefits~~<u>Schedule of Benefits</u> for the Diabetes Care Management Program.		

Benefit Description	In-Network	Out-of-Network
Dialysis	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Dialysis • Hemodialysis or peritoneal dialysis and supplies. • Covered when ordered by a physician and administered in a hospital, health care facility, and physician's office or at home. Outpatient, inpatient or home dialysis must be prior authorized by PEBP's utilization management company. • See the <i>Utilization Management</i> information.		
Benefit Description	In-Network	Out-of-Network
Durable Medical Equipment (DME)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Durable Medical Equipment (DME) • DME requires precertification by the UM company when the cost is expected to exceed \$1,000. • Rental of DME ~~to~~ <u>will be subject to cover</u> Medicare guidelines concerning rental to purchase criteria. • Repair or maintenance of standard models at the option of the Plan to include equipment maintenance agreements. ○ Repair, adjustment or servicing or medically necessary replacement of the DME due to a change in the covered person's physical condition, or if the equipment cannot be satisfactorily repaired. • DME, including but not limited to, insulin pumps, insulin supplies, oxygen, equipment, and supplies required for its administration, is covered only when its use is medically necessary, and it is ordered by a physician or health care practitioner. • Certain blood glucose monitors are covered under this Plan. In-Network, the Plan pays 80% after the Plan Year Deductible. • Participants enrolled in and actively engaged in the Diabetes Care Management Program are eligible to receive one glucose monitor each Plan Year at no cost in accordance with the DCM Program requirements, refer to the <i>Diabetes Care Management Disease Program (DCM) (Enhanced Benefits)</i> * pumps are eligible for purchase and must be prior authorized by the UM company.		

Benefit Description	In-Network	Out-of-Network
Rental to purchase following Medicare guidelines for certain lifelong DME. Examples of lifelong durable medical equipment include, but are not limited to, CPAP and BiPAP machines, and electric wheelchairs. Please check with PEBP's third-party claims administrator or utilization management company for assistance. Contact the third-party claims administrator for the purchase of certain DME such as breast pumps. See the <i>Exclusions</i> section related to corrective appliances and durable medical equipment. To help determine what durable medical equipment is covered, see the definition of "Durable Medical Equipment" in <i>Key Terms and Definitions</i>, below.		
Benefit Description	In-Network	Out-of-Network
No Surprises Act		
Emergency Room	Plan pays 80% after Plan Year Deductible	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible, subject to the No Surprises Act.
Urgent Care Services	Plan pays 80% after Plan Year Deductible	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Emergent and Urgent Care Services The federal No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from a Non-PPO provider at an in-network facility. Beneficiaries receiving these services will only be responsible for paying their in-network cost sharing and cannot be balance billed by the provider or facility for emergency services. Emergency Services Emergency Services are covered: - Without the need for a prior authorization determination, even if the services are provided out-of-network; - Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility, as applicable, with respect to the services; - Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities; - Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO provider or a PPO emergency facility;		

Benefit Description	In-Network	Out-of-Network
By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by a PPO provider or a PPO emergency facility. Your cost sharing amount for Emergency Services from Non-PPO Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount (QPA). <i>* <u>In addition to the No Surprises Act, the Plan complies with the requirements of NRS 695G.170 with respect to coverage for medically necessary emergency services at any hospital</u>~~see also NRS 695G.170 for medically necessary emergency services at any hospital in Nevada.~~</i> <i>Post Stabilization Services</i> Emergency Services furnished by a Non-PPO Provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until: - The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; and - The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed; and - The participant or beneficiary gives informed consent to continued treatment by the nonparticipating provider, acknowledging that the participant or beneficiary understands that continued treatment by the nonparticipating provider may result in greater cost to the participant or beneficiary. <i>Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility</i> With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-PPO provider at a PPO facility, the items or services are covered by the plan: - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,		

Benefit Description	In-Network	Out-of-Network
By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such Non-PPO provider were equal to the Recognized Amount for the items and services. By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a PPO provider, Non-emergency items or services performed by a Non-PPO provider at a PPO facility will be covered based your out-of-network coverage if: ○ At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and ○ The participant or dependent gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary. The notice and consent exception does not apply to Ancillary services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-PPO provider satisfied the notice and consent criteria, and therefore these services will be covered: ○ With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider, ○ With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and ○ With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a PPO provider. Your cost sharing amount for Non-emergency Services at PPO Facilities by Non-PPO Providers will be based on the lessor of billed charges from the provider or the Qualifying Payment Amount.		

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from a non-PPO provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from a Non-PPO provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a PPO provider.
- In general, you cannot be balance-billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a PPO provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your Network (PPO) deductible and Network (PPO) out-of-pocket maximum in the same manner as those received from a PPO provider.

Payments to non-PPO Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services. Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-PPO provider. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the non-PPO provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a non-PPO provider at a PPO facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review. Please see the External Review procedures in the SPD for further information.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

- You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and

Benefit Description	In-Network	Out-of-Network
- You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider. Per NRS 695G.164, the Plan provides coverage for continued medical treatment for a medical condition from a provider of health care whose contract with the insurer is terminated during active medically necessary treatment. Unless excepted, this is until the later of: - The 120th day after the date the contract is terminated; or - If the medical condition is pregnancy, the 45th day after - The date of delivery; or - If the pregnancy does not end in delivery, the date of the end of the pregnancy. <i>Incorrect PPO Provider Information</i> A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf. If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.		

Benefit Description	In-Network	Out-of-Network
Enteral Formula and Special Food Product Inherited Metabolic Disease	Plan pays 80% after Plan Year Deductible; <u>with Maximum benefit limitationsbenefit \$2,500 per Plan Year for Special Food Products</u>	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; <u>with benefit limitationsMaximum benefit \$2,500 per Plan Year for Enteral Formula</u>
Explanations and Limitations Special Food Product and Enteral Formula for Inherited Metabolic Disease <u>or for Medically Necessary treatment of a mental health diagnosis.</u> Enteral Formulas and Special Food Products are covered in accordance with NRS 689B.0353. There is a \$2,500 maximum benefit per Plan Year for Special Food Products for the treatment of a person with inherited metabolic diseases. <u>The maximums will not apply to Medically Necessary treatment of a mental health disorder).</u> <u>Inherited metabolic diseases is characterized under NRS 689B.0353 as the following:</u> <u>deficient metabolism, or</u> <u>malabsorption originating from congenital defects, or</u>		

Benefit Description	In-Network	Out-of-Network
Enteral Formula and Special Food Product Inherited Metabolic Disease	Plan pays 80% after Plan Year Deductible; <u>with Maximum benefit limitationsbenefit \$2,500 per Plan Year for Special Food Products</u>	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; <u>with benefit limitationsMaximum benefit \$2,500 per Plan Year for Enteral Formula</u>
Explanations and Limitations Special Food Product and Enteral Formula for Inherited Metabolic Disease <u>or for Medically Necessary treatment of a mental health diagnosis.</u> <u>defects arising shortly after birth,</u> <u>for amino acid, organic acid, carbohydrate or fat.</u> Documentation to substantiate the presence of an inherited metabolic disease, including the documentation that the product purchased is a Special Food Product or Enteral Formula may be required before the Plan will reimburse for the cost associated with Special Food Products or Enteral Formulas.		

Benefit Description	In-Network	Out-of-Network
Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception - Only diagnostic procedures for fertility and infertility are payable for the employee and spouse/domestic partner. - Diagnostic procedures for fertility and infertility are subject to the Plan Year Deductible. - No coverage for the treatment of fertility or infertility. See the <i>Exclusions</i> section for drugs, medicines, and nutrition; fertility and infertility; maternity services; and sexual dysfunction services. - Procedures related to sexual dysfunction may be covered. See the <i>Exclusions</i> section of this document for more information. - Coverage is provided for vasectomies and tubal ligations. Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals are excluded. - Male surgical sterilization is subject to the Plan Year Deductible and Coinsurance. - Male contraception such as condoms are not covered under this Plan.		

Benefit Description	In-Network	Out-of-Network
Gender Dysphoria	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Treatment of Gender Dysphoria In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include consideration of the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization. This plan does not discriminate on the basis of gender identity or expression. Claim or coverage appeal shall include a consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment. The plan does not provide coverage cosmetic benefits as defined by Senate Bill 163. “Cosmetic Surgery” under the bill means: - Means a surgical procedure that: - Does not meaningfully promote the proper function of the body - Does not prevent or treat illness or disease; and - Is primarily directed at improving the appearance of a person. - This Includes, without limitation, cosmetic surgery directed at preserving beauty. Procedures, services, and supplies related to surgery and sex hormones associated with gender affirmation/confirmation should be reviewed by the UM company for medical necessity.		

Benefit Description	In-Network	Out-of-Network
Genetic Counseling/Testing	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Genetic Testing and Counseling Certain Genetic Testing and Counseling require precertification. Contact the UM company for precertification requirements for covered genetic testing. Benefits include amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), alpha-fetoprotein (AFP), BRCA1 and BRCA2, apo E. Amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in pregnant women only if the procedure is medically necessary		

Benefit Description	In-Network	Out-of-Network
Genetic Counseling/Testing	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Genetic Testing and Counseling as determined by the UM company. - Genetic counseling when provided before and/or after amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis. - BRCA1 and BRCA2 counseling for individuals already diagnosed with breast and/or ovarian cancer. - Apo E genetic test to help physicians identify those individuals at highest risk for heart disease and determine the most appropriate dietary and fitness program for the covered PEBP participant. - BRCA1 and BRCA2 genetic test - BRCA1 and BRCA 2 testing may be covered under the Preventive/Wellness benefit when indicated after genetic counseling in accordance with the USPSTF A & B recommendation. This list is not all-inclusive for what genetic tests may be covered. Contact the UM company for coverage details and precertification requirements for covered genetic testing. In accordance with Assembly Bill 155 from the 82nd Legislative Session in 2023, the Plan provides benefits for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence. See the <i>Key Terms and Definitions</i> and the <i>Exclusions</i> sections relating to genetic testing and counseling, including non-payment for pre-parental genetic testing.		

Benefit Description	In-Network	Out-of-Network
Hearing Aids	<u>Plan pays 80% after Plan Year Deductible (maximum benefit \$1,500 per device, per each ear)</u>	<u>Plan pays 50% after Plan Year Deductible (maximum benefit \$1,500 per device, per each ear)</u>
Explanations and Limitations Hearing Aids <u>Air conduction hearing aids are considered medically necessary when one or more of the following hearing loss criteria are met in either or both ears:</u> <u>• Hearing thresholds 40 dB HL or greater at two or more of these frequencies: 500, 1000, 2000, 3000, 4000 Hz; or</u> <u>• Hearing thresholds 26 dB HL or greater at three of these frequencies; or</u> <u>• For high frequency hearing loss, defined as loss occurring only above 2000 Hz: a. Hearing thresholds of 26 dB HL or greater at three or more of these frequencies: 2000, 3000, 4000, 6000 or 8000 Hz</u> <u>• Speech recognition is less than 80 percent in either or both ears regardless of hearing threshold level.</u> <u>Participants who meet the above hearing loss criteria: Each air conduction hearing aid is subject to Deductible, then the Plan pays 80% up to a maximum benefit of \$1,500 per device, per device, per each ear, every three years.</u> <u>Participants may submit a copy of their hearing aid payment receipt from the hearing aid provider to the third-party claims administrator to request reimbursement for the hearing aid benefit, less applicable copayment(s), and to receive credit towards the Out-of-Pocket Maximum.</u> <u>Over the Counter hearing aids are excluded from plan benefits.</u> <u>~~See Corrective Appliances, above.~~</u>		

Benefit Description	In-Network	Out-of-Network
Hinge Health	\$0; not subject to Deductible or Coinsurance	Not Covered
Explanations and Limitations Hinge Health Digital Musculoskeletal (MSK) Care program Hinge Health's Digital MSK Program is offered through the Pharmacy Benefit Manager and is designed to help members with Musculoskeletal Care using digital technology. The program offers qualifying participants virtual physical therapy focusing on prevention, acute injury, chronic and surgical care programs via digital physical therapy plus additional physical and behavioral support through a full clinical-care team. Members will also have access to other services, such as pelvic floor therapy, advanced wearable technology for electrical nerve stimulation and pain relief, expert medical opinion consultation, health education, etc. Members will complete a screener to assess which Digital MSK Clinic™ programs is right for them. The questionnaire screener leverages data analytics combined with a dedicated clinical care team review to match each member's personal needs with the right program tools and resources. This program is managed by Express Scripts and is provided at no cost to members.		

Benefit Description	In-Network	Out-of-Network
Home Health Care and Home Infusion Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; or for infusion drug services 110% of the Medi-Span AWP after Plan Year Deductible
Explanations and Limitations Home Health Care and Home Infusion Services • Home Health Care and Home Infusion requires precertification by the UM company. • Home health care and home infusion services are covered only when ordered by a physician or health care practitioner. • Benefits include part-time, intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion services, subject to maximum Plan benefits. • The maximum Plan benefit for home health care (skilled nursing care services) and supplies to provide home health care and home infusion services is 60 visits per person per Plan Year. Additional visits are subject to preauthorization by the UM Company. • A home health care visit will be considered a periodic visit by a nurse or therapist, or four (4) hours of home health services. • Charges are covered for private duty nursing by a licensed nurse (RN or LVN/LPN) only when care is medically necessary and not custodial in nature. Outpatient private duty nursing care on a 24-hour shift basis is not covered. • Outpatient private duty nursing care on a 24-hour shift basis and/or home services other than skilled		

Benefit Description	In-Network	Out-of-Network
Home Health Care and Home Infusion Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; or for infusion drug services 110% of the Medi-Span AWP after Plan Year Deductible
Explanations and Limitations Home Health Care and Home Infusion Services nursing care are not covered. • Home services other than skilled nursing care are not covered • See <i>Exclusions</i> section related to home health care and custodial care, including personal care and childcare.		

Benefit Description	In-Network	Out-of-Network
Hospice	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Hospice The hospice care program administers palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill patients. • The following hospice care services are covered for members with a terminally ill, limited life expectancy of six (6) months. Additional days would have to be preauthorized by the UM Company: Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week • Outpatient bereavement counseling services provided by a licensed ~~masters~~master's level clinician or a licensed pastoral care counselor for the patient's immediate family (covered spouse and or dependent children) provided as part of the hospice service. Bereavement counseling beyond that included as a part of the hospice program is payable under the Behavioral Health benefits of this Plan. For more information, see Hospice Care in the <i>Key Terms and Definitions</i> section. See Hospice Care in the <i>Key Terms and Definitions</i> section for additional information.		

Benefit Description	In-Network	Out-of-Network
Hospital Services (Inpatient)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Hospital Services (Inpatient) Elective hospitalization is subject to precertification. Hospitalization is subject to concurrent review. See the <i>Utilization Management</i> section for more information. - Room and board and facility fees in a semiprivate room with general nursing services; Specialty Care Units (e.g., intensive care unit, cardiac care unit); lab, x-ray, and diagnostic services; related medically necessary ancillary services (e.g., prescriptions, supplies). - Newborn care and circumcision. - Elective hospitalization is subject to precertification. All hospitalization is subject to concurrent review. See the <i>Utilization Management</i> section for more information. - Private room is payable at the semi-private rate unless it is determined that a private room is medically necessary, or the facility does not provide semi-private rooms. - Outpatient services with an observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement under this Plan. - Under the following circumstances, the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services: - Under the following circumstances, the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services. - Dental general anesthesia for an individual when services are rendered in a hospital or outpatient surgical facility, when the individual is being referred because in the opinion of the dentist, the individual: - Is under age 18 and has a physical, mental, or medically compromising condition; or - Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy; or - Patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient. - Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist. - No payment is extended toward the dentist or the assistant dental provider under this Plan. - No coverage for non-emergency hospital admission: No coverage for care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.		

Benefit Description	In-Network	Out-of-Network
Hospital Services (Inpatient)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Hospital Services (Inpatient) Inpatient private duty nursing by a licensed nurse (RN, LVN or LPN) is covered only when care is medically necessary and not custodial, and the hospital's intensive care unit is filled, or the hospital has no intensive care unit.		

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		
Free-standing lab facility Preferred non-hospital-based lab facilities: Lab Corp or Quest	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Outpatient hospital-based lab facility and hospital-based lab draw station Lab services for pre-admission testing, urgent care, and emergency room only	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Laboratory Outpatient Services - Outpatient lab services are covered when medically necessary, when ordered by a physician or health care practitioner, and when services are performed in accordance with the Laboratory Outpatient Services benefit described in this section.  Free-standing, non-hospital -based laboratory facility: The Plan covers outpatient routine and preventive lab services performed at free-standing, non-hospital-based lab facilities. Although there may be other in-network free-standing, non-hospital-based lab facilities in the network, the Plan's preferred facilities include Lab Corp and Quest. Routine and preventive lab services include: - Medically necessary routine labs when ordered by a physician or other licensed provider acting within the scope of his/her license as part of comprehensive medical care. - Preventive laboratory services such as but not limited to basic metabolic panel, lipid <u>panel</u>, ~~or general health panele~~<u>etc.</u> Refer to the <i>Preventive Care/Wellness Services</i> for information regarding benefits for screening tests and preventive lab testing. Outpatient hospital-based lab facilities and hospital-based lab draw stations: The Plan covers outpatient lab services for pre-admission testing when performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for		

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		
which admission or surgery is planned. - If a free-standing, non-hospital-based outpatient laboratory facility is not available within 50 miles of your residence, you may use a hospital-based laboratory facility or hospital-based draw station. - See the <i>Key Terms and Definitions</i> section for the definitions of <i>Free-standing Laboratory Facility</i> and <i>Outpatient Hospital-Based Laboratory</i> and <i>Outpatient Hospital-Based Laboratory Draw Station</i>.		

Benefit Description	In-Network	Out-of-Network
Mastectomy and Reconstructive Services and Breast Reconstruction after Mastectomy	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Reconstruction Services and Breast Reconstruction after Mastectomy This Plan complies with the Women’s Health and Cancer Rights Act of 1998 (WHCRA) Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. For any covered individual who is receiving mastectomy-related benefits, coverage will be provided for: - All stages of reconstruction of the breast on which the mastectomy has been performed. - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and - External prostheses that are needed before or during reconstruction; and - Treatment of physical complications of all stages of the mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery). Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy as mandated by the Women’s Health and Cancer Rights Act. Prophylactic surgery is covered when prior authorized by the UM company. See also the <i>Exclusions</i> sections related to cosmetic services including reconstructive surgery.		

Benefit Description	In-Network	Out-of-Network
Maternity and Newborn Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Maternity Services • This Plan covers hospital and birth (birthing) center charges and professional fees for medically necessary maternity services. • Prenatal and delivery is covered for an employee or spouse/domestic partner only. For covered dependent children, only prenatal coverage is provided for maternity, except for complications of pregnancy for the dependent child (see the definition of Complications of Pregnancy in the <i>Key Terms and Definitions</i> section of this document). • Some preventive prenatal services including, but not limited to, obstetrical office visits, breastfeeding support, screening for gestational diabetes, blood type and Rh lab services for spouses and dependent children may be covered under the preventive care benefit. The preventive benefit does not include delivery of the newborn(s). • Coverage for newly born and adopted children and children placed for adoption includes coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center. • Hospital length of stay for childbirth: This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the Plan or its UM Company for prescribing a length of stay not more than those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). • Elective termination of pregnancy is covered only when the attending physician certifies that the mother's health would be endangered if the fetus were carried to term. Termination of pregnancy - See the Genetic Testing section of this ~~Schedule of Medical Benefits~~<u>Schedule of Benefits</u>. • See Breastfeeding Support section for information and benefits related to this type of service. See the exclusions related to Maternity Services in the <i>Exclusions</i> section. • See the <i>Enrollment and Eligibility Master Plan Document</i> for information regarding how to enroll a newborn dependent child(ren). When the member has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days (NRS 689B.033). Individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.		

Benefit Description	In-Network	Out-of-Network
Nondurable Supplies	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge or 110% of the Medi-Span AWP after Plan Year Deductible
Explanations and Limitations Nondurable Supplies Coverage is provided for up to a 31-day supply per month of: • Sterile surgical supplies used immediately after surgery. • Supplies needed to operate, or use covered durable medical equipment or corrective appliances. • Supplies needed for use by skilled home health or home infusion personnel, but only during their required services. To determine what nondurable medical supplies are covered, see the definition of Nondurable Supplies in the <i>Key Terms Definitions</i> section. Please see the <i>Participant Contact Guide</i> for information regarding the preferred diabetic supplies mail order program. Diabetic supplies are also payable under the prescription drug benefit, see the section on <i>prescription drug benefits</i> in this document for more information.		

Benefit Description	In-Network		Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)			
Office Visits	Plan pays 100%; not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Deductible
Laboratory Test (must be performed using a free-standing, non-hospital-based laboratory)	Plan pays 100%; not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Deductible
Nutritional Counseling Services	Plan pays 100%; not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Deductible
Weight loss medications	Preferred Retail 30-Day Supply	Smart90 Retail or ESI Home Delivery 90-Day Supply	
Preferred Generic	*\$5 Copay	\$15 Copay	Not covered
Preferred Brand	*\$25 Copay,	*\$75 Copay,	Not covered

Benefit Description	In-Network	Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)		
Non-Preferred Brand	Not covered	Not covered
Explanations and Limitations Obesity Care Disease Management Program (Enhanced Benefits) Preferred Retail Network Pharmacies: Copayments apply if you fill your prescription at an Express AdvantageNetwork (-EAN) retail pharmacy. If you fill your prescription at a non-EAN retail pharmacy, you will pay an additional \$10 per prescription. If you currently use a non-EAN pharmacy and you want to avoid the \$10 upcharge, call an EAN pharmacy to transfer your prescription. Certain weight loss medications may not be available in 90-day supply. Contact Express-Scripts for information about your prescribed medication. The Obesity Care Management (OCM) Program is a disease management program that provides enhanced benefits to participants who have been diagnosed as obese by their physician, who meet the criteria in this section, and have enrolled in the OCM Program. The OCM Program is a voluntary opt-in program that requires enrollment with the third-party claims administrator to determine if you meet the criteria for participation in the program. If the third-party claims administrator determines you to be eligible for the program, the effective date of enrollment and enhanced benefits is determined by the third-party claims administrator. For enrollment information, contact the third-party claims administrator listed in the <i>Participant Contact Guide</i>. <u>How to enroll in the OCM Program:</u> • Contact the third-party claims administrator for a list of In-Network weight loss providers. The list of In-Network weight loss providers and the <i>OCM Enrollment and Evaluation Form</i> may be obtained by logging into the E-PEBP Portal at www.pebp.state.nv.us https://pebp.nv.gov/ and selecting UMR. • Schedule an appointment with a provider from the list of participating In-Network weight loss providers. • Attend your scheduled appointment and have your provider complete, sign and submit the <i>Enrollment and Evaluation Form</i> to the third-party claims administrator's address or fax number provided on the form. • The third-party claims administrator will review the information submitted by your provider and if the information indicates that you meet the criteria for the weight loss program benefits, the third-party claims administrator will enroll you in the program and notify the Pharmacy Benefit Manager of your enrollment. • If you do not meet the criteria for the weight loss program and enhanced benefits, the third-party claims administrator will notify of the denial of the OCM Program's enhanced benefits. OCM Program participation criteria for adults 18 years and older and services must be provided by: • An In-Network provider who specializes in weight loss services. • An In-Network provider who is certified by the American Board of Bariatric Medicine (ABBM). • An In-Network provider who is in training to become certified by the American Board of Bariatric Medicine (ABBM); or		

Benefit Description	In-Network	Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits) - If no provider as described above is available within 50 miles of a participant's residence, then any In-Network provider. The patient's BMI must be greater than 30 kg/m², with or without any co-morbid conditions present, or greater than 25 kg/m² (or waist circumference greater than 35 inches in women, 40 inches in men) if one or more of the following co-morbid conditions are present: - Coronary artery disease. - Diabetes mellitus type 2. - Hypertension (Systolic Blood Pressure greater than or equal to 140 mm Hg or Diastolic Blood Pressure greater than or equal to 90 mm Hg on more than one occasion). - Obesity-hypoventilation syndrome. - Obstructive sleep apnea. - Cholesterol and fat levels measured (Dyslipidemia): - HDL cholesterol less than 35 mg/dL. - LDL cholesterol greater than or equal to 160 mg/dL; or - Serum triglyceride levels greater than or equal to 400 mg/dL. <u>For children ages two to 18 years:</u> - All the above criteria. - Services must be provided by an In-Network provider who specializes in childhood obesity; and - Child must present a BMI ≥ 85th percentile for age and gender. <u>Engagement in the OCM Program:</u> In addition to meeting the criteria above, you must remain actively engaged by complying with the treatment plan established by you and weight loss provider. <u>Monitoring Engagement in the OCM Program:</u> Your OCM provider must submit monthly reports to include your weight loss (weight, BMI, and waist circumference) and your compliance with the treatment plan. Submission of these reports will be a requirement for payment under the OCM Program's enhanced benefits. If your monthly weight loss reports are not received by the third-party claim's administrator, your benefits under this program will end, and your coverage will return to the standard CDHP benefits where other Plan limitations will apply. The effective date of the return to the standard CDHP benefits will be the first day of the month following the non-compliance notification received from the third-party claim's administrator. You and your weight loss provider will determine your final weight loss goal when you initially start participating in the OCM Program. Once you have met your final weight loss goal, the OCM Program's enhanced benefits will return to the standard CDHP benefits on the first day of the following month. The OCM Program does not provide enhanced benefits for ongoing maintenance care. Ongoing maintenance care will be subject to the standard CDHP benefits. <u>Laboratory Services:</u>		

Benefit Description	In-Network	Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)		
Routine wellness laboratory testing must be performed at an In-Network free-standing laboratory facility, for example Lab Corp or Quest. A hospital-based outpatient laboratory/draw station is not a free-standing laboratory. <u>Nutritional Counseling Services:</u> The frequency of nutritional counseling services will be determined by the claims administrator and based on your weight loss provider's recommendation and medical necessity. <u>Weight Loss Medications:</u> - The Plan covers certain only short-term use obesity/weight loss generic medications as identified by the Plan's pharmacy benefits manager. Contact the pharmacy benefit manager or refer to the Plan's prescription drug formulary to determine what weight loss medications are covered by the enhanced benefit. - Copayment for a 31-90-day supply is subject to three times the listed 30-day retail copayment. - This Plan does not coordinate prescription drug plan benefits. - Medications purchased at non-participating pharmacies are not covered under this Plan. <u>Other limitations:</u> - Weight loss medications: Preferred Retail Network Pharmacies, Smart90 Retail, and Express Scripts Home Delivery Program requirements apply. Refer to the <i>Schedule of Prescription Drug Benefits</i> for coverage limitations, cost implications and details regarding these programs. The Obesity Care Management Program is administrated by the Claims Administrator.		

Benefit Description	In-Network	Out-of-Network
Oral Surgery, Dental Services, and Temporomandibular Joint Disorder Injury to teeth; Oral and or craniofacial surgery.	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
	*TMJ related services: Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
Explanations and Limitations Oral and Craniofacial Services Expenses for dental services may be covered under the medical plan if the expenses are incurred for the repair or replacement of injury to teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the medical Plan, an accident does not include any injury caused by biting or chewing.		

Benefit Description	In-Network	Out-of-Network
Oral Surgery, Dental Services, and Temporomandibular Joint Disorder	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
Injury to teeth; Oral and or craniofacial surgery.	*TMJ related services: Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
○ Treatment of injury to teeth must be provided by a dentist or physician and is limited to restoration of teeth to a functional level, as determined by the Plan Administrator or its designee. • Coverage for dental services as the result of an injury to teeth will be extended under the medical plan to a maximum of two years following the date of injury, regardless of date enrolled in the plan. Restorations past the two-year time frame may be considered under the dental benefits described in the PEBP Self-funded Dental PPO Plan Master Plan Document available at www.pebp.state.nv.ushttps://pebp.nv.gov/. • Certain oral or craniofacial surgery is required to be prior authorized by the utilization management company. See the <i>UM</i> section of this document or refer to <i>Participant Contact Guide</i>. • Oral or craniofacial surgery is limited to surgical procedures to remove tumors, cysts, abscess including dental abscess and cellulitis, or for acute injury. • Frenectomy based on medical necessity as determined by the UM company. • *Temporomandibular Joint (TMJ) services are payable under the medical Plan when medically necessary but not if treatment is recognized as a dental procedure, involves extraction of teeth or application of orthodontic devices (e.g., braces) or splints. For additional information, see the <i>Exclusions</i> section related to dental services.		

Benefit Description	In-Network	Out-of-Network
Outpatient Surgery Facility	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
Explanations and Limitations Outpatient Surgery Facility • See the <i>UM</i> section for precertification requirements. • Outpatient ambulatory surgical facility/surgical center. • Physician fees payable under the physician services section of this ~~<i>Schedule of Medical Benefits</i>~~<i>Schedule of Benefits</i>. • Outpatient surgery with an observation period that lasts more than 23 hours will be considered and paid as an Inpatient confinement under this medical Plan. • Outpatient facility fees and anesthesia associated with medical necessary dental services for an individual when the individual is being referred by the dentist, and the following criteria are met: ○ Is under age 18 and has a physical, mental, or medically compromising condition; or ○ Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy; or patient has a documented mental or physical		

Benefit Description	In-Network	Out-of-Network
Outpatient Surgery Facility	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
impairment requiring general anesthesia for the safety of the patient; or is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist. No payment is extended toward the dentist or the assistant dental provider fees under this medical Plan. Refer to the dental benefits described in the PEBP Self-funded PPO Dental Plan Master Plan Document available at www.pebp.state.nv.ushttps://pebp.nv.gov/.		

Benefit Description	In-Network	Out-of-Network
Physician and Other Health Care Practitioner Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Physician and Other Health Care Practitioner Services This benefit includes physician and health care practitioner's fees for services provided in a hospital, emergency room, urgent care center, a health care practitioner's office or at home. Physician and health care practitioners include licensed providers acting within the scope of their license, such as but are not limited to the following: - Surgeon - Assistant surgeon (if medically necessary) - Anesthesia by physicians and Certified Registered Nurse Anesthetists (CRNA) - Pathologist; Radiologist - Physician Assistant; Nurse Practitioner; Nurse Midwife - Homeopathic Physicians, Christian Science Practitioners, Oriental Medicine Doctor (OMD) only for Acupuncture - Podiatrist - Psychologist, Psychiatrist, Licensed Clinical Social Worker The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery/Surgeries" in the <i>Key Terms and Definitions</i> section. Assistant surgeon fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. A Certified Surgical Assistant (see <i>Key Terms and Definitions</i> section) is payable as an assistant surgeon. Podiatry benefits include routine foot care for the treatment of foot problems such as bunions, corns, calluses, and toenails are covered only for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet. No coverage is provided for prophylactic surgery or treatment as defined in the <i>Key Terms and Definitions</i> section and as explained in the <i>Exclusions</i> section, unless otherwise specified in this document.		

Benefit Description	In-Network	Out-of-Network
Physician and Other Health Care Practitioner Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Physician and Other Health Care Practitioner Services No coverage for homeopathic treatments, supplies, remedies, or substances.		

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
Colorectal Cancer Screening (Colonoscopy/bowel prep, or Cologuard)	Plan pays 100%, not subject to Deductible	Not Covered
Women's Preventive Services <i>Well-woman visits; screening for gestational diabetes; human papillomavirus testing; counseling/screening: human immune deficiency virus, <u>mammograms*</u>, interpersonal and domestic violence</i>	Plan pays 100%, not subject to Deductible	Not Covered
BRCA Risk Assessment and Genetic Counseling/Testing	Plan pays 100%; not subject to Deductible	Not Covered
<i>BRCA Risk Assessment and Genetic Counseling/Testing in accordance with the USPSTF A & B guidelines; BRCA testing requires Precertification.</i>		
Breastfeeding Support/Equipment*	Plan pays 100%, Not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
<i>Coverage for comprehensive lactation support and counseling from trained providers for women during the prenatal and postpartum period and up to one year following delivery. Coverage for breastfeeding equipment and supplies in conjunction with each live birth. The Plan covers one manual or standard electric breast pump per live birth.</i> <i>*Contact the third-party claims administrator for the purchase of covered breast pumps. Rental for heavy duty electrical (hospital grade) breast pump covered only when the UM company determines it is medically necessary and only during the newborn's inpatient hospital stay.</i>		
Contraceptives / Family Planning (females only)	Plan pays 100%, not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible; pharmacy not covered

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
<i>Contraceptives/Family Planning: This Plan complies with the coverage requirements for contraception and related health services set forth in NRS 695G.1715; ~~including required provision concerning~~ coverage for up to a 12-month supply of FDA-approved contraceptive methods, including sterilization procedures, and patient education and counseling for women with reproductive capacity. The FDA requires the services, including over-the-counter products/methods, to be prescribed by a physician.</i> <i>In accordance with Senate Bill 280 from the 82nd Legislative Session in 2023, the Plan provides benefits for contraceptive injection or the insertion of a device at a hospital immediately after an insured gives birth.</i>		
<i><u>Examples of Contraceptives/Family planning under NRS 695G.1715, may include the following:</u></i>		
• Elective sterilization • Surgical sterilization implant • Implantable rods • Copper-based intrauterine devices • Progesterone-based intrauterine devices • Injections	• Progestin-based drugs • Extended/continuous-regimen drugs • Estrogen and progestin-based patches • Vaginal contraceptive rings • Combined estrogen-and progestin-based drugs	• Diaphragms w/spermicide • Sponges w/spermicide • Cervical caps w/spermicide • female condoms • Spermicide
<i>~~The following is a list of examples of preventive care services. For a full list of the most up-to-date preventive services, visit the websites listed in the Explanation and Limitations section, below:~~</i>		
• ~~Physical exam, screening lab and x-rays~~ • ~~Well child visits~~ • ~~Adult/child routine immunizations~~ • ~~Mammogram—annual screening*~~ • ~~Colorectal cancer screening**~~	• ~~Human Papillomavirus vaccine (NRS 695G.171)~~ • ~~Pelvic exam/Pap smear/breast exam~~ • ~~Prostate screening (NRS 695G.177)****~~ • ~~Hypertension screening~~ • ~~Routine hearing exam~~	• ~~Osteoporosis screening~~ • ~~Healthy Diet/Physical Activity Counseling***~~ • ~~Obesity Screening and Counseling~~ • ~~Depression Screening~~ • ~~Breastfeeding support~~ • ~~Prenatal obstetrical office visits~~ • ~~Smoking/tobacco cessation~~
Explanations and Limitations Preventive Care/Wellness Benefits		

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
<u>This plan is an IRS qualified High Deductible Health Plan and is required to comply with Section 223 of the Internal Revenue Code. Section 223 addresses preventative care benefits permitted to be provided by a high-deductible health plan that are not subject to cost-share.</u> Many preventive care services are provided as part of physical exams. These include regular checkups and well-child exams. Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 21 to 65 years of age or older (per USPSTF guidelines). Preventive care focuses on evaluating your current health status when you are symptom free and allows you to obtain early diagnosis and treatment to help avoid more serious health problems. During your preventive care visit, your doctor will determine what tests, health screenings and immunizations are right for you based on many factors such as your age, gender, overall health status, personal health history and your current health condition. Your physician may recommend a preventive service that is not listed in this document. For additional information regarding preventive benefit information, contact the third-party claims administrator listed in the <i>Participant Contact Guide</i>. Preventive care services identified through the following links is recommended services. It is up to the participant and their physician or provider of care to determine which services to provide. Unless otherwise mandated by the Patient Protection and Affordable Care Act (PPACA), IRS rules and regulations for HSAs, or in accordance with applicable Nevada Revised Statutes, the Plan Administrator has the authority to determine which services, including frequency and quantity limits will be covered at the 100% wellness benefit. This Plan covers recommended preventive care services with no cost sharing when provided by In-Network providers. Preventive Care Services are not subject to and will not apply to the Plan Year Deductible or Out-of-Pocket Maximum. Some preventive care services do have service quantity limitations. Routine lab services from independent labs may not be paid as wellness unless the TPA system finds a corresponding wellness office visit within a reasonable number of days prior or after lab date to validate wellness diagnosis. Human Papillomavirus testing and vaccination ~~under~~ <u>pursuant to NRS 695G.171.</u> <u>*Mammogram:</u> The first preventative mammograms of the Plan Year is covered at 100% for women aged 40 years and older under the Affordable Care Act and USPSTF guidelines or beginning at age 35 for members with a high-risk of breast cancer, when performed in-network. <u>**Colorectal cancer screening:</u> For adults aged 45 years and older who are at average risk of colorectal cancer in accordance with the American Cancer Society's qualified recommendations; or beginning at age 40 for members with a high-risk of colorectal cancer. <u>***Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions</u> for adults aged 18 years and older are covered under		

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
the Wellness/Preventive Benefit when referred by a primary care practitioner; for those who have a basal metabolic index (BMI) of 30 or greater; and have additional cardiovascular disease (CVD) risk factors. This wellness/preventive benefit is limited to twelve (12) Healthy Diet/Physical Activity Counseling or Obesity Screening/Counseling visits per Plan Year according to recommendations from the USPSTF. Additional visits are subject to a specialist visit copay, deductible, or coinsurance where applicable. **** Prostate Cancer Screening limited to 1 preventative per plan year and offered in accordance with NRS 695G.177 which includes reference to the American Cancer Society standards. Smoking/Tobacco Cessation: • Prescription and over-the-counter smoking/tobacco cessation products are covered under the prescription drug program. Over-the-counter smoking cessation products must be accompanied by a prescription written by a physician. • Some examples of cessation products eligible to be paid at 100% include Chantix (by prescription only), nicotine gum, nicotine patches, and nicotine lozenges. Some limitations on quantity may apply and are at the discretion of the Pharmacy Benefit Manager and your physician. • Benefits for over-the-counter products are limited to those that are FDA approved and recommendations by the Surgeon General. • Over-the-counter smoking/tobacco cessation products may be obtained by presenting your physician's written prescription to an In-Network pharmacy, or you can submit your purchase receipt for the product with your physician's written prescription attached to the Prescription Drug Reimbursement Claim Form (this form is located at www.pebp.state.nv.ushttps://pebp.nv.gov/). • Second-line therapies such as clonidine hydrochloride and nortriptyline hydrochloride are sometimes used in the management of smoking/tobacco-cessation; however, due to the lack of an FDA-approved indication for smoking cessation, as well as undesirable side effect profiles, currently prohibit these agents from achieving first-line classification and therefore, not covered under the <i>Preventive Care/Wellness Services</i> Benefit. • The Plan does not cover electronic cigarettes. For more information, please visit or contact the third-party claims administrator. Preventive Services for Adults and Families: Visit the U.S. Preventive Services Task Force at https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ Preventive Services for Women, Including Pregnant Women: Visit Human Resources & Services Administration (HRSA) at https://www.hrsa.gov/womens-guidelines/index.html Vaccines & Immunizations for infants, children, teens, and adults: Visit the U.S. Department of Health & Human Services at https://www.cdc.gov/vaccines/index.html Preventive Health Services: Visit HealthCare.gov at https://www.healthcare.gov/coverage/preventive-care-benefits/		

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
American Cancer Society /Colorectal Screening: https://www.cancer.org/ <i><u>The following is a list of examples of preventive care services. For a full list of the most up-to-date preventive services, visit the websites listed, below :</u></i> • <u>Physical exam, screening lab and x-rays</u> • <u>Well child visits</u> • <u>Adult/child routine immunizations</u> • <u>Human Papillomavirus vaccine (NRS 695G.171)</u> • <u>Pelvic exam/Pap smear/breast exam</u> • <u>Prostate screening (NRS 695G.177)****</u> • <u>Obesity Screening and Counseling</u> • <u>Prenatal obstetrical office visits</u> Preventive screening services are provided in accordance with national organizations, state, and federal laws: • <u>United States Preventive Services Task Force (USPSTF) A & B Recommendations</u> • <u>Section 2713(a)(5) of the Public Health Service Act</u> • <u>Patient Protection and Affordable Care Act of 2010 (PPACA);</u> • <u>Health Resources and Services Administration (HRSA);</u> • <u>Centers for Disease Control (CDC);</u> • <u>Advisory Committee on Immunization Practices (ACIP);</u> • <u>Health and Human Services (HHS);</u> • <i>as mandated by Nevada Revised Statute;</i> • <i>and as mandated by federal law</i> ~~This Plan complies with as related to contraceptive methods, utilization management, step therapy, precertification, categorization of prescription drugs (meaning Preferred Generic, Preferred Brand and Non-Preferred Brands), and cost-sharing.~~		

Benefit Description	In-Network	Out-of-Network
~~Radiation Therapy Radiology (X-Ray), Nuclear Medicine & Radiation Therapy Services (Outpatient)~~	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations <u>Radiation Therapy, including</u> Radiology (X-Ray), Nuclear Medicine & Radiation Therapy Services (Outpatient) The Plan covers medically necessary specialty radiology when ordered by a physician or health care practitioner acting with the scope of their license, including MRI, MRA, MRS MRT, PET, SPEC, and CT scan.		

Precertification required for CT, MRI, SPECT and PET. For other precertification requirements, see the *Utilization Management (Prior Authorization)* section.

The Plan covers technical and professional fees associated with:

- diagnostic and curative services, including radiation therapy, and
- pre-admission testing: Outpatient radiology tests performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Refer to the *Preventive Care/Wellness Services* section of this document for information regarding benefits for screening radiology services and other preventive radiology testing.

Benefit Description	In-Network	Out-of-Network
Real Appeal	No cost to Participants	Not Covered
Explanations and Limitations Nevada Public Employees' Benefits Program has partnered with UMR's Real Appeal program. Real Appeal provides eligible members a benefit for virtual weight loss and weight management coaching sessions. Sessions are covered under the preventive care benefit resulting in no cost-sharing to members. Real Appeal supports members eighteen (18) years of age and older. This support includes, but not limited to, one-on-one coaching and online group sessions with supporting video content delivered by a virtual coach. A qualified enrolled member will receive: • Access to a coach who will guide you through the program and develop a custom plan that fits your needs, preferences, and goals. • 24/7 access to digital tools and dashboards. • A Real Appeal kit containing health weight management tools that may include fitness guides, recipes, digital food and weight scales • Support from online group classes with a coach and other members who share what's helped them achieve success. For more information, contact the Plan's third-party claims administrator listed in the Participant Contact Guide.		

Benefit Description	In-Network	Out-of-Network
Rehabilitation Services (Cardiac, Physical, Occupational, and Speech Therapy)	Inpatient or Outpatient: Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Rehabilitation Services (Physical, Occupational, and Speech Therapy) - Rehabilitation services are covered only when ordered by a physician or other provider acting within the scope of their license. - Inpatient rehabilitation admission requires prior authorization. - Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year. <u>Visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder.</u>~~(limit not applied to therapy treating a behavioral health condition).~~ - There is no limit for Cardiac Rehabilitation services. - Benefits for rehabilitation therapy are limited to services given for acute or recently acquired conditions that, in the judgement of the member's physician, are subject to significant improvement through short-term therapy. - Short term active, progressive rehabilitation services for occupational, physical, or speech therapy must be performed by a licensed or duly qualified therapist/provider acting within the scope of their license. - Inpatient rehabilitation services in an acute hospital, rehabilitation unit or facility or skilled nursing facility for short term, active, progressive rehabilitation services that cannot be provided in an outpatient or home setting. - Maintenance Rehabilitation and coma stimulation services are not covered (see specific exclusions relating to rehabilitation therapies in the <i>Exclusions</i> section). - Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagia, swallowing defects, to correct speech disorders due to childhood developmental delays and disorders due to illness, injury, or a surgical procedure. Speech therapy is payable following surgery to correct a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy), an injury, or sickness that is other than a learning ~~or mental~~ disorder. See the see the <i>Utilization Management</i> section for prior authorization requirements. PEBP also offers participants access to Hinge Health Digital Musculoskeletal (MSK) Care program for virtual therapy focusing on prevention, acute injury, chronic and surgical care programs. See Hinge Health, above, for more information.		

Benefit Description	In-Network	Out-of-Network
Second Physician Opinion Includes only one office visit per opinion	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Second Physician Opinion For your second opinion, you may choose any In-Network, Board-certified specialist who is not an associate of the attending physician. <u>2nd.MD is PEBP's preferred second opinion Service. See benefits in the Schedule of Benefits, below, for additional information.</u>		

Benefit Description	In-Network	Out-of-Network
2nd.MD (Second Opinion Service)	Plan Pays 100%, not subject to Deductible	Not Covered
Telemedicine Doctor on Demand (DoD) only		Not Covered
Medical Visit	\$49, after Deductible	Not Covered
Psychology Visit (25-minute visit)	\$79 , after Deductible	Not Covered
Psychology Visit (50-minute visit)	\$129, after Deductible	Not Covered
Psychiatry Visit (initial 45-minute visit)	\$229, after Deductible	Not Covered
Psychiatry Visit (15-minute follow-up visit)	\$99, after Deductible	Not Covered
Telehealth (other telemedicine providers)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Telemedicine and Telehealth • Doctor on Demand telemedicine services is PEBP's contracted telehealth provider and are considered In-Network. To learn more, visit http://www.doctorondemand.com/pebp. • 2nd.MD provides eligible members with direct access to elite specialists across the county for expert second opinions. Specialists answer questions about disease, cancer, chronic conditions, surgery or procedure, medications, and treatment plans. Specialists are board certified, leaders in research, and pioneers in medicine. To learn more visit www.2nd.MD/PEBP or call 1-866-841-2575. • Alternatively, telemedicine may be available from in-network providers and is covered on the same basis as in-person services. It is your responsibility to ensure the providers you use are		

in-network providers. Failure to use in-network providers will result in a denial of benefits and higher cost to you

- This Plan ~~also~~ adheres to the provisions of [NRS 695G.162](#) regarding [coverage for services provided through telehealth](#).

Benefit Description	In-Network	Out-of-Network
Skilled Nursing Facility (SNF) and Subacute Care Facility	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Skilled Nursing Facility (SNF) and Subacute Care Facility

- Admission to a skilled nursing facility or subacute care facility must be ordered by a physician and requires prior authorization (see the *Utilization Management* section of this document).
- Skilled nursing facility (SNF) confinement or subacute care facility confinement payable up to 60 days per Plan Year for confinements related to the same cause. Additional visits are subject to preauthorization by the UM Company.

Benefit Description	Center of Excellence	Non-Center of Excellence
Transplant Services (Organ, and Tissue)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Transplants (Organ and Tissue)

- Coverage is provided only for eligible services related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.
- Coverage is provided for the donor when the receiver is a participant under this Plan. Coverage is provided for organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his or her plan will pay first and the benefit under this Plan will be reduced by the amount payable by the donor's plan.
- Expenses incurred by a participant of this Plan who donates an organ or tissue are not covered unless the person who receives the donated organ/tissue is also a participant covered by this Plan.
- Transplantation-related services require precertification (see the *Utilization Management* section of this document for details). Coverage is provided only for eligible services related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.
- See the *Exclusions* section related to experimental and investigational services and transplants.
- To receive maximum Plan benefits, members must use a Center of Excellence for single organ or combined organs and tissue transplants. Transplant Center of Excellence facilities will be identified by

Benefit Description	Center of Excellence	Non-Center of Excellence
Transplant Services (Organ, and Tissue)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Transplants (Organ and Tissue) the claim's administrator. For information regarding transplant benefits and Centers of Excellence facilities, contact the third-party claims administrator at 888-763-8232. - This Plan provides for reimbursement of certain costs associated with travel and ~~lodging hotel~~ accommodations for the patient and one additional person (spouse/domestic partner, family member or friend) when associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. For travel expense benefits, refer to the <i>Travel Expenses</i> section. - Expenses incurred for travel and ~~lodging hotel~~ accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered. - PEBP does not provide advance payment for travel expenses related to organ or tissue transplants.		

Benefit Description	
Travel Expenses	Subject to IRS Limitations under Publication 502 and Code 213(d) Subject to Deductible and Out-of-Pocket Maximum
Explanations and Limitations Travel Expenses This Plan allows for the reimbursement of certain travel and hotel accommodation expenses permitted under IRS Regulation 213(d) and IRS Publication 502 for qualified medical expenses for the member and one additional person (travel companion) when the expenses are associated with the following services, have been prior authorized by the UM company, and when the member resides 50 or more miles from the provider location: - Organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence. - Elective surgeries performed as exclusive hospitals/ambulatory facilities and - Outpatient infusion services performed at exclusive outpatient infusion centers. - Travel for a participant located in a State with restricted access to abortion to the nearest care center for abortion services covered under this Plan. Travel expenses are covered when incurred in conjunction with the member's: - Transplant or bariatric surgery (does not include pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon. Travel expenses incurred on or after one year are not eligible for reimbursement. - Hip and knee total joint replacement surgery performed at an approved exclusive Nevada hospital/ ambulatory surgery facility when prior authorized by the utilization management company (including pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon; and	

Benefit Description	
Travel Expenses	Subject to IRS Limitations under Publication 502 and Code 213(d) Subject to Deductible and Out-of-Pocket Maximum
Explanations and Limitations Travel Expenses - Travel expenses related to an organ or tissue transplant, or bariatric surgery scheduled or performed at a facility or other provider type that is not a Center of Excellence as determined by the Plan Administrator or its designee will not be covered. Travel expenses related to an inpatient or outpatient surgery that is not determined to be a preferred hospital/ambulatory surgical facility by the UM company will not be covered. There are no exceptions. - If the travel companion has their own separate PEBP Plan, travel expense reimbursement will not apply to the companion. - PEBP does not provide advance payment for travel expenses. - This Plan incorporates the travel expense reimbursement guidelines established in IRS Regulation 213(d) and IRS Publication 502. - The least expensive method of transportation must be used. - Standard mileage reimbursement for the use of a personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center is based on the mileage from the member's residence to and from the facility (based on an objective source such as Google Maps). - The Plan Administrator or its designee has full authority to approve or deny all or part of the travel expenses. The reduction and/or denial of travel expenses cannot be appealed. - Travel expenses are subject to Deductible and Out-of-Pocket Maximum. Excluded travel expenses: The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved): - Alcoholic beverages. - Car maintenance. - Vehicle insurance. - Flight insurance. - Cards, stationery, stamps. - Clothing. - Dry cleaning. - Entertainment (cable televisions, books, magazines, movie rentals). - Flowers. - Household products. - Household utilities, including cell phone charges, house cleaner, baby-sitter, or day care services. - Kennel fees. - Laundry services. - Meals (inasmuch as it is excluded under the IRS Publication 502 and Regulations under 213(d)). - Security deposits.	

Benefit Description	
Travel Expenses	Subject to IRS Limitations under Publication 502 and Code 213(d) Subject to Deductible and Out-of-Pocket Maximum
Explanations and Limitations Travel Expenses • Toiletries. • Travel expenses related to a facility or provider that is not a certified Center of Excellence, exclusive hospital/ambulatory surgical facility, or outpatient infusion facility; and • Travel expenses incurred on or after one year following surgery are not eligible for reimbursement. • Travel expenses are subject to the annual cost sharing requirements. Pre-approval for travel expenses: • Travel expenses must be pre-approved by PEBP or its designee ○ If the member is unable to obtain pre-approval because the organ or tissue transplant required immediate travel, the member may submit travel costs to PEBP or its designee after the transplant surgery. ○ Pre-approval will provide an estimation of your travel reimbursement. A Travel Pre-Authorization form is available at www.pebp.state.nv.ushttps://pebp.nv.gov/. Submitting Travel Reimbursement form and receipts: • Requests for travel expense reimbursement must be submitted to PEBP using the Travel Reimbursement form available at www.pebp.state.nv.ushttps://pebp.nv.gov/. • Travel Reimbursement forms and receipts must be submitted within 12 months of the date of the surgery/procedure. ○ The form must be completed, including the start and end times, destination, and purpose of trip ○ Must include original itemized receipts identifying the name(s) of the person(s) incurring the expense. Reimbursement of eligible travel expenses, including any relating to a travel companion, will be payable to the primary participant. Reimbursement will be based on actual expenses incurred and the actual number of days and travel times and may differ from the pre-approval estimation.	

Benefit Description	In-Network	Out-of-Network
Vision Screening Exam (Preventive)	Plan pays 80% after Plan Year Deductible	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Vision Screening Exam* • One annual preventive vision screening exam including refractive error testing per Plan Year. • Hardware such as but not limited to contact lenses, lenses and frames are not covered. • *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. • PEBP does not maintain a network specific to vision care; however, the PPO network does have a list of some vision providers.		

Schedule of Prescription Drug Benefits

Benefits for prescription drugs are provided through the prescription drug plan administered by the Pharmacy Benefit Manager, Express Scripts ("ESI"). Coverage is provided only for those pharmaceuticals (drugs and medicines) obtained from In-Network providers and approved by the U. S. Food and Drug Administration (FDA) as requiring a prescription and FDA approval for the condition, dose, route, duration, and frequency, if prescribed by a physician or other practitioner.

The following schedule includes explanations and limitations that apply to each benefit; however, the explanations and limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any precertification requirements), *Exclusions*, *Benefit Limitations and Exclusions*, *Key Terms and Definitions* and other sections that may apply to a specific benefit.

For helpful tools such as "Price a Medication" see the *Participant Contact Guide* section or go to the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
Preferred/Formulary Generic Drugs	Plan pays 80% after Plan Year Deductible	Not Covered
Preferred/Formulary Brand Drugs	Plan pays 80% after Plan Year Deductible	Not Covered
Non-Preferred/Non-Formulary Brand Drugs	You pay 100% of the cost of the medication; Deductible and Out-of-Pocket Maximum credit is not applied	Not Covered
Specialty Pharmaceutical Drug (Accredo Specialty Pharmacy)	<u>You pay 20% after Plan Year Deductible for drugs on the SaveOnSP program.</u> <u>OR</u> <u>Copay limit of \$100 min and \$250 max applies</u> ~~Plan pays 80% after Plan Year Deductible~~	Not Covered
Preventive Medications (Limited only to those preventive drugs identified by the pharmacy benefit manager)	ACA Mandated Preventive Drugs: Plan Pays 100%, not subject to Plan year Deductible	Not Covered

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
	Other Preventive Drugs: Plan pays 80%, not subject to Plan Year Deductible	
Explanations and Limitations Prescription Drug Benefit This Plan does not coordinate prescription drug plan benefits. Some over the counter (OTC) drugs and prescription drugs are eligible to be covered under the Plan's <i>Preventive Care/Wellness Services</i> benefit in accordance with the Affordable Care Act; whereby, the Plan will waive the Copays and Deductibles and products are paid at 100%. Please contact Express Scripts for more information. Certain OTC female contraception products are covered when presented with a prescription from your physician to your pharmacy. These types of products include the female condom, sponges, and spermicides. Refer to the <i>Women's Preventive ~~Care/Wellness~~ Services</i> section for more information or call Express Scripts, whose contact information is in the <i>Participant Contact Guide</i>. Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. Contact the Pharmacy Benefit Manager listed in the <i>Participant Contact Guide</i> or visit www.express-scripts.com to check vaccine coverage and locate your nearest In-Network pharmacy. Contact the pharmacy to verify their current vaccination schedule and vaccine availability. Coverage is also provided for, but not limited to: • Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (whooping cough) • Prenatal & pediatric prescription vitamins • Prescription female oral contraceptives • Insulin, diabetic supplies (such as lancets, syringes, test strips), insulin pumps, and insulin pump supplies. ○ Insulin pumps and supplies are covered under the pharmacy benefit's base day and quantity limits, subject to copayments, deductibles, or coinsurance. • Orally Administered Chemotherapy (NRS 695G.167): The Copayment, after deductible, or Coinsurance amount for orally administered chemotherapy drugs will be consistent with the drug's formulary tier for retail, home delivery and Specialty pharmacy; and in accordance with NRS 695G.167, the cost will not exceed \$100 per prescription for a 30-day supply. For more information, see <i>Key Terms and Definitions</i> section. • Prescription drugs irregularly dispensed for purposes of synchronization of Chronic medication pursuant to the provisions of NRS 695G.1665 • This Plan also complies with NRS 695G.172, regarding coverage of topical ophthalmic product.		

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits ○ Refills of topical ophthalmic products will be covered when medically necessary, including when requested: (a) After 21 days or more but before 30 days after receiving any 30-day supply of the product; (b) After 42 days or more but before 60 days after receiving any 60-day supply of the product; or (c) After 63 days or more but before 90 days after receiving any 90-day supply of the product. • Medically necessary prescription drugs to treat sickle cell disease and its variants pursuant to the provisions of {NRS 695G.174}. • Human Papillomavirus testing and vaccination under NRS 695G.171. • In accordance with Assembly Bill 156 from the 82nd Legislative Session in 2023, the Plan provides benefits for substance use disorder including coverage for all- drugs approved by- the- United -States -Food -and -Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone. • In accordance with Senate Bill 167 from the 82nd Legislative Session in 2023, the Plan provides prescription benefits for psychiatric conditions for drugs that are approved by the Food and Drug Administration or the use of a drug to treat a psychiatric condition that is supported by medical or scientific evidence when prescribed by a Provider acting within the scope of their license. These prescription drugs are not subject to medical management techniques, such as step therapy. <i>Preventive Drug Benefit Program</i> The Preventive Drug Benefit Program 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 logging on to www.pebp.state.nv.ushttps://pebp.nv.gov/ or by contacting Express Scripts located in the <i>Participant Contact Guide</i> section. The plan adheres to NRS 695G.1715 regarding contraception and related health services. <i>Specialty <u>Prescription</u> Drugs</i> Specialty drugs are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, etc. Certain drugs fall into a category called specialty drugs. Specialty drugs and prescriptions are generally limited to a 30-day supply. Specialty drugs are available only through the Accredo, the Plan's Specialty Pharmacy. ~~Check with~~		

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits ~~Express Scripts to determine if your prescription is considered specialty (see the Participant Contact Guide).~~ ~~Certain drugs fall into a category called specialty drugs. Specialty drugs are available only through the Specialty Pharmacy listed the Participant Contact Guide section, and prescriptions are limited to a 30-day supply.~~ Plan participants are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. Contact Express Scripts to determine if your prescription is considered specialty. Special pharmaceuticals, which include injectables, oral medications, and medications given by other routes of delivery, may be delivered in any setting. Special pharmaceuticals are pharmaceuticals that typically have: • Limited access. • Treat complex medical conditions. • Complicated treatment regimens. • Compliance issues. • Special storage requirements; or • Manufacturer reporting requirements. This Plan's Pharmacy Benefit Manager maintains a list of special drugs classified as special pharmaceuticals. For information regarding special pharmaceuticals, contact <u>Express Scripts</u>.~~the Pharmacy Benefit Manager listed in the Participant Contact Guide.~~ <u>For Specialty Drugs covered under the SaveOnSP program, the coinsurance applies. For Specialty Drugs not part of the SaveOnSP program, the respective coinsurance applies with a copay limitation of \$100 minimum and a maximum of \$250.</u>		
<i>Preferred Retail Pharmacy Network</i> For short-term prescriptions, such as antibiotics, use a Preferred Retail Pharmacy (for lower copays) or a Non-Preferred Retail Pharmacy (where you will pay \$10 extra for each short-term prescription). ~~Your~~<u>The</u> Preferred Retail Pharmacy Network has more than 34,000 pharmacies consisting of approximately 50% independent pharmacies in addition to grocers and other stores. To find a preferred pharmacy near you, register or log in to express-scripts.com/findapharmacy or call Express Scripts' Member Services at 855-889-7708. <i>Smart90 Retail and Home Delivery Program</i> 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		

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits 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 both a 90-day supply and to either a participating retail pharmacy or Express Scripts Home Delivery Pharmacy. 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. Smart90 Retail Pharmacy To locate a participating Smart90 Retail Pharmacy or a Preferred Retail Network Pharmacy, log in to the E-PEBP Portal located at www.pebp.state.nv.ushttps://pebp.nv.gov/ and select <i>Express Scripts</i>. You can also get pharmacy information by calling Express Scripts' Member Services at 855-889-7708. You can transfer your medications easily in-store, by phone or online. Express Scripts Home Delivery You may use home delivery through the Express Scripts Home Delivery Pharmacy to receive a 90-day supply of your maintenance medications and have them mailed to you with free standard shipping. Not all drugs are available via mail order. Check with Express Scripts for further information on the availability of your prescription medication. Enrolling in home delivery is easy! First, log in to express-scripts.com. If you are enrolling a new prescription in home delivery: • Contact your doctor and ask them to e-prescribe a 90-day prescription directly to Express Scripts • OR send a request through Express Scripts' website by selecting "Forms" or "Forms & Cards" from the "Benefits" menu, print and mail-order form and follow the mailing instructions • OR call Express Scripts' Member Services at 855-889-77058 and they will contact your doctor for you if you are enrolling a current prescription: Transfer retail prescriptions to home delivery by clicking "Add to Cart" for eligible prescriptions and check out. You can also refill and renew prescriptions. Express Scripts will contact your doctor and take care of the rest. Check Order Status to track the shipping of your prescriptions. Please allow up to 14 days. Please keep in mind, longer delivery times may be due to additional correspondence need with prescribers, medication availability and/or delivery times from the shipping vendor.  Generics Preferred Program When your doctor prescribes a brand-name drug and a generic substitute is available, you will automatically receive the generic drug unless:		

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits Your doctor writes “dispense as written” (DAW) on the prescription; or You request the brand-name drug at the time you fill your prescription. If you choose generic medicines, you get safe medicines at lower cost. Your cost for the generic drug will be less than the cost for the brand-name drug. If a generic is available, but you, or your doctor, request the brand-name drug, you will pay the applicable brand cost.  Payment assistance (manufacturer-funded patient assistance) for specialty drugs will not apply toward your Deductible and Out-of-Pocket Maximum. <i>SaveonSP Program</i> As part of your prescription drug plan, ~~Nevada Public Employees’ Benefits Program~~ PEBP has partnered with an Express Scripts’ cost assistance program, SaveonSP, to help save money on certain specialty medications. Through the SaveonSP Program, manufacturer-funded assistance is available to help assisting members with the cost of the Program drug(s) is reimbursed by the manufacturer at no cost to the participant. The medications included in the SaveonSP Program are classified as Non-Essential Health Benefits under the Affordable Care Act. The cost of these drugs will not be applied towards satisfying your deductible or out-of-pocket maximum. Members currently taking a medication or those who will be taking a medication that is on the <i>Non-Essential Benefit Specialty Drug List</i>, are eligible to participate in the program. • Select medications on the <i>Non-Essential Benefit Specialty Drug List</i> will be free of charge (\$0) to members who participate. • Prescriptions must be filled through Accredo Specialty Pharmacy. • The medications and associated cost included in this program are subject to the Pharmacy Benefit Manager’s clinical rules. • If the medication you are taking is on the <i>SaveonSP Non-Essential Benefit Specialty Drug List</i> and you wish to participate, call SaveonSP at 1-800-683-1074.  Participation in the SaveonSP Program is voluntary; however, if you are taking or will be taking a medication that is on the Non-Essential Benefit Specialty Drug List, and you choose not to participate in the SaveonSP Program, you will be responsible for the cost of the medication and the cost will not apply toward your Deductible or Out-of-Pocket Maximum.		

Diabetes Care Value

Express Scripts offers a program that supports members with diabetes (type 1 and 2), pre-diabetes, and even common comorbidities like obesity. ESI's digital diabetes prevention and obesity solution offers a personalized coaching and weight loss program to help patients avoid type 2 diabetes. The Diabetes Care Value is administered by Express Scripts and qualifying participants will receive a personal invitation, with instructions, to join the program.

Diabetic Medications and Supplies

Participants who enroll and participate in PEBP's Diabetes Care Management Program may receive up to a 90-day supply of preferred diabetic supplies and the cost of those supplies will not be subject to annual Deductible or Coinsurance requirements. Diabetic supplies under this program must be filled through Express Scripts Home Delivery pharmacy and include blood glucose monitors, test strips, insulin, syringes, alcohol pads, and lancets. For more information contact Express Scripts' Member Services at 855-889-7708.

Extended Absence Benefit

If you are going to be away from your home for an extended period, either in the country or outside of the country, you may obtain an additional fill (30 or 90-day supply) of your prescription drugs from your local retail or mail order pharmacy. This limited benefit must be requested in advance by the participant to the prescription drug Plan Administrator listed in the *Participant Contact Guide*. A maximum of two (2) early refills are allowed every 180 days. You may be required to obtain a new written prescription from your physician and any necessary prior authorizations.

Out-of-Country Emergency Medication Purchases

This Plan may cover emergency prescription drugs purchased if you reside in the United States and travel to a foreign country. You will need to pay for the drug at the time of purchase and later submit for reimbursement from ~~the Pharmacy Benefit Manager~~ Express Scripts. Prescription drug purchases made outside of the United States are subject to Plan provisions, Benefit Limitations and Exclusions~~limitations and exclusions~~, clinical review, and determination of medical necessity. The review may include application of pertinent Food and Drug Administration (FDA) regulations~~The review will also include regulations determined by the FDA~~. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the United States.

If your purchase is eligible for reimbursement, you must use the Direct Claim Form available from the prescription drug Plan Administrator. Direct Claim Forms may be requested from the prescription drug plan or obtained by logging in to www.express-scripts.com. In addition to the Direct Claim Form, you are required to provide:

- A legitimate, legible copy of the written prescription completed by your physician.
- Proof of payment from you to the provider of service (typically your credit card invoice).
- Prescription and receipt must be translated to English and include the American——equivalent National Drug Code for the prescription purchased.
- Reimbursement request must be converted to United States dollars.

Any foreign purchases of prescription medications will be subject to Plan limitations such as:

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits • Benefits and coverage • Deductibles • Coinsurance • Dispensing maximums • Annual benefit maximums • Medical Necessity • Usual and Customary (U&C) or prescription drug pharmacy benefit manager contracted allowable • FDA approval • Plan prior authorization requirements Contact the Express Scripts before traveling or moving to another country to discuss any criteria that may apply to a prescription drug reimbursement request. <i>Out-of-Network Pharmacy ~~Benefit~~</i> Prescriptions filled at a domestic (inside the United States) out-of-network pharmacy location, are not authorized for reimbursement under the prescription drug Plan. Prescription drugs must be filled at a participating in-network pharmacy location. <i>Other Limitations:</i> • This Plan does not coordinate prescription drug plan benefits with other prescription drug plans. It is the participant's responsibility to use the appropriate primary and secondary (if applicable) prescription plan. • See exclusions related to medications in the ~~Exclusions~~<i>Benefit Limitations and Exclusions</i> section of this document. The formulary is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.		

Benefit Limitations and Exclusions

This Plan does not cover certain services. This chapter lists the general medical and pharmacy benefit exclusions of this Plan. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum. Additional exclusions that apply to only a service or benefit are listed in the description of that service or benefit in the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits* sections. This list is not all-inclusive; if you have questions about a service or supply, contact the Claims Administrator listed in the *Participant Contact Guide*.

Expenses That Do Not Accumulate Toward Your Out-of-Pocket Maximum

The following services do not accumulate toward the out-of-pocket maximum, and you will be responsible for paying these expenses out of your own pocket.

- All expenses for medical and pharmacy services and supplies that are not covered by the Plan, to include but not limited to, expenses that exceed the CDHP network contract rate, services listed in the *Benefit Limitations and Exclusions* section.
- All charges in excess of the usual and customary charge determined by the Plan Administrator.
- Any additional amounts you must pay because you failed to comply with the utilization management requirements described in the *Utilization Management* section.
- Benefits exceeding those services or supplies subject to maximum individual or lifetime limit(s) for certain eligible medical expenses as listed in the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits*; and
- Certain wellness or preventive services that are paid by this Plan at 100% do not accumulate towards the out-of-pocket maximum.
- The value of manufacturer rebates for drugs on the SaveOnSP non-essential drug list.

This list is not all-inclusive and may not include certain services and supplies that are not listed above.

Benefit Limitations

In addition to the exclusions listed below, refer to the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits* sections for the maximum individual or lifetime limit(s) and any Plan Year limit applicable to certain covered expenses. Plan Year limits are met by days, hours, visits, or dollar limits paid under all components of the Plan.

Lifetime Maximum

This Plan imposes a lifetime maximum on some health care services and procedures. For information on the lifetime maximums, refer to the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits* sections.

Exclusions Under the ~~Medical~~ Plan

The following is a list of services and supplies or expenses not covered by this Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and terms of the Plan and determines eligibility and entitlement to Plan benefits. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum.

Abortion: Elective termination of pregnancy (abortion) is excluded from the plan, other than medically indicated abortions that are medically necessary to save the life of the mother and complications of such abortions.

This plan provides abortion benefits in accordance with [NRS 422.250](#).

Alternative/Complimentary Health Care Exclusions: Expenses for chelation therapy (except as may be medically necessary for treatment of mental health, acute arsenic, gold, mercury, or lead poisoning) and for diseases due to clearly demonstrated excess of copper or iron. Expenses for prayer, religious healing, or spiritual healing, except services provided by a Christian Science Practitioner. Expenses for naturopathic, Naprapathy services or treatment/supplies. Expenses for homeopathic treatments/supplies that are not FDA approved.

Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.

Bariatric and Overweight Surgery: The Plan's individual lifetime maximum is one (1) bariatric surgery while covered under any current or previous PEBP self-funded health plan.

Bariatric and Overweight Surgery Not Performed at a Center of Excellence Provider: Benefits are excluded for bariatric/weight loss surgery performed at an Out-of-Network facility, Out-of-Network surgeon, or when Out-of-Network ancillary providers are used, notwithstanding services covered under the No Surprises Act. PEBP or its designee will determine the In-Network Center of Excellence facility.

Behavioral Health Care Exclusions

- ~~Expenses for hypnosis and hypnotherapy.~~
- Expenses for behavioral health care services related to:
 - adoption counseling;
 - non medically necessary court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws);
 - custody counseling;
 - dance,
 - poetry, or
 - art therapy;
 - developmental disabilities;
 - dyslexia;

- learning disorders;
- ~~attention deficit disorders (with or without hyperactivity, except when the services are for diagnosis, the prescription of medication as prescribed by a physician or other health care practitioner, or when accompanied by a treatment plan as submitted to the Plan or its designee) or the treatment is related to the management of ADD/ADHD without prescription drugs and is approved by the Plan or its designee;~~ family planning counseling;
- marriage ~~and/or~~ couples ~~and or sex~~ counseling (the exclusion for marriage/couples counseling will not limit individual mental health counseling for an otherwise covered mental health condition);
- intellectual disability;
- pregnancy counseling;
- vocational disabilities, and
- organic and non-organic therapies
 - including (but not limited to) crystal healing, EST, primal therapy, L-Tryptophan, vitamin therapy, religious/spiritual, etc.
- Expenses for tests to determine the presence of or degree of a person's dyslexia or learning disorder unless the visit meets the criteria for benefits payable for the diagnosis or treatment of Autism Spectrum Disorders.

Complications of a non-covered service: Expenses for care, services or treatment required because of complications from a treatment or service not covered under this Plan, except complications from an abortion.

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge medical practice to have access to the medical services provided by the concierge medical practice.

Clinical Trials: See *Experimental and Investigational* in the *Key Terms and Definitions* section.

Controlled Substance or Intoxicated: Services/treatment which involve an injury to which a contributing cause was the insured's commission of or attempt to commit a felony, except if a result of a medical or behavioral health condition, or domestic violence, even if the condition was not diagnosed at the time of the injury. See [NRS 695G.405](#).

Corrective Appliance, Orthotic Device Expenses, and Appliances: Any items that are not:

- corrective appliances,
- orthotic devices or orthotic braces that straighten or change the shape of a body part,
- prosthetic appliances, or
- durable medical equipment (as each of those terms is defined in the *Key Terms and Definitions* section)

This ~~includes~~, but not limited to, personal comfort items like:

- -air purifiers,
- humidifiers,

- electric heating units,
- swimming pools,
- spas,
- saunas,
- escalators,
- lifts,
- motorized modes of transportation determined to be not medically necessary,
- pillows,
- orthopedic mattresses,
- water beds, and
- air conditioners are excluded.

Expenses for cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome. Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment are not covered. Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.

Cosmetic Services and Surgery: The Plan excludes expenses for cosmetic services and surgery or any drugs used for cosmetic purposes, including but not limited to health and beauty aids. Complications resulting from Cosmetic Services or Surgery are not covered.

~~There is no coverage for travel costs.~~

Prophylactic surgery is covered under certain circumstances. Contact the UM company.

Participants should use the Plan's precertification procedure to determine if a proposed surgery or service will be considered cosmetic surgery or medically necessary reconstructive services.

*Breast augmentation/augmentation mammoplasty excluded, except as otherwise covered and described above.

Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken/missed appointments, general telephone calls not including telehealth, or photocopying fees.

Court-Ordered Treatment: Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, laboratory and other diagnostic testing and other services including hospitalizations or partial hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless the Plan Administrator or its designee determines that such services are independently medically necessary.

Custodial Care: Expenses for custodial care as defined in the *Key Terms and Definitions* section, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, including any service

that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary. Services required to be performed by physicians, nurses or other skilled health care providers are not considered to be provided for custodial care services and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Dental Services: Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness, or injury affecting the mouth or another part of the body.

Except as described as an inclusion in the ~~Schedule of Medical Benefits~~Schedule of Benefits, services involving:

- -treatment to the teeth;
- extraction of teeth;
- repair of injured teeth;
- general dental services;
- treatment of dental abscesses or granulomas;
- treatment of gingival tissues (other than for tumors);
- dental examinations;
- restoration of the mouth, teeth, or jaws because of injuries from
 - biting,
 - chewing, or
 - accidents;
- artificial implanted devices;
- braces;
- periodontal care or surgery;
- teeth prosthetics and bone grafts regardless of etiology of the disease process; and
- repairs and restorations except for:
 - appliances that are medically necessary to stabilize or repair sound and natural teeth after an injury;
 - dental and or medical care including mandibular or maxillary surgery,
 - orthodontia treatment,
 - oral surgery,
 - pre-prosthetic surgery,
 - any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth in the ~~Schedule of Medical Benefits~~Schedule of Benefits.

Coverage for dental services as the result of an injury to sound and natural teeth may be extended under the medical Plan to a maximum of two (2) years following the date of the injury. Restorations past the two-year time frame will be considered under the dental benefits described

in the PEBP Self-Funded Dental PPO Plan Master Plan Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthodontia is a specific Plan exclusion.

Drugs, Medicines, Nutrition or Devices:

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been prescribed for a medically necessary indication or are Experimental and/or Investigational as defined in the *Key Terms and Definitions* section.
- Non-prescribed, non-Legend and over the counter (OTC) drugs or medicines (except as preventive care medications required by the Affordable Care Act).
- Foods and nutritional supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs, and minerals (regardless of whether they can be purchased OTC or whether they require a prescription), except when provided during hospitalization; prenatal vitamins or minerals requiring a prescription;
- Special Food Product (as defined in the *Key Terms and Definitions* section), except for the benefit described as covered under Special Food Product in the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits* section or elsewhere in this document under the section titled *Obesity Care Management Program*;
- Naturopathic, Naprapathy, or homeopathic treatments/substances.
- Weight control or anorexiant, except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy or where otherwise noted in this document under the section titled *Obesity Care Management Program*;
- Compounded Prescriptions in which there is not at least one ingredient that is a Legend Drug requiring a Prescription, as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, or other health care facility.
- Vaccinations, immunizations, inoculations, or preventive injections that are not covered under the Summary of ~~Medical~~ Benefits section.
- Marijuana and any derivative, including CBD, THC, edibles, etc. are not a covered benefit under this Plan.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the prescription drug program.

- Drugs to enhance athletic performance such as anabolic steroids (including off-labeled growth hormone). Coverage for human growth hormone or equivalent is excluded unless specifically covered and described in the *Summary of ~~Medical~~ Benefits*.
- Non-prescription male contraceptives, e.g., condoms.
- Dental products such as topical fluoride preparations and products for periodontal disease, except as a preventive service required under the Affordable Care Act.
- Hair removal or hair growth products (*i.e.*, *Propecia*, *Rogaine*, *Minoxidil*, *Eflornithine*, *etc.*).
- Vitamin A derivatives (retinoids) for dermatologic use.
- Vitamin B-12 injections (except for treatment of mental health, pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (unless otherwise specified in the ~~Schedule of Medical Benefits~~Schedule of Benefits).
- Anti-aging treatments (even if FDA-Approved for other clinical indications)

Durable Medical Equipment:

See the exclusions related to Corrective Appliance, Orthotic Device Expenses, and Appliances.

Educational Services: Expenses for educational/vocational services, supplies or equipment including (but not limited to) computers, software, printers, books, tutoring, visual aids, auditory aides, and speech aides, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, or self-esteem, etc. (even if they are required because of an injury, illness, or disability of a covered individual).

Electronic cigarettes: The Plan does not cover electronic cigarettes.

Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by you or your covered dependents' employer; or for benefits otherwise provided under this Plan or any other plan that PEBP contributes to or otherwise sponsors (e.g., HMOs).

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefits as described in this document.

Expenses Exceeding Usual and Customary Charges, the Plan's Maximum Allowable Charge, Prevailing Rates and PPO Contracted Rates: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Plan's Maximum Allowable Charge, Usual and Customary Charge, prevailing rates or PPO contracted rate as defined in the *Key Terms and Definitions* section, except as required by independent dispute resolution under the No Surprises Act.

Expenses for Which a Third-Party Is Responsible: See “Third-Party Liability” of the Health and Welfare Wrap document that can be found on [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) (NAC 287.755).

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided either before the patient became covered under the Plan or after the date the patient’s coverage ends, except under those conditions described in COBRA Continuation Coverage.

Experimental and/or Investigational Services: Unless mandated by law, expenses for any medical services, supplies, drugs, or medicines that are determined by the Plan Administrator, UM company or its designee to be experimental and/or investigational services.

Fertility and Infertility Treatment:

Except as otherwise specified in the ~~Schedule of Medical Benefits~~Schedule of Benefits section, all other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) are excluded. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy; the promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the participant’s ability to become pregnant or to carry a pregnancy to term; and any payment made by or on behalf of a participant who is contemplating or has entered into a contract for surrogacy to a provider or individual related to any services potentially included in the scope of surrogacy services; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are also excluded.

Foot/Hand Care:

Expenses for non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and expenses for routine foot care (including but not limited to: trimming of toenails, removal of corns and callouses, preventive care with assessment of pulses, skin condition and sensation) or hand care, (including manicure and skin conditioning), unless the Plan Administrator or its designee determines such care to be medically necessary.

Routine foot care from a podiatrist for treatment of foot problems such as corns, calluses and toenails are payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

Gender Dysphoria and/or Gender Services: The Plan provides benefits to individuals seeking services for the treatment of gender dysphoria and gender incongruence in accordance with [Senate Bill 163](#) from the 82nd Legislative Session in 2023.

Certain procedures associated with gender dysphoria treatment and/or gender related surgery found to be non-medically necessary in the Treatment for Gender Dysphoria section above are not covered.

~~There is no coverage for travel costs.~~

Genetic Testing and Counseling: Coverage is not available for tests solely for research, or for the benefit of individuals not covered under this Plan.

Expenses for genetic testing and counseling are excluded, unless otherwise specified in this Plan's ~~Schedule of Medical Benefits~~[Schedule of Benefits](#).

Growth Hormone: Coverage for off-labeled growth hormone.

Gym Fees: Fees by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists, even if recommended by a professional to treat a medical condition.

Hair: Expenses for or related to hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Eflornithine; or for hair replacement devices, including (but not limited to) wigs, toupees and/or hairpieces or hair analysis. Patients undergoing chemotherapy may be able to receive benefits for some hair replacement devices, as listed above.

Hearing Care: Special education and associated costs in conjunction with sign language education for a patient or family members.

Hearing Aids: Over the Counter hearing aids are excluded from the Plan.

Home Birth/Delivery: Planned birth/delivery at home and associated services are not covered by this Plan. Guidelines for Perinatal Care published by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG) that the hospital, including a birthing center within the hospital complex, or a freestanding birthing center, provides the safest setting for labor, delivery, and the postpartum period. The use of other settings is not covered by this Plan. Facilities providing obstetrical care should have the services listed as essential components of a Level 1 hospital.

Home Health Care:

- Expenses for any home health care services that are not medically necessary, other than part-time, intermittent skilled nursing services and supplies.
- Expenses for a homemaker, custodial care, childcare, adult care, or personal care attendant, except as provided under the Plan's hospice coverage.
- Expenses for any home health care services that is not provided by an organization or professional licensed by the state to render home health services.

- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the Summary of ~~Medical~~ Benefits and ~~Schedule of Medical Benefits~~Schedule of Benefits.

Expenses for any services provided substantially or primarily for the participant's convenience or the convenience of a caregiver.

Hospital Employee, Medical Students, Interns or Residents: Expenses for the services of an employee of a hospital, skilled nursing facility or other health care facility, when the facility is obligated to pay that employee.

Hypnosis and Hypnotherapy: (As defined by CMS) an artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility.

Illegal Act: Expenses incurred by a covered individual for injuries resulting from commission (or attempted commission by the covered individual) of an illegal act as determined by the plan administrator which involved violence or threat of violence to another person, or in which any weapon or explosive is used by the covered individual, unless such injury is the result of a physical or mental health condition or domestic violence. The Plan Administrator's determination that this exclusion applies shall not be affected by any prosecution, or acquittal of (or failure to prosecute) the covered individual in connection with the acts involved, unless such injury is the result of a physical or mental health condition or domestic violence.

Internet/Virtual Office Visit: Expenses related to an online internet consultation with an out-of-network physician or other health care practitioner (also called a virtual office visit/consultation), physician-patient web service or physician-patient e-mail service (including receipt of advice, treatment plan, prescription drugs or medical supplies obtained) from an online internet provider who is not a participating provider in the Plan network except as specifically provided.

Maternity/Family Planning:

- Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms.
- Termination of Pregnancy: Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies the health of the mother would be endangered if the fetus were carried to term and complications of such termination.
- Childbirth courses.
- Expenses related to delivery associated with a pregnant dependent child, except for expenses related to complications of pregnancy.
- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs.
- For nondurable supplies.
- Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.

Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary, as defined in the *Key Terms and Definitions* section.

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required because of an injury, illness, or disability of a covered individual, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc.).

No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

No Provider Recommendation or Order: Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician or other licensed provider acting within the scope of their license.,

Non-Emergency Hospital Admission: Care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.

Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses) of a health care provider, participant except where otherwise specified in the Utilization Management section for organ/tissue transplants and bariatric weight loss surgery or certain surgeries performed in a surgery center, inpatient hospital or outpatient setting as determined by the Plan Administrator or the UM company.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: All expenses incurred by you or any of your covered dependents arising out of or during employment if the injury, illness, or condition is subject to coverage, in whole or in part, under any workers' compensation, or occupational disease (or similar) law.

Orthodontia: Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an injury or illness.

Personal Comfort Items: Expenses for patient convenience, including (but not limited to) care of family members while the covered individual is confined to a hospital (or other health care facility, or to bed at home), guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

Private Room in a Hospital or Health Care Facility: The use of a private room in a hospital or other health care facility, unless the facility has only private room accommodations, or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

Prophylactic Surgery or Treatment: Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery, as defined in the *Key Terms and Definitions* section of this document, when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for:

- Avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results, in certain circumstances; or
- Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder. Participants should use the Plan's UM company to assist in the determination of a proposed surgery to determine if it is or is not covered under this Plan.

NOTE: Some prophylactic surgeries may be covered under this Plan if certain criteria are met. Please refer to the ~~Schedule of Medical Benefits~~Schedule of Benefits section. For additional information, please contact this Plan's UM company or Claims Administrator.

Prophylactic drugs are excluded.

Rehabilitation Therapy (Inpatient or Outpatient):

- Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing, and related services.
- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
- Expenses for maintenance rehabilitation, as defined in the *Key Terms and Definitions* section.
- Expenses for speech therapy for functional purposes including (but not limited to) stuttering, and stammering ~~and conditions of psychoneurotic origin.~~
- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living or for Medically Necessary treatment of a mental health or substance use disorder diagnosis.
- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency.

Service Animals: Purchase, training, or maintenance of any type of service animal, even if designated as medically necessary.

Smoking/Tobacco Cessation: Expenses for non-prescription (over the counter) tobacco/smoking cessation products such as nicotine gum or patches, unless prescribed by a physician. There are no benefits payable for the use of electronic cigarettes. Prescription smoking/tobacco cessation products are payable under the prescription drug benefit as described in the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits* section.

Stand-By Physicians or Health Care Practitioners: Expenses for any physician or other provider who did not directly provide or supervise medical services to the patient, even if the physician or practitioner was available on a stand-by basis.

Taxes: Sales taxes, unless specifically covered in the Plan. See also CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, Chapter 21, Section 2122.2.G.

Telephone Calls: Expenses for all telephone calls between a physician or other health care provider and any patient, other health care provider, UM company or vendor; or any representative of this Plan for any purpose whatsoever.

Transplant (Organ and Tissue) Experimental and/or Investigational:

Human organ and/or tissue transplants that are experimental and/or Investigational, including (but not limited to) donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post-operative services and drugs or medicines, and all complications thereof.

Non-human (Engrafted) organ and/or tissue transplants or implants, except heart valves.

- Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this Plan

Travel Outside of the United States: Any services received outside the United States are excluded unless deemed to be urgent or emergency care.

Vision Care:

Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery); and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded, except as otherwise specified in this Plan's *Summary of ~~Medical Benefits~~ and *Schedule of Medical Benefits***Schedule of Benefits*.

War or Similar Event: Expenses incurred because of an injury or illness due to you or your covered dependent(s)' participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Weight Management and Physical Fitness:

- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs, and prescription drugs, except those services specified in the *Summary of ~~Medical Benefits~~* and *~~Schedule of Medical Benefits~~Schedule of Benefits*. Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Expenses for weight loss surgery performed without a precertification from the UM company will be denied.
- Expenses related to programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.
- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of an eating disorder (such as anorexia, bulimia, ~~etc or acute starvation.~~). Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under any PEBP self-funded medical Plan (e.g., LD PPO Plan, CDHP, and Exclusive Provider Organization Plan).

Other Benefit Exclusions

- Stress reduction therapy or cognitive behavior therapy for sleep disorders.
 - The exclusion for cognitive therapy does not apply to Medically Necessary treatment of a mental health or substance use condition.
- Sleep therapy (except for central or obstructive apnea when medically necessary and when a precertification has been received from the UM company), behavioral training or therapy, milieu therapy (unless the care is otherwise medically necessary), biofeedback (unless included with psychotherapy), behavior modification, sensitivity training, hypnosis, electrohypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.
- Charges that result from appetite control, ~~food addictions~~, or any treatment of obesity, unless otherwise provided in the *Summary of ~~Medical Benefits~~* and *~~Schedule of Medical Benefits~~Schedule of Benefits*.

~~Except as otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.~~

- Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (BEST), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.

- Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or Chiropractor's office, or at a retail location are excluded, unless otherwise specified in the *Summary of ~~Medical Benefits~~ and ~~Schedule of Medical Benefits~~Schedule of Benefits*.

Medical Claims Administration

How Medical Benefits are Paid

Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP's third-party claims administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or copayments apply, you are responsible for paying your share of these charges.

If services are provided through the PPO network, the PPO health care provider may submit the proof of claim directly to PEBP's third-party claims administrator; however, you will be responsible for the payment to the PPO health care provider for any applicable Deductible, Coinsurance, or copayments.

If a health care provider does not submit a claim directly to PEBP's third-party claims administrator and instead sends the bill to you, you should follow the steps outlined in this section regarding How to File a Claim. If, at the time you submit your claim, you furnish evidence acceptable to the Plan administrator or its designee (PEBP's third-party claims administrator) that you or your covered dependent paid some or all those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan Year Deductible and Coinsurance amounts are met.

How to File a Medical Claim

All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

See also, [NAC 287.610](#).

Most providers send their bills directly to the PEBP's claims administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party claims administrator or PEBP's website (see the *Participant Contact Guide* in this document for details on address, phone, and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information is necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains all the following information:

- A description of the services or supplies provided including appropriate procedure codes.
- Details of the charges for those services or supplies.
- Appropriate diagnosis code.
- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Claims Administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny Deductible and Out-of-Pocket Maximum credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list:

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- Providers such as hospitals and facilities that bill for single or bulk items such as orthopedic devices/implants or other types of biomaterials shall provide to the third-party claim's administrator a copy of the manufacturer's/organization's invoice (that directly supplied the device/implant/biomaterial to the healthcare provider). This Plan will deny payment for such medical devices until a copy of the invoice is provided to this Plan's Claims Administrator.

Claims are processed by the third-party claims administrator in the order that they are received.

It is your responsibility to maintain copies of the EOB documents provided to you by PEBP's third-party claims administrator or prescription drug administrator. Copies of EOB documents are available on the Claims Administrator's website but cannot be reproduced. PEBP and its third-

party claims administrator do not provide printed copies of EOB documents outside of the original mailing.

Where to Send the Claim Form

Send the completed claim form, the bill you received (retain a copy for your records) and any other required information to the Claims Administrator at the address listed in the *Participant Contact Guide* in this document.

Appeals

You have the right to ask PEBP or its designees to reconsider a claim or Utilization Management Adverse Benefit Determination resulting in a denial, reduction, termination, failure to provide or make payments (in whole or in part) for a service or treatment, Rescission of coverage (retroactive cancellation), or HRA claim.

Discretionary Authority of PEBP and Designee

In carrying out their respective responsibilities under the Plan, PEBP and its designees have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in this document.

~~Medical and Dental~~ Claims and HRA Appeals

Written Notice of Adverse Benefit Determination

The Plan or its designee, the third-party administrator, will notify you in writing on an Explanation of Benefits (EOB) of an Adverse Claim Determination resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal. When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

You will be provided with:

- (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- (b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- (c) a full and fair review that considers all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- (d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

Level 1 Claim Appeal

[NAC 287.670](#)

If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third-party administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause can be demonstrated. The written request for appeal must include:

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit your own comments in writing. The third-party administrator will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The third-party administrator will issue a decision of your Level 1 Claim Appeal in writing within 20 days after receipt of your request for appeal.

You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:

- (a) information that is sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
- (b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review (when external review is applicable);
- (c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
- (d) reference the specific Plan provision(s) on which the determination is based;

- (e) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- (f) an explanation of the Plan's appeal process and Level 2 appeal process and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- (g) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- (h) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
- (i) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
- (j) disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

The notification will explain the steps necessary if you wish to proceed to a Level 2 Appeal if you are not satisfied with the response at Level 1.

Level 2 Claim Appeal

[NAC 287.680](#)

If you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request forms* are available at ~~www.pebp.state.nv.us~~<https://pebp.nv.gov/> or by request by contacting PEBP Customer Service. Furthermore, you are welcome to submit Level 2 Claim Appeals online through a form that can be found under the subheading "Filing an Appeal" under PEBP's contact us web page. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal **must** include a copy of:

- Any document submitted with your Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use all resources available to ensure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. A Level 2 Appeal

determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.

External Claim Review

NAC 287.690

Standard Request

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. An *External Review Request Form* is available on the PEBP website at www.pebp.state.nv.ushttps://pebp.nv.gov/. The OCHA will assign an independent external review organization within five 5 days after receiving the request. The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

A Request for External Claim Review must include:

- completed and signed External Review Request Form.
- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Web:

[https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_\(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

Appealing a Utilization Management Determination

The utilization management (UM) company is staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer utilization review services. The review includes a process to determine the medical necessity, appropriateness, location, and cost effectiveness of health care services. Depending on the

service, a review may occur before, during, or after the services are rendered, including, but not limited to precertification/pre-authorization; concurrent and/or continued stay review; discharge planning; retrospective review; and case management.

Pursuant to applicable [NRS 695G](#), you have the following appeal processes for any adverse benefit determination made during the precertification, concurrent review, retrospective review, or case management. An appeal may be initiated by the participant, treating provider, parent, legal guardian, or person authorized to make health care decisions by a power of attorney.

The UM company will utilize a physician (other than the physician who rendered the original decision) to review the appeal. This physician is Board Certified in the area under review and is in active practice. Refer to the *Participant Contact Guide* for the UM company's contact information.

Internal UM Appeal Review

Expedited Internal UM Appeal Review

You may request an expedited appeal review of a denied precertification of a hospital admission, availability of care, continued stay or health care service for which you received emergency services but have not been discharged from the facility providing the care; or if the physician certifies that failure to proceed in an expedited manner may jeopardize your life or health or the life or health of your covered dependent or the ability for you or your covered dependent to regain maximum function.

Requests for an expedited internal UM appeal review may be made by telephone or any other reasonable means to the UM company that will ensure the timely receipt of the information required to complete the appeal process. If your physician requests a consultation with the reviewing physician, this will occur within one business day. The UM company will decide on an expedited appeal within 72 hours of receipt of the information needed to complete the appeal. The results of the determination of an expedited appeal will be provided immediately to the managing physician by phone and in writing to the patient, managing physician, facility, and the third-party claim's administrator.

If the appeal review request is denied, the UM company will provide the member with an adverse benefit determination letter including the clinical rationale for the non-certification decision and the member may pursue an external appeal as described in [NRS 695G.241](#) - [NRS 695G.275](#).

Standard Internal UM Appeal Review

If you have a denied precertification request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue) and you do not qualify for an expedited appeal, you may request a standard appeal review. Requests for standard appeal review may be made by writing to the UM company.

Requests for standard appeal review must be made within 180 days of the date of the denial/non-certification. Actual medical records are encouraged to be provided to assist the reviewer.

Standard appeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service treatment will be completed within 20 days of the receipt of the request. The results of the determination of a standard appeal will be provided in writing to the patient, managing physician, facility, and third-party claim's administrator.

A participant or their designee can choose to bypass the internal appeals process from adverse benefit determinations resulting from the UM company and request a review by an external review organization.

External UM Appeal Review

An external review may be requested by a participant and/or the participant's treating physician after you have exhausted the internal UM appeal review process. This means you may have the right to have the Plan Administrator or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgement as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

Expedited Request for External Review (Pre-Service Urgent UM Appeal) [NRS 287.04335](#)

For adverse benefit determinations resulting from the UM company, a participant or their designee can choose to bypass the internal UM appeal process and request a review by an external review organization.

Expedited external review is available only if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination and the patient's treating provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered individual or would jeopardize the covered individual's ability to regain maximum function. Pursuant to [NRS 695G.271](#), the Office for Consumer Health Assistance (OCHA) will approve or deny a request for an external review of an adverse determination not later than 72 hours after receipt from the provider. If OCHA determines the request qualifies for expedited review, a final of the external review will made by the external review organization within 72 hours of receipt and the provider and participant will be notified within 24 hours.

A participant may file a request for an expedited external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. An expedited external review request form, which includes a certification of treating provider for expedited consideration can be found on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

The request must be submitted to:

Office for Consumer Health Assistance

3320 W. Sahara Avenue, Suite 100

Las Vegas NV 89102

Phone: (702) 486-3587,

(888) 333-1597

Web:

[https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_\(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

Standard Request for External UM Review

A standard request for external UM review may be filed with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. A standard external review request form can be found on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

A standard external review decision will be made within 45 days of OCHA's receipt of the request.

As with the expedited external review, a standard external review must be submitted to the Office for Consumer Health Assistance at the contact information listed above.

Experimental and/or Investigational Claim/UM External Review

If you received a denial for a service, durable medical equipment, procedure, or other therapy because the third-party administrator or the UM company determined it to be experimental and/or investigational, or subject to the No Surprises Act, or rescission of coverage, you may request an external review. To proceed with the experimental and/or investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.

A "Physician Certification of Experimental/Investigational /Denials" is located under "Forms" on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

After this form is completed by the treating physician, it should be attached to the Request for External Review" form and submitted to the Office for Consumer Health Assistance at:

Office for Consumer Health Assistance

3320 W. Sahara Avenue, Suite 100

Las Vegas NV 89102

Phone: (702) 486-3587,

(888) 333-1597

Web: [https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_\(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

Prescription Drug Review and Appeals

A participant has the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. The Pharmacy Benefit Manager reviews both clinical and administrative coverage review requests, including those cases related to specialty drugs dispensed through Accredo specialty pharmacy.

Clinical Coverage Review

The initial clinical coverage review is a request for coverage or medication that is based on clinical conditions of coverage that are set by this Plan—for example, medications that require a prior authorization. To make an initial determination for a clinical coverage review request, the prescribing physician must submit specific information for review.

How to Request a Clinical Coverage Review

The preferred method to request an initial clinical review is for the prescribing physician to submit the prior authorization request electronically. Alternately, the participant's prescribing physician or pharmacist may call Express Scripts at 1-800-753-2851 or the prescriber may submit a request in writing using a Benefit Coverage Review Form, which can be obtained by calling Express Scripts Member Services at 1-855-889-7708. (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

Administrative Coverage Review

The initial administrative coverage review is a request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Administrative Coverage Review

To request an initial administrative coverage review, the participant must submit the request in writing to Express Scripts to the attention of the Benefit Coverage Review Department (see *Participant Contact Guide* section).

For an administrative coverage review request, the participant must submit information to the pharmacy benefits manager to support the request.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy, or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by calling Express Scripts at 1-800-753-2851.

If the necessary information is provided to Express Scripts so that a determination can be made, the initial determination and notification for a clinical coverage or administrative coverage review will be made within the timeframe below:

- Standard Pre-Service: 15 days for retail pharmacy and five (5) days for home delivery; and
- Standard Post-Service: 30 days.

Level 1 Appeal or Urgent Appeal

When an initial administrative or clinical coverage review request has been denied, a request for appeal of the denial may be submitted by the participant within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to Express Scripts' Benefit Coverage Review Department:

- Name of patient.
- Participant ID number.
- Phone number.
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the initial adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including physician/prescriber statements/letters, bills, or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone at 1-800-753-2851 or fax 1-877-852-4070 to Express Scripts. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are by Express Scripts' pharmacist, physician, panel of clinicians, trained prior authorization staff member, or an independent third-party prescription drug utilization management company.

Level 1 Appeal Decisions and Notifications

Express Scripts will render Level 1 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 20 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to

respond prior to issuance of any final adverse benefit determination. Standard Post-Service: [NAC 287.670](#).

Level 2 Appeal

When a Level 1 Appeal has been denied, a request for a Level 2 Appeal may be submitted by the participant within 35 days from receipt of notice of the Level 1 Appeal denial. To initiate a Level 2 Appeal, you must request by mail or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department.

An urgent Level 2 Appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department (see the *Participant Contact Guide* section). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Level 2 Appeal Decisions and Notifications

Express Scripts will render Level 2 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 30 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. Standard Post-Service: [NAC 287.680](#)

External Reviews

The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental and investigation. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to the independent review organization (see *Participant Contact Guide*) within 4 (four) months of the date of the Level 2 Appeal denial. (If the date that is 4 (four) months from that date is a Saturday, Sunday, or a holiday, the deadline will be the next business day).

Standard External Review: the pharmacy benefit manager will review the external review request within 5 (five) business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and the patient will be notified within 1 (one) business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO, and the Appeal information will be compiled and sent to the IRO within 5 (five) business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgement or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the pharmacy benefit manager for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and the pharmacy benefit manager written notice of its decision. If the IRO has determined that the claim does not involve medical judgement or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regarding maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Coordination of Benefits

For detailed information, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

Which Benefits are Subject to Coordination?

When Participants have medical, dental or vision coverage from some other source, benefits are determined using Coordination of Benefits (COB). COB operates so that one of the plans (i.e., the primary plan) will pay its benefits first. The other plan or policy, (i.e., the secondary plan) may then provide additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

Participants must let the Plan Administrator, or its designee, know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and dental deductibles. This Plan’s prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.

For the purposes of this COB section, the word “plan” refers to any group or individual medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual either on an individual basis or as part of a group of employees, retirees or other individuals.

A Participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such fully insured plan and the rules and procedures described in such fully insured plan’s applicable Summary of Insurance.

A Participant in a self-insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures set forth in this Section 4.4. The PEBP delegates to the third-party administrator of such self-insured plan the duty to administer and interpret the provisions of this Section 4.4. and to adopt, document and communicate any rules and procedures necessary or appropriate to implement the COB procedures, as set forth herein:

Which Plan Pays First: Order of Benefit Determination Rules

PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any plan that does not use these same rules always pays its benefits first.

When two plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second).

If the first of the ~~following~~ rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

These rules are detailed in the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

Coordination with Medicare

Coordination with Medicare is not applicable for retirees and their dependents who are eligible for Medicare Part A and Medicare Part B and who are required to transition to the Medicare Exchange.

This Plan has coordination of benefits for Medicare as it relates to:

- Entitlement to Medicare Coverage,
- When the Participant Is Not Eligible for Premium Free Medicare Part A,
- Coverage Under Medicare and This Plan When a Participant has End-Stage Renal Disease (ESRD),
- How Much This Plan Pays When It Is Secondary to Medicare,
- When the Retiree or the Retiree’s Covered Spouse or Domestic Partner is Enrolled in Medicare Part B,
- When the Participant Enters Into a Medicare Private Contract

For details, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

Coordination with Other Government Programs

This Plan has coordination of benefits as it relates to:

- Medicaid,
- Medicare,
- Tricare,
- Veterans Affairs,
- Worker’s Compensation, and
- Medicare Disability.

For more details, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

Subrogation and Third-Party Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the injury, irrespective of the way they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). All payments made by the Plan for which it claims a right of subrogation are referred to as subrogated payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. All payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury.

The Participant must cooperate fully, always, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested to secure and protect the subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

- (1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of subrogation.
- (2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
- (3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate *Health and Welfare Benefits Wrap Plan* document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) for more information regarding third-party liability and subrogation.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) 3427 Goni Road, Ste 109 Carson City, NV 89706 Customer Service: (775) 684-7000, (702) 486-3100, or (800) 326-5496 Fax: (775) 684-7028 www.pebp.state.nv.us https://pebp.nv.gov/	Plan Administrator • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR <u>Claims Submission</u> P O Box 30541 Salt Lake City, UT 84130-0541 EDI #39026 <u>Appeal of Claims</u> P O Box 30546 Salt Lake City, UT 84130-0546 <u>Customer Service</u> (888) 763-8232 www.UMR.com <u>Diabetes Care Management form submission</u> UMR 27 Corporate Hill Drive Little Rock, AR 77205 Fax: 800-458-0701 Email: diabetes@UMR.com	Third-party Claims Administrator/Third-party Administrator/PPO Network/ Disease Management Administrator • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Disease Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Sierra Health-Care Options, Inc PO BOX 15645 Las Vegas, NV 89144-5648 Customer Service : 888-323-1461 Fax : 800-288-2264	Utilization Management and Case Management Company • Pre-Certification/Prior Authorization • Utilization Management • Case Management • Transplants

Participant Contact Guide	
Express Scripts Pharmacy <u>Customer Service</u> (855) 889-7708 www.Express-Scripts.com <u>Accredo Patient Customer Service:</u> (800) 803-2523 <u>Accredo Physician Service Line</u> (800) 987-4904 option 5 <u>Express Scripts / Accredo Prior Authorization</u> (800) 753-2851 Electronic option: express-scripts.com/PA <u>Specialty Medication SaveonSP copay assistance</u> (800) 683-1074 www.saveonsp.com/pebp	Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and EPO Plan • Prescription drug information • Retail network pharmacies • Prior authorization • Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies • Accredo Specialty Drug Services • Coverage and Clinical reviews • Appeals • External Review Requests • Copay/Deductible/Coinsurance assistance
HSA Bank HRA Claim Submission PO Box 2744 Fargo, ND 58108-2744 hsaforms@hsabank.com Fax: 855-764-5689 www.hsabank.com Customer Service: 833-228-9364 askus@hsabank.com myaccounts.hsabank.com	HSA and HRA Claims Administrator • HSA/HRA Claims and claim appeals
Diversified Dental Services 5470 Kietzke Lane, Ste 300 Reno, NV 89511 ProviderRelations@ddsppo.com 1-866-270-8326 diversifieddental.com	PPO Dental Network • Statewide PPO Dental Providers • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 www.myhpnstateofnevada.com/	Southern Nevada Health Maintenance Organization (HMO) • Medical claims/provider network

Participant Contact Guide	
VIA Benefits 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888)598-7545 https://my.viabenefits.com/pebp Phone: (888) 598-7545 Fax: (402) 231-4310	Medicare Exchange and Medicare HRA administrator • Medigap (Supplemental) plans • Medicare Advantage Plans (HMO and PPO) • HRA claims administrator
United Healthcare Specialty Benefits Group Number: 370074 Customer Service: 1-888-763-8232 UnitedHealthcare Specialty Benefits P.O. Box 7149 Portland, ME 04112-7149	• Basic Life Insurance for eligible active and retirees • Member Assistance Program • Global Travel Assistance
Office for Consumer Health Assistance 3320 W. Sahara Ave, Suite 100 Las Vegas, NV 89102 Customer Service: (702) 486-3587 or (888) 333-1597 https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/	Consumer Health Assistance • Concerns and problems related to coverage • Provider billing issues • External review information
Corestream PEBP+ Customer Care: (775) 249-0716 E-mail: pebpcustomer@corestream.com www.corestream.com <u>Voluntary Life, Critical Illness, Accident, and Hospital Indemnity Insurance</u> The Standard Insurance Company (888) 288-1270 www.standard.com/mybenefits/nevada	PEBP+ Voluntary Benefits Administrator • Accident Insurance • Auto Insurance • Critical Illness • Disability Insurance (Long-term and Short-term) • Home Insurance • Hospital Indemnity • Identity Theft • Legal Services • Life Insurance (Supplemental) • Pet Insurance • Vision Care

Key Terms and Definitions

The following terms or phrases are used throughout this MPD. These terms or phrases have the following meanings. These terms and definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

Active Rehabilitation: refers to therapy in which a patient, who can learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Actively Engaged:

- Participation in regular office visits with your provider. The frequency of the office visits will be determined by your provider who will in turn report this information to the third-party administrator for monitoring.
- Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss provider including but not limited to routine exercise, proper nutrition and diet, and pharmacotherapy if prescribed. Commitment to your weight loss treatment will be measured by the third-party administrator who will review monthly progress reports submitted by the provider; and
- Losing weight at a rate determined by the weight loss provider.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding, or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

When benefits for the services of an acupuncturist are payable by this Plan, the acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, be certified by the National Certification Commission for Acupuncturists (NCCA).

Adverse Benefit Determination: [NRS 695G.012](#) - Means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity,

appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Air Ambulance: A medical transport by a rotary wing air ambulance, as defined in [42 CFR 414.605](#), or fixed wing air ambulance, as defined in [42 CFR 414.605](#), for patients.

Allogenic: Refers to transplants of organs, tissues, or cells from one person to another person. Heart Transplants are always Allogenic.

Allowable Expenses: The Maximum Allowable Charge for any medically necessary, eligible item of expense, at least a portion of which is covered under the Plan. When some other non-Medicare plan pays first in accordance with the application to benefit determinations provision in the *Coordination of Benefits* section, this Plan's allowable expenses shall in no event exceed the other non-Medicare plan's allowable expenses.

When some other non-Medicare plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of each service rendered, by determining the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other non-Medicare plan include the benefits that would have been payable had claim been duly made; therefore, whether or not it is made.

Ambulance: A vehicle or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated, and staffed primarily for performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or

Where licensing is not required, it meets all the following requirements:

- It is operated under the supervision of a licensed physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area.
- It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthesiologist who is administering the anesthetic, and that the anesthesiologist or anesthesiologist remain present throughout the surgical procedure.
- It provides at least one operating room and at least one post-anesthesia recovery room.

- It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
- It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or x-rays), an operative report and a discharge summary.

An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.

Ancillary Services/Charges: Charges for services provided by a hospital or other facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Ancillary services, for purposes of the No Surprises Act, are, with respect to a PPO health care facility:

Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,

Items and services provided by assistant surgeons, hospitalists, and intensivists;

Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and

Items and services provided by a Non-PPO provider if there is no PPO provider who can furnish such item or service at such facility.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional, or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Annual/Annually: For the purposes of this Plan, annual and annually refers to the 12-month period starting July 1 through June 30.

Appliance (Dental): A device to provide or restore function or provide a therapeutic (healing) effect.

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Approved Clinical Trial: A phase I, II, III, or IV trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted.

An Approved Clinical Trial's study must be:

- (1) approved or funded by one or more of:
 - (a) the National Institutes of Health (NIH),
 - (b) the Centers for Disease Control and Prevention (CDC),
 - (c) the Agency for Health Care Research and Quality (AHCRO),
 - (d) the Centers for Medicare and Medicaid Services (CMS),
 - (e) a cooperative group or center of the NIH, CDC, AHCRO, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA),
 - (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or
 - (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;
- (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- (3) a drug trial that is exempt from investigational new drug application requirements.

Assistant Surgeon: A medically qualified doctor who assists the surgeon of record perform a procedure.

Autism Spectrum Disorders and related terms Have the meanings ascribed to them under [NRS 695G.1645](#) and [NRS 427A.875](#).

Autologous: Refers to transplants of organs, tissues, or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.

Average Wholesale Price (AWP): The average price at which drugs are purchased at the wholesale level.

Bariatric Surgery Center of Excellence: This provider has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical

treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

- Behavior modification program supervised by a qualified professional.
- Consultation with a dietician or nutritionist.
- Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen.
- Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise Therapist or other qualified professional.
- Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
- Reduced-calorie diet program supervised by dietician or nutritionist.

Base Plan: The self-funded Consumer Driven Health Plan (CDHP); the base plan is also defined as the “default plan” where applicable in this document and other materials produced by PEBP ([NRS 287.045](#)).

Behavioral Health Disorder: Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause.

Behavioral health disorders covered under this Plan may include, but are not limited to depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods and is provided by behavioral health practitioners as defined in this section. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the *Exclusions* section.

Behavioral Health Practitioner: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a master's degree, or other provider who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Behavioral Health Treatment: Services, including room and board, given by a behavioral health treatment facility or area of a hospital that provides behavioral or mental health or substance abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment

for the illness that is identified under the DSM code is considered a behavioral health treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated, and staffed primarily for providing a program for diagnosis, evaluation, and effective treatment of behavioral health disorders and which fully meets one of the following two tests:

- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements: has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the direction of a full-time registered nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological, and social needs of the patient.

A behavioral health treatment facility that qualifies as a hospital is covered by this Plan as a hospital and not a behavioral health treatment facility. A transitional facility, group home, halfway house or temporary shelter is not a behavioral health treatment facility under this Plan unless it meets the requirements above in the definition of behavioral health treatment facility.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, subject to the Plan's Maximum Allowable Charge, or negotiated fee schedule, after calculation of all Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements:
- It is operated and equipped in accordance with any applicable state law for providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.
- It is equipped to perform routine diagnostic and laboratory examinations, including (but not limited) to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
- It has available to handle foreseeable emergencies, trained personnel, and necessary equipment, including (but not limited to) oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
- It provides at least two beds or two birthing rooms.

- It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.
- It has a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It has the capacity to administer local anesthetic and to perform minor surgery.
- It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
- It is expected to discharge or transfer patients within 48 hours following delivery.

A birth (or birthing) center that is part of a hospital, as defined in this section, will be a birth (or birthing) center for the purposes of this Plan.

Business Day: Refers to all weekdays, except Saturday or Sunday, Nevada holiday, or federal holiday.

Case Management: A process administered by the UM company in which its medical professionals work with the patient, family, caregivers, providers, Claims Administrator, Pharmacy Benefit Manager and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential providers.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

Certified Surgical Assistant: A person who does not hold a valid health care license as an RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon, and who acts within the scope of his/her license or certification. Such individuals are payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

Chemical Dependency: This is another term for Substance Abuse. (See also the definitions of Behavioral Health Disorders and Substance Abuse).

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC) and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal column (vertebrae); and who acts within the scope of his or her license.

Chiropractic Services: PEBP considers chiropractic services to be medically necessary when all the following criteria are met:

- participant has objective medical findings of a neuro-musculoskeletal disorder; and
- a clearly defined treatment plan has been established including treatment and discharge goals; and
- services are not for maintenance purposes.

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings.

Chronic Medication Synchronization:

“Chronic medication” means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent, or lasting indefinitely.

“Synchronization” means the alignment of the dispensing of multiple medications by a single contracted pharmacy for improving a patient’s adherence to a prescribed course of medication. This includes providing coverage for less than a 30-day supply to enable synchronization.

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Clinical Trials: See *Experimental and Investigational* in the *Key Terms and Definitions* section.

Coinsurance: That portion of *Eligible Medical Expenses* for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses more than the Plan’s Deductible. The Coinsurance varies depending on whether In-Network or Out-of-Network providers are used.

Complications of Pregnancy: Any condition that requires hospital confinement for medical treatment, and if the pregnancy is not terminated, is caused by an injury or sickness not directly

related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or, any condition that requires hospital confinement and if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.

Compound Drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Concierge Medicine: Is a relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of all medical or dental care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care, and direct practice medicine. Most concierge medicine practices do not bill insurance.

Concurrent Review: A managed care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the utilization management company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility.

Continuing Care Patient: An individual who, with respect to a provider or facility-

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Convalescent Care Facility: See the definition of *Skilled Nursing Facility*.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how Plan benefits are payable when a person is covered by two or more health care plans.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. This can be in

addition to Coinsurance amounts due on the same incurred charges. Copayments are limited to certain benefits under this program.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or device) and Prosthetic Appliance (or device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator, UM company, or its designee.

Cost-Efficient: See the definition of medically necessary for the definition of cost-efficient as it applies to medical services that are medically necessary.

Cost-Share or Cost S-sharing: The amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Non-PPO providers, or the cost of items or services that are not covered under the plan.

Cost Sharing Amount for Emergency and Non-emergency Services at PPO Facilities performed by Non-PPO Providers, and air ambulance services from Non-PPO providers will be based on the Recognized Amount.

Covered Individual: Any employee or retiree (as those terms are defined in this Plan), and that person's eligible spouse or dependent child who has completed all required formalities for enrollment for coverage under the Plan and is covered by the Plan.

Covered Medical Expenses: See the definition of *Eligible Medical Expenses*.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible medical, prescription drug and dental expenses you are responsible for paying before the Plan begins to pay benefits. The dental Deductibles are discussed in the separate PPO Dental Master Plan Document.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the Temporomandibular Joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies coverage is provided in the PPO Dental Plan (refer to the separate PPO Dental Plan MPD available at [www.pebp.state.nv.us](https://pebp.nv.gov/)<https://pebp.nv.gov/>) and are not covered under the medical expense coverage of this Plan unless the medical Plan specifically indicates otherwise in the *Schedule of Medical Benefits* *Schedule of Benefits*.

Dependent: Any of the following individuals: Dependent child(ren), spouse or domestic partner as those terms are defined in this document.

Dependent Child(ren): See also ([NAC 287.312](#)). For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),
- any other person who:
 - (1) Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
 - (2) Is unmarried.

Disability: A determination by the Plan Administrator or its designee (after evaluation by a physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as intellectual disability, cerebral palsy, epilepsy, neurological disorder, or psychosis.

Domestic Partner: As defined by [NRS 122A.030](#).

Drug: See the definition for prescription drug.

Durable Medical Equipment: As defined by Centers for Medicare & Medicaid Services, the term DME is defined as equipment which, according to 42 CFR §414.202:

- Equipment that can withstand repeated use; ~~and~~
- is primarily and customarily used for a medical purpose ~~and~~
- generally, is not ~~generally~~ useful in the absence of an injury or illness; and
- is not disposable or non-durable; and
- is appropriate for the patient's home.

Durable medical equipment includes (but is not limited to) apnea monitors, augmentation devices, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Elective Hospital Admission, Service or Procedure: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that they are medically necessary; and the charges for them are usual and customary and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule; and coverage for the services or supplies is not excluded (as provided in the [Exclusions](#) section); and the Plan Year maximum benefits for those services or supplies has not been reached.

Emergency: See the definition for Medical Emergency.

Emergency Medical Condition: A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Care: Medical and health services provided for an Emergency Medical Condition as defined above.

This Plan does not require precertification for medically necessary emergency services provided at any hospital in accordance with [NRS 695G.170](#). For information, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Emergency Services means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-PPO provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness, or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.

Employer: Unless specifically indicated otherwise when used in this document, employer refers to an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

Enteral Formulas: Enteral Formulas is subject to [NRS 689B.0353](#).

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Experimental and/or Investigational Services: [NRS 695G.173](#) Required provision concerning coverage for treatment received as part of clinical trial or study.

Unless mandated by law, the Plan Administrator or its designee has the discretion and authority to determine if a service or supply is, or should be, classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply.
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
- In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
- With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered experimental and/or investigational if it is:
 - Approved by the FDA as an "Investigational new drug for treatment use"; or
 - Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease," as that term is defined in FDA regulations; or
 - Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
 - The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

In determining if a service or supply is or should be classified as experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for precertification under the Plan's utilization management program:

- Medical records of the covered person.
- The consent document signed, or required to be signed, to receive the prescribed service or supply.
- Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply.
- Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including (but not limited to) "United States Pharmacopoeia Dispensing Information"; and "American Hospital Formulary Service".
- The published opinions of the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
- Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
- The latest edition of "The Medicare Coverage Issues Manual."
- Nevada Statutes mandate the following criteria be met in cases of Cancer and Chronic Fatigue Syndrome:
 1. A policy of health insurance must provide coverage for medical treatment in a clinical study or trial if:
 - a. Treatment is for either Phase I, II, III, IV cancer or Phase II, III, IV Chronic Fatigue Syndrome.
 - b. Study is approved by:
 - i. Agency of National Institute of Health.
 - ii. A cooperative group (see bill for exact definition).
 - iii. FDA for new investigational drug
 - iv. US Dept. of Veteran Affairs.
 - v. US Dept. of Defense.
 - c. Health care provider and facility have authority to provide the care for Phase I cancer.
 - d. Health care provider and facility have experience to provide the care for Phase II, III, IV cancer or chronic fatigue syndrome.
 - e. No other treatment considered a more appropriate alternative.

- f. Reasonable expectation based on clinical data that treatment will be at least as effective as other treatments.
- g. Study is conducted in Nevada.
- h. Participant signs a statement of consent that he has been informed of:
 - i. The procedure to be undertaken.
 - ii. Alternative methods of treatment.
 - iii. Associated risks of treatment.
- 2. Coverage for medical treatment is limited to:
 - a. A drug or device approved for sale by the FDA.
 - b. Reasonably necessary required services provided in treatment or as a result of complications to the extent that they would have otherwise been covered for Phase II, III, IV cancer or chronic fatigue syndrome.
 - c. The cost of any routine health care services that otherwise would have been covered for an insured for Phase I cancer.
 - d. Initial consultation; and
 - e. Clinically appropriate monitoring.
- 3. Treatment is not required to be covered if provided free by sponsor.
- 4. Coverage does not include:
 - a. Portions customarily paid by other government or industry entities.
 - b. A drug or device paid for by manufacturer or distributor.
 - c. Excluded health care services.
 - d. Services customarily provided free in study.
 - e. Extraneous expenses related to study.
 - f. Expenses for persons accompanying participant in study.
 - g. Any item or service provided for data collection not related to study.
 - h. Expenses for research management of study.

NOTE: To determine how to obtain a precertification of any procedure that might be deemed to be experimental and/or investigational, see the *precertification* in the *Utilization Management* section.

Explanation of Benefits (EOB): When a claim is processed by the claims administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your Deductible, if your out-of-pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Expedited Appeal: If a participant appeals a decision regarding a denied request for precertification (pre-service claim) for an urgent care claim, the participant or participant's authorized representative can request an expedited appeal, either orally or in writing. Decisions regarding an expedited appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

External Review: An independent review of an adverse benefit determination conducted by an external review organization.

External Review Organization: An organization that

- 1) conducts an external review of a final adverse benefit determination; and
- 2) is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.

Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Free-Standing Laboratory Facility: Free-standing laboratory facilities are stand-alone facilities that are not affiliated with a hospital system. Examples of preferred free-standing laboratory facilities include Labor Corp or Quest.

Formulary: A list of generic and brand name drug products available for use by participants. This is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

Gender Dysphoria: In accordance with [Senate Bill 163](#) from the 82nd Legislative Session in 2023: "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

- (1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.
- (2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.
- (3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.
- (4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.
- (5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.
- (6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

Generic; Generic Drug: A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the pharmacist as being generic. (See also the Prescription Drug section of the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits* and the *Prescription Drug* subsection of the *Medical Exclusion* section).

Genetic Counseling: Counseling services provided before or in the absence of genetic testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of genetic testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from genetic testing, or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations. Tests that assist the health care practitioner in determining the appropriate course of action or treatment for a medical condition.

Gestational Carrier: Gestational carrier means an adult woman who is not an intended parent and who enters into a gestational agreement to bear a child conceived using the gametes of other persons and not her own. [NRS 126.580](#)

Government-Provided Services (Tricare/CHAMPUS, VA, etc.): Expenses for health care services provided to a covered participant that federal, state, or local law (e.g., Tricare/Champus, VA, except the Medicaid program), expenses for care required by a public entity and care for which there would not normally be a charge.

Health Care Facility: (for non-emergency services) is each of the following:

- A hospital (as defined in [section 1861\(e\) of the Social Security Act](#));
 - A hospital outpatient department;
 - A critical access hospital (as defined in [section 1861\(mm\)\(1\) of the Social Security Act](#));
- and

- An ambulatory surgical center described in [section 1833\(i\)\(1\)\(A\) of the Social Security Act](#)

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, or other provider who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* section).

Health Reimbursement Arrangement (HRA): A Health Reimbursement Arrangement (HRA) is an employer-funded spending account that can be used to pay qualified medical expenses. The HRA is 100% funded by the employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted or insurance coverage kicks in. The contribution amount per employee is set by the employer, and the employer determines what the funds can be used to cover and if the dollars can be rolled over to the next year. In most cases, if the employee leaves the employer, they cannot take remaining HRA funds with them.

Health Savings Account (HSA): An account that allows individuals to pay for current health expenses and save for future qualified medical and Retiree health expenses on a tax-free basis.

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency (as those terms are defined in this section).

Home Health Care Agency: An agency or organization that provides a program of Home Health Care and meets one of the following three tests:

- It is approved by Medicare; or
- It is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or

- If licensing is not required, it meets all the following requirements:
- It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or registered nurse to the home.
- It has a full-time administrator.
- It is run according to rules established by a group of professional health care providers including physicians and registered nurses.
- It maintains written clinical records of services provided to all patients.
- Its staff includes at least one registered nurse, or it has nursing care by a registered nurse available.
- Its employees are bonded.
- It maintains malpractice insurance coverage.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." See also the *Exclusions* section of this document regarding homeopathic treatment and services. When the services of homeopaths are payable by this Plan (e.g., an office visit), the homeopath must be properly licensed to practice homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post-graduate courses or training in a program approved by the American Institute of Homeopathy.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a limited life expectancy. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family.

A hospice agency must meet one of the following tests:

- It is approved by Medicare; or is licensed as a hospice agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
 - a. It provides 24-hour-a-day, 7 day-a-week service.
 - b. It is under the direct supervision of a duly qualified physician.
 - c. It has a full-time administrator.
 - d. It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.

- e. The main purpose of the agency is to provide hospice services.
- f. It maintains written records of services provided to the patient.
- g. It maintains malpractice insurance coverage.
- h. A hospice agency that is part of a hospital will be considered a hospice agency for the purposes of this Plan.

Hospital: A public or private facility or institution, other than one owned by the U.S Government, licensed and operating according to law, that:

- Is legally operated in the jurisdiction where it is located.
- Is engaged mainly in providing inpatient medical care and treatment for injury and illness in return for compensation.
- Has organized facilities for diagnosis and major surgery on its premises.
- Is supervised by a staff of at least two physicians.
- Has 24-hour-a-day nursing service by registered nurses; and
- Is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or skilled nursing facility or similar institution; or a Long-Term Acute Care Facility (LTAC).

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, birth (or birthing) center, hospice, skilled nursing facility, sub-acute care facility, or other place for rest, custodial care, or the aged shall not be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician, and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be an illness only for coverage under this Plan. However, infertility is not an illness for coverage under this Plan.

Independent Freestanding Emergency Department: A health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Inherited Metabolic Disorder: See also NRS 689B.0353. A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates, or fats, as diagnosed by a physician using standard blood, urine, spinal fluid, tissue, or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an Inherited Metabolic Disorder under this Plan. See Special Food Products.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth): An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to sound and natural teeth are payable under the medical Plan .

In-Network Provider: Means an In-Network provider that the network or one of its rental networks have contracted with or have arrangements with to provide health services to covered individuals. An In-Network provider has agreed to charge participants a discounted rate. To determine if a provider is an In-Network provider log on to [www.pebp-state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/). You may also call the number on the back of your ID card and a customer service representative can help you locate an In-Network provider.

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network services that are provided by a health care provider that is not a member of the PPO network.

In-Network Contracted Rate: The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the In-Network contracted amount may be applied to Out-of-Network provider charges.

Inpatient Services: Services provided in a hospital or other health care facility during the period when charges are made for room and board.

Intensive Care Unit: A section, ward, or wing within the hospital which:

- Is separated from other hospital facilities.
- Is operated exclusively for providing professional care and treatment for critically ill patients.
- Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use.
- Provides room and board; and
- Provides constant observation and care by registered nurses or other specially trained hospital personnel.

Intensive Outpatient Program: An intensive outpatient program (IOP) is a kind of treatment service and support program used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification. IOP operates on a small scale and does not require the intensive residential or partial day services typically offered by the larger, more comprehensive treatment facilities.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance Rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where

additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and or preserve the patient's functional level. Maintenance rehabilitation is not covered by the Plan.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are costlier than others that can achieve the same result.

Maximum Amount; Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Plan Administrator considering and after having analyzed:

- The reasonable and appropriate amount.
- The terms of the Plan:
- Plan negotiated and contractual rates with provider(s).
- The actual billed charges for the covered services; and
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with a service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s).
- Medicare Allowable

The Plan will reimburse the actual charge(s) if they are less than the Plan's Maximum Allowable Charge amount(s). The Plan has the discretionary authority to decide if a charge is reasonable and appropriate, as well as medically necessary. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical management technique: Has the meaning ascribed to it within [NRS 695G](#) which means a practice which is used to control the cost or use/utilization of health care services, prescription drugs, or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.

Medically Necessary: Has the meaning ascribed to it in accordance with [NRS 695G.055](#): "Medically necessary" means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

1. Provided in accordance with generally accepted standards of medical practice;
2. Clinically appropriate with regard to type, frequency, extent, location and duration;
3. Not primarily provided for the convenience of the patient, physician or other provider of health care;
4. Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and

5. The most clinically appropriate level of health care that may be safely provided to the insured.

A medical or dental service or supply will be appropriate if:

- It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility:
- The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

Medically Necessary for External Review: Means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Part A: Hospital insurance provided by the federal government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the federal government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the federal government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.

Medi-Span: A national drug pricing information database for drug pricing analysis and comparison.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a Midwife or certified as a Certified Nurse Midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Morbid Obesity: Characterized by body mass index $>40 \text{ kg/m}^2$ as defined by the National Library of Medicine.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage, or herbal tea. Note: Naturopathy providers, treatment, services, or substances are not a payable benefit under this Plan.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap, or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the [Schedule of Medical Benefits](#)[Schedule of Benefits](#) are covered by this Plan. All others are not.

Non-Network: See *Out-of-Network*.

Non-PPO emergency facility: An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health

plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

Non-PPO Provider or Non-Participating Provider: A health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA) and authorized to administer Anesthesia in collaboration with a physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners under the laws of the state or jurisdiction where the services are rendered.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills to regain independence.

Office Visit: A direct personal contact between a physician or other health care practitioner and a patient in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is an office visit for the purposes of this Plan.

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism, Retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Orthotic (Appliance or Device): A type of corrective appliance or device, either customized or available “over-the-counter,” designed to support a weakened body part, including (but not limited to) crutches, custom designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical Plan, this definition does not include dental orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

Other Prescription Drugs: Drugs that require a prescription under state law but not under federal law.

Out-of-Network Rate: With respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system

Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan’s Preferred Provider Organization (PPO), as distinguished from In-Network services that are provided by a health care provider that is a member of the PPO. Greater expense could be incurred by the participant when using Out-of-Network providers.

Out-of-Pocket Maximum (OOPM): The maximum amount of Coinsurance each covered person or family is responsible for paying during a Plan Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of eligible covered expenses for the remainder of the Plan Year. See the section on Out-of-Pocket Maximum in the *Medical Expense Coverage* section for details about what expenses do not count toward the Out-of-Pocket Maximum.

Outpatient Hospital Laboratory and Outpatient Hospital-Based Laboratory Draw Station: Outpatient hospital-based laboratory facilities include lab services performed in a hospital outpatient setting. Outpatient hospital-based laboratory draw stations are hospital affiliated whereby the draw station collects specimens and sends them to the central hospital lab for processing.

Outpatient Services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Partial Hospitalization Service: Also known as PHP, is a type of program used to treat mental illness and substance abuse in which the patient continues to reside at home but commutes to a treatment center up to seven days a week. This service model focuses on the overall treatment of the individual and is intended to avert or reduce in-patient hospitalization. Services are typically provided in either a hospital setting or by a free-standing community mental health center. Treatment during a typical day may include group therapy, psych-educational groups, skill building, individual therapy, and psychopharmacological assessments, and check-ins. Programs are available for the treatment of alcoholism and substance abuse, Alzheimer's disease, anorexia and bulimia, depression, bipolar disorder, anxiety disorders, schizophrenia, and other mental illnesses.

Participant: The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse or dependent of a retiree. [NAC 287.095](#)

Participating Provider: A health care provider who participates in the Plan's Preferred Provider Organization (PPO).

Passive Rehabilitation: Refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until the patient can achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be medically necessary for the purposes of this Plan.

Pharmacy: A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery, or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform Activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician Assistant (PA): A person legally licensed as a physician assistant, who acts within the scope of his or her license and acts under the supervision of a physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising physician; under the laws of the state or jurisdiction where the services are rendered.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, all Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

Plan Year Deductible: The amount you must pay each Plan Year before the Plan pays benefits.

Plan Year Maximum Benefits: The maximum amount of benefits payable each Plan Year for certain medical expenses incurred by any covered Plan participant (or covered family member of the Plan participant).

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

Positive Annual Open Enrollment Period: This process requires that each eligible employee or eligible retiree affirmatively make his or her benefit elections during the PEBP annual enrollment period. Even if you do not want to make any coverage changes, you must affirmatively make your elections, or you will be defaulted to self-coverage only under the PEBP base Plan.

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis, 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury.

Precertification (preauthorization, prior authorization): Is a process used by the UM company and Pharmacy Benefit Manager to determine if a prescribed procedure, including, but not limited to inpatient admission, concurrent review, DME, outpatient services, or medication are medically necessary before the services and supplies are received. A precertification is not a guarantee of payment.

Preferred Provider Organization (PPO): A group or network of health care providers (e.g., hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted or reduced rates.

Prescribed for a Medically Necessary Indication: The term medically necessary indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

Prescription Drugs: For the purposes of this Plan, prescription drugs include:

- Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug, and Cosmetic Act requires to be labeled, “Caution - Federal law prohibits dispensing without prescription”.
- Other prescription drugs: drugs that require a prescription under state law but not under federal law; or
- Compound drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prescription Prior Authorization (PA): Also known as “coverage review,” this is a process the Plan’s Pharmacy Benefit Manager might use to decide if your prescribed medicine will be covered. The Plan uses this to help control costs and to ensure the medicine being prescribed is an effective treatment for the condition.

Primary Care Doctor or Primary Care Physician (PCP): Per NRS 695G.060, “Primary care physician” means a physician or group of physicians who:

1. Provides initial and primary health care services to an insured;
2. Maintains the continuity of care for the insured; and
3. May refer the insured to a specialized provider of health care.

This may include Aa physician in family practice, internal medicine, pediatrics, obstetrics and gynecology.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: Means the Public Employees’ Benefits Program established in accordance with [NRS 287.0402](#) to [287.049](#), inclusive.

Prophylactic Surgery: A surgical procedure performed for

- avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or
- treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages.

An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth are performed by a dentist or dental hygienist.

Prospective Payment System (PPS): This Plan follows CMS's Prospective Payment System (PPS) where the Plan's payment is based on a predetermined, fixed amount payable to a facility for inpatient or outpatient hospital services. The Plan will not allow separate reimbursement for specific HCPCS supplies, DME, orthotics, prosthetics, biological, and drugs billed on a HCFA claim form by any physician or other qualified healthcare professional in the following facility POS (place of service) 19, 21, 22, 23, and 24, see the following POS descriptions:

- **POS 19 Off Campus – Outpatient Hospital:** A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **POS 21 Inpatient Hospital:** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
- **POS 22 On Campus – Outpatient Hospital:** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision physicians to patients admitted for a variety of medical conditions.
- **POS 23 Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness and injury is provided.
- **POS 24 Ambulatory Surgery Center:** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Prosthetic Appliance (or Device): A type of corrective appliance or device designed to replace all or part of a missing body part, including (but not limited to) artificial limbs, heart pacemakers, or

corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* Section).

Qualified Individual: A covered individual who is eligible, according to clinical trial protocol, to participate in an approved clinical trial and either: (i) the referring health care professional is an in-network provider and has concluded that the covered individual's participation in the clinical trial would be appropriate; or (ii) the covered individual provided medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

Qualified Medical Child Support Orders (QMCSO): QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce and also include a National Medical Support Notice. A QMCSO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- Specifies your last known name and address and the child's last known name and address.
- Describes the type of coverage to be provided, or how the type of coverage will be determined.
- States the period to which it applies; and
- Specifies each plan to which it applies.

The QMCSO cannot require the Plan to cover any type or form of benefit that they do not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions. You and the affected child will be notified if an order is received.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR 716-6(c). ~~29 CFR 716-6(c)~~.

Quantity Limit: The maximum amount of a medication the Plan covers during a period of time. These limits are set for safety reasons and to help reduce costs.

Reasonable and/or Reasonableness: Means charges for services or supplies which are necessary for the care and treatment of an illness or injury. The determination that charges are reasonable will be made by the Plan Administrator taking into consideration the following:

- The facts and circumstances giving rise to the need for the service or supply.
- Industry standards and practices as they are related to similar scenarios; and
- The cause of the injury or illness necessitating the service or charge.

The Plan Administrator's determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities:

- The National Medical Associations, Societies, and Organizations;
- The Centers for Medicare and Medicaid Services (CMS);
- Centers for Disease Control and Prevention; and
- The Food and Drug Administration.

To be reasonable, charges must follow generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether a charge is reasonable. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charges that are not reasonable and therefore not eligible for payment by the Plan.

Recognized Amount: means (in order of priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

For air ambulance services furnished by Non-PPO providers, *Recognized Amount* is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease, or tumor, or for breast reconstruction following a total or partial mastectomy.

Reference Based Pricing/Reference Price: A methodology that determines the cost for a covered service based on a market or industry benchmark or reference price. The Plan Administrator may utilize this method in determining the Maximum Allowable Charge.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, or medically necessary treatment of a behavioral health condition, and that is performed by a licensed therapist acting within the scope of his or her license. See the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits* and the *Exclusions* section of this document to

determine the extent to which rehabilitation therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

Reimbursable Payments: Payments made by this Plan for benefits, including any payment for a covered pre-existing condition that are or become the responsibility of another party under the subrogation provisions as described in this MPD.

Rescission: A cancellation or discontinuance of coverage under the Plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the Plan if

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage

Retiree: Unless specifically indicated otherwise, when used in this document, Retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule.

Second Opinion: A consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

Serious and Complex Condition: With respect to a participant, beneficiary, or enrollee under the Plan one of the following:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a condition that is—
- is life-threatening, degenerative, potentially disabling, or congenital; and
 - requires specialized medical care over a prolonged period of time.

Service Area: The geographic area serviced by the In-Network providers who have agreements with the Plan's network.

Sickle Cell Disease: An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and

die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable.

Significantly Inferior Coverage: The PEBP Board has defined Significantly Inferior Coverage as either:

- A mini-med or other limited benefit plan; or
- Catastrophic coverage plans with a Deductible equal to or greater than \$5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility or Extended Care/Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, sick people or people with disabilities, and that meets all the following requirements:

- Is licensed pursuant to state and local laws.
- Is operated primarily for providing skilled nursing care and treatment for individuals convalescing from injury or illness.
- Is approved by and is a participating facility with Medicare.
- Has organized facilities for medical treatment.
- Provides 24-hour-a-day nursing service under the full-time supervision of a physician or registered nurse.
- Maintains daily clinical records on each patient.
- Has available the services of a physician under an established agreement.
- Provides appropriate methods for dispensing and administering drugs and medicines.
- Has transfer arrangements with one or more hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one physician; and
- Is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

A skilled nursing facility that is part of a hospital, as defined in this document, will be considered a skilled nursing facility for the purposes of this Plan.

Special Food Product: ([NRS 689B.0353](#)) A food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Specialist Physician: A doctor who has completed advanced education and training in a specific field of medicine. Per CMS, a specialist is a doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication,

Spinal Manipulation / Chiropractic Care: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by physicians.

Spouse: The employee's lawful spouse. The Plan will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

Standard Plan Benefits (Standard Benefits): Standard Plan Benefits or Standard Benefits under this Plan means the participant is covered under the Plan's Standard Benefits and is not eligible for enhanced benefits due to non-participating and or engaging in the Diabetes Care Management or Obesity Care and Overweight Management Programs.

State: When capitalized in this document, the term State means the State of Nevada.

Step Therapy: see also "Medical Management technique." A process designed to help control high medicine costs. If the Plan applies step therapy to your medication, it will require that you try a lower-cost medication that is proven effective to treat your condition, before it will cover a higher-cost medicine. If the lower cost medicine does not treat your condition effectively, the Plan's coverage will "step" you to a higher-cost medicine to find a medicine that treats your condition effectively at the lowest possible cost.

The Plan also complies with step therapy for treatment of cancer or cancer symptom that is part of step therapy protocol per [NRS 695G.1675](#).

Sub-acute Care Facility: A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide sub-acute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, to the patient's home or to a suitable skilled nursing facility, and that meets all of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Sub-Acute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and
- It maintains on its premises all facilities necessary for medical care and treatment; and
- It provides services under the supervision of physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse; and
- It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
- It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of behavioral health disorders and chemical dependency.

Surgery/Surgeries: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the claims administrator will determine which multiple surgical procedures will be considered as primary, secondary, bilateral, add-on, or separate (incidental) procedures for determining benefits under this Plan.

Multiple Surgical Procedure Allowances:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: usual and customary, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Bilateral secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.

- Add-on to secondary procedure in same operative area: limited to 100% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Separate (incidental) procedure in same operative area as any of the above: not covered.
- Separate operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.

Telehealth: Telehealth means the delivery of services from a provider of health care to a patient at a different location using information and audio-visual communication technology, not including facsimile, or electronic mail. See also [NRS 629.515](#)

Telehealth is a general term used to describe clinical services provided to patients through electronic communications not through a vendor. This can be patient-to-physician. Examples include patient consultation with a specialist that is out of the patient's geographical area or patient has a virtual visit with their primary care physician. Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health.

Telemedicine: Telemedicine (vendor/virtual visit) is the practice of medicine using technology to deliver care at a distance via electronic communications through a vendor.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The Temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring, or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Termination: Includes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Therapist: A person trained in and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy. *See the Occupational, Physical and Speech Therapy section.*

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, which injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. (See the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits* and *Exclusions* section for additional information regarding transplants. See also the *Utilization Management* section of this document for information about precertification requirements for transplantation services).

Xerographic: Refers to transplants of organs, tissues, or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xerographic transplants are not covered by this Plan, except heart valves.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate, even though health and life are not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include (but are not limited to) fever, sprains, bone, or joint injuries, continuing diarrhea, vomiting, or bladder infections.

Urgent Care Claim: Means a claim for benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not urgent care claims could seriously jeopardize the participant's life, health, or the ability to regain maximum function by waiting for a routine appeal decision. An urgent care claim also means a claim for benefits that, in the opinion of a physician with knowledge of the participant's medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for precertification of an urgent care service was denied, the participant could request an expedited appeal for the urgent care claim.

Urgent Care Facility: A public or private hospital-based or free-standing facility, which includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance when the facility is open.

Usual and Customary: Covered expenses which are identified by PEBP, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) most patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, country, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made.

To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, subject to the Plan’s Maximum Allowable Charge or negotiated fee schedule for any procedure, service, or supply, and whether a specific procedure, service or supply is usual and customary. Usual and customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, Average Wholesale Price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

Utilization Management (UM): A managed care process to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include (but is not limited to): precertification; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM, utilization review services, UR services, utilization management, concurrent review, or retro review services) are provided by licensed health care professionals employed by the utilization management company operating under a contract with the Plan.

Utilization Management Company (UM company): The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan’s utilization management services.

Visit: See the definition of office visit.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary, even though they are not provided because of illness, injury, or congenital defect. The Plan’s coverage of well-baby care is described under *Preventive Care/Wellness Services* and in the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits*.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.

Public Employees' Benefits Program



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Consumer Driven Health Plan: PEBP Self-Funded Health Plan

Coverage Period: 07/01/2023 – 06/30/2024
Coverage for: Employee + Family | **Plan Type:** PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pebp.state.nv.us. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 775-684-7000 or 1-800-326-5496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-network: Employee only: \$1, ~~56~~ 00 Family: \$3, ~~29~~ 00 Individual w/in Family: \$2,800. Out-of-network: <u>Employee only: \$1,600</u> Family: \$3, ~~29~~ 00; Individual w/in Family \$2,800	Generally, you pay all costs up to the <u>deductible</u> , except <u>preventive services</u> and certain <u>copayments</u> . Individuals within the family must meet their own individual <u>deductible</u> until the total expenses paid by all family members meets the overall family <u>deductible</u> . In-network and Out-of-Network <u>Deductibles</u> accumulate separately. Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>In-network Preventive care</u> services are covered before you meet your <u>deductible</u> .	Some items and services covered if the <u>deductible</u> has not been met; however, a <u>copayment</u> or <u>coinsurance</u> may apply. Example: <u>preventive services</u> and medications on the preventive drug list. For more additional limitations, refer to the CDHP Master <u>Plan</u> Document (MPD). For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	The <u>Plan</u> does not include separate <u>deductibles</u> for specific services. Separate <u>deductibles</u> apply to <u>network providers</u> and <u>out-of-network providers</u> . You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>Network providers</u> : Employee only: \$4,000; Family \$8,000, individual within Family: \$6,850. <u>Out-of-network</u> : Employee only: \$10,600; Family \$21,200	The <u>in-network Out-of-pocket limit</u> is the most an Individual or a Family must pay in a <u>Plan</u> Year for Eligible Medical Expenses. The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

For more information about limitations and exceptions, see the Consumer Driven Health Plan Master Plan Document at www.pebp.state.nv.us.

What is not included in the <u>out-of-pocket</u> limit?	Penalties, <u>premiums</u> , balance-billing charges, <u>excluded services</u> , <u>prescription drug copay</u> assistance, non-covered services, and health care this <u>plan</u> doesn't cover.	Penalties you pay for failure to obtain required <u>preauthorization</u> , <u>premiums</u> , non-use of 30-day Express Advantage <u>Network</u> , non-compliance with 90-day retail/mail order, manufacturer-funded <u>copay</u> assistance, non-use of SaveonSP (for non-essential <u>specialty drugs</u>); penalties of balance-billing, and non-covered supplies and services. Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Will you pay less if you use a <u>network provider</u>?	Yes. See www.pebp.state.nv.us or call 1-888-763-8232 for a list of participating <u>providers</u> .	You will pay less if you use a <u>network provider</u>. You will pay more if you use an out-of-<u>network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need <u>specialist referral</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
If you visit a health care provider's office or clinic	<u>Primary care</u> visit to treat an injury or illness	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Balance billing</u> applies to <u>out-of-network claims</u> , except as provided by federal and state law.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Balance billing</u> applies to <u>out-of-network claims</u> , except as provided by federal and state law.
	<u>Preventive care/screening/immunization</u>	No charge	Not Covered	<u>Preventive care</u> must be provided <u>in-network</u> . Refer to the CDHP MPD for exceptions for explanations and limitations. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Routine labs must be performed at a free-standing lab. <u>Balance billing</u> applies to <u>out-of-network claims</u> , except as provided by federal and state law.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	May require <u>preauthorization</u> . <u>Balance billing</u> applies to <u>out-of-network claims</u> , except as provided by federal or state law.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.pebp.state.nv.us	Generic drugs	20% <u>coinsurance</u>	Not Covered	30-day supply for short-term medications must be filled at Express Advantage <u>Network</u> (EAN) pharmacy to avoid a surcharge. Penalty applies if you do not use a Smart90 retail/home delivery pharmacy for long-term medications. Some <u>drugs</u> require <u>preauthorization</u> . Penalty applies for not participating in the SaveonSP for <u>drugs</u> on the Essential Benefit <u>Specialty Drug</u> list. <u>Copay</u> assistance for <u>specialty drugs</u> do not apply to <u>deductible/Out-of-pocket limit</u> .
	Preferred brand drugs	20% <u>coinsurance</u>	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	Not Covered	
If you have outpatient surgery	Facility fee (i.e., ASC)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required or 50% penalty applies. <u>Balance billing</u> applies to <u>out-of-network</u> , except as provided by federal law.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

For more information about limitations and exceptions, see the Consumer Driven Health Plan Master Plan Document at www.pebp.state.nv.us.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-Network provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Emergency room care</u> paid as <u>in-network</u> ; <u>Balance billing</u> may apply to <u>out-of-network</u> ; <u>out-of-network</u> medical transportation, and <u>urgent care</u> subject to the <u>Plan's</u> Maximum Allowable Charge, except as provided by federal or state law. See the CDHP MPD for information.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required or 50% penalty applies. <u>Balance billing</u> applies to <u>out-of-network</u> , except as provided by federal or state law
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services. If <u>preauthorization</u> is not obtained, benefits may be reduced by 50%. <u>Balance billing</u> applies to <u>out-of-network</u> , except as provided by federal or state law
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Routine prenatal care obtained from <u>Plan Provider</u> is covered at no charge. Maternity care, including non-routine maternity care, may include tests and services subject to <u>cost sharing</u> as described elsewhere in this SBC. (i.e., Ultrasound, Lab). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a [<u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u>] may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. Limited to 60 visits per person <u>plan year</u> . <u>Balance billing</u> applies to <u>out-of-network provider claims</u> , except as provided by the No Surprises Act.

For more information about limitations and exceptions, see the Consumer Driven Health Plan Master Plan Document at www.pebp.state.nv.us.

	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> after 90 combined visits. <u>Balance billing</u> applies to <u>out-of-network claims</u> .
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. <u>Balance billing</u> applies to <u>out-of-network claims</u> , except as provided by the No Surprises Act.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. Limited to 60 days per <u>Plan Year</u> related to the same cause.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for equipment over \$1,000.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required after 185 days.
If your child needs dental or eye care	Children's eye exam	\$25 <u>copayment</u> /visit	\$25 <u>copayment</u> /visit	Limited to 1 routine vision exam <u>plan</u> year. \$95 maximum benefit.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	Coverage available under separate dental <u>plan</u> .

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Orthodontia expenses
- Private-Duty nursing
- Routine foot care

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-326-5496 or 775-684-7000. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact HealthSCOPE Benefits Customer Service at 1-888-763-8232

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

For more information about limitations and exceptions, see the Consumer Driven Health Plan Master Plan Document at www.pebp.state.nv.us.

If your plan does not meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: See Attachment A

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	
\$1, ~~5~~ 600	
■ Specialist [<u>coinsurance</u>]	20%
■ Hospital (facility) [<u>coinsurance</u>]	20%
■ Other [<u>coinsurance</u>]	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles	\$1, ~~5~~ 600
Copayments	\$0.00
Coinsurance	\$2,2 ~~2~~ 08
<u>What is not covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,7~~88~~86₈

Managing Joe's type 2 Diabetes*

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	
\$1, ~~5~~ 600	
■ Specialist [<u>coinsurance</u>]	20%
■ Hospital (facility) [<u>coinsurance</u>]	20%
■ Other [<u>coinsurance</u>]	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles	\$1, ~~6~~ 500
Copayments	\$0.00
Coinsurance	\$7 ~~88~~ 820
<u>What is not covered</u>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,4~~48~~36₈

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1, ~~6~~ 500
■ Specialist [<u>coinsurance</u>]	20%
■ Hospital (facility) [<u>coinsurance</u>]	20%
■ Other [<u>coinsurance</u>]	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$1, ~~6~~ 500
Copayments	\$0.00
Coinsurance	\$24 ~~6~~ 0
<u>What is not covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,7~~84~~60

The plan would be responsible for the other costs of these EXAMPLE covered services.

For more information about limitations and exceptions, see the Consumer Driven Health Plan Master Plan Document at www.pebp.state.nv.us.

Attachment A

Language Access Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-763- 8232 (TTY Users, Dial 7-1-1)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-763- 8232 (TTY Users, Dial 7-1-1)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-763- 8232 (TTY Users, Dial 7-1-1)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-763- 8232 (TTY Users, Dial 7-1-1) 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-763- 8232 (TTY Users, Dial 7-1-1)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-763- 8232 (መስማት ለተሳናቸው፡(TTY Users, Dial 7-1-1)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้ บริการช่วยเหลือ ทางภาษา ได้ฟรี โทร 1-888-763- 8232 (TTY Users, Dial 7-1-1)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-763- 8232 (TTY Users, Dial 7-1-1) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-1-7 (رقم هاتف الصم والبكم: 8232-763-888-1)

В Н И М А Н И Е: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-763- 8232 (телетайп: 7-1-1).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-763- 8232 (ATS: 7-1-1).

تماس بگیریډ 1-888-763-8232 (TTY: 7-1-1) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se todogi, mo oe, Telefoni mai: 1-888-763- 8232 (TTY Users, Dial 7-1-1)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-763- 8232 (TTY Users, Dial 7-1-1)

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-888-763- 8232 (TTY Users, Dial 7-1-1)



Access.
Quality.
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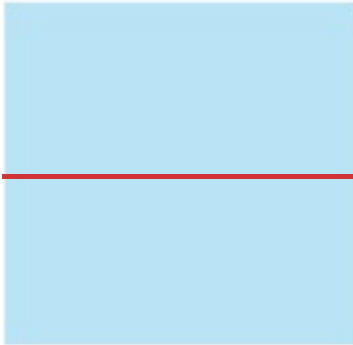


PPO (LOW DEDUCTIBLE) PLAN MASTER PLAN DOCUMENT

PLAN YEAR 202~~43~~45

(EFFECTIVE JULY 1, 202~~43~~45 – JUNE 30, 202~~53~~54)

DRAFT



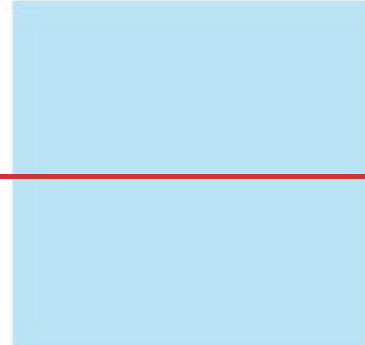
NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

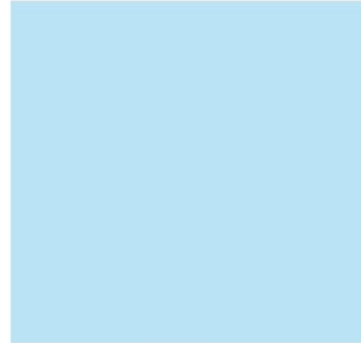
775-684-7000

702-486-3100

or 1-800-326-5496

www.pebp.state.nv.us





Public Employees' Benefits Program
3427 Goni Road, Suite 109
Carson City, NV 89706

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DRAFT

Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

~~“One Time HSA or HRA Funding for Active State Employees” — Add language that clarifies “Legislatively approved enhancements, such as HSA/HRA funding and enhanced basic life insurance amounts may be subject to change in subsequent plan years.”~~

Utilization Management

~~“Impatient Admissions” — Remove “All” and “Same day surgeries.” Refer to the Outpatient and Physician Surgery category for outpatient and same day surgery prior authorization requirements.~~

Schedule of Medical Benefits

~~“Continuity of Coverage” which is within the “No Surprises Act” — Add the clarifying statement “Per NRS 695G.164, the Plan provides coverage for continued medical treatment for a medical condition from a provider of health care whose contract with the insurer is terminated during active medically necessary treatment. Unless excepted, this is until the later of:~~

- ~~• The 120th day after the date the contract is terminated; or~~
- ~~• If the medical condition is pregnancy, the 45th day after:~~
 - ~~○ The date of delivery; or~~
 - ~~○ If the pregnancy does not end in delivery, the date of the end of the pregnancy.”~~

“Preventative Services”

- ~~• Update mammogram by removing specification to 2-D or 3-D for mammograms.~~
- ~~• While already covered, specify Prostate Cancer Screening to coincide with NRS 695G.177: Add “Limited to 1 preventative per plan year and offered in accordance with NRS 695G.177 which includes reference to the American Cancer Society guidelines.”~~

Schedule of Prescription Drug Benefits

~~The Pharmacy Benefit Manager, Express Scripts, has offered a benefit for our members not expressly noted in the plan documents. Add “Diabetes Care Value: Express Scripts offers a program that supports members with diabetes (type 1 and 2) pre-diabetes, and even common comorbidities like obesity. ESI’s digital diabetes prevention and obesity solution offers a personalized coaching and weight loss program, including an app connected scale, to help patients avoid type 2 diabetes. The Diabetes Care Value is administered by Express Scripts and qualifying participants will receive a personal invitation, with instructions, to join the program.”~~

Benefit Limitations and Exclusions

~~“Abortion” — Add “This plan provides abortion benefits in accordance with NRS 422.250.”~~

~~“Corrective Appliance” — Update limitation language for motorized modes of transportation to include “determined to be not medically necessary.”~~

~~“Maternity/Family Planning” — Clarified “Expenses related to delivery associated with a newborn of a pregnant dependent child.”~~

~~Appeals~~

~~Updated contact information for Office of Consumer Health Assistance.~~

~~Coordination of Benefits~~

~~Added information from the Health and Welfare Wrap Document for member benefit.~~

~~Key Terms and Definitions~~

~~“Medically Necessary” — Update the definition for Medically Necessary to include “Has the meaning ascribed to it in accordance with NRS 695G.055.”~~

~~“Step Therapy” — Add to the definition to include “see also “Medical Management technique” and “The Plan also complies with step therapy per NRS 695G.1675.”~~

~~Add “Medical management technique: Has the meaning ascribed to it within NRS 695G which means a practice which is used to control the cost or use/utilization of health care services, prescription drugs, or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.”~~

Outcomes from the 82nd Legislative Session 2023

Utilization Management

~~“Outpatient and Physician Diagnostic Services” — Update to clarify that Genetic Testing includes Biomarker Testing as this is generally used interchangeably. This is related to Assembly Bill 155.~~

~~“Gender Dysphoria” — Update to remove “Coverage for procedures is based on the UM company’s clinical policy for medical necessity.” Added “In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.”~~

Schedule of Medical Benefits

~~“Genetic Testing” — Add “Biomarker testing: In accordance with Assembly Bill 155 from the 82nd Legislative Session in 2023, the Plan provides benefits for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.”~~

~~“Women’s Contraceptives” under “Preventative Services” — Add plan language “In accordance with Senate Bill 280 from the 82nd Legislative Session in 2023, the Plan provides benefits for contraceptive injection or the insertion of a device at a hospital immediately after an insured gives birth.”~~

~~“Gender Dysphoria” — Remove limitations and add to plan language:~~

~~“In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.~~

~~This plan does not discriminate on the basis of gender identity or expression. Claim or coverage appeal shall include a consult with a provider of health care who has experience in prescribing or delivering gender affirming treatment. The plan does not provide coverage cosmetic benefits as defined by Senate Bill 163.~~

~~Cosmetic Surgery means:~~

- ~~Means a surgical procedure that:~~
 - ~~Does not meaningfully promote the proper function of the body~~
 - ~~Does not prevent or treat illness or disease; and~~
 - ~~Is primarily directed at improving the appearance of a person.~~
- ~~This includes, without limitation, cosmetic surgery directed at preserving beauty."~~

~~Prescription Drug Benefits~~

~~Add to plan language:~~

~~"In accordance with Assembly Bill 156 from the 82nd Legislative Session in 2023, the Plan provides benefits for substance use disorder including coverage for all drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone."~~

~~"In accordance with Senate Bill 167 from the 82nd Legislative Session in 2023, the Plan provides prescription benefits for psychiatric conditions for drugs that are approved by the Food and Drug Administration or the use of a drug to treat a psychiatric condition that is supported by medical or scientific evidence when prescribed by a Provider acting within the scope of their license. These prescription drugs are not subject to medical management techniques, such as step therapy."~~

~~Benefit Limitations and Exclusions~~

~~"Cosmetic Services and Surgery" — Add language and clarified: "Breast augmentation/augmentation mammoplasty excluded, except as otherwise covered and described above." This is related to Senate Bill 163 from the 82nd Legislative Session in 2023.~~

~~"Gender Dysphoria and/or Gender Services" — Related to Senate Bill 163 from the 82nd Legislative Session in 2023:~~

~~Remove "No more than one genital surgery in the individual's lifetime when covered under any current or previous PEBP health plan." And "A surgery to reverse a surgery to treat gender dysphoria will not be covered."~~

~~Add "The Plan provides benefits to individuals seeking services for the treatment of gender dysphoria and gender incongruence in accordance with Senate Bill 163 from the 82nd Legislative Session in 2023."~~

~~Key Terms and Definitions~~

~~"Gender Dysphoria" — Change definition: "In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023: "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the~~

~~gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:~~

~~A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.~~

~~A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.~~

~~A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.~~

~~A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.~~

~~A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.~~

~~A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.”~~

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP offers medical, vision, dental, and life insurance, in addition to flexible spending accounts, and other voluntary benefits for eligible state and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may access whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and Plan requirements. These plans include the Consumer Driven Health Plan (CDHP), ~~EPO~~Exclusive Provider Organization (EPO) Plan, ~~Low-Deductible~~ PPO (Low Deductible) Plan, and the Health Plan of Nevada HMO Plan. You are also encouraged to research plan provider access and quality of care in your service area.

PEBP participants choosing this Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the Active Employee Health and Welfare Wrap Plan, Retiree Health and Welfare Wrap Plan, Section 125 Document, Health Reimbursement Arrangement Summary Plan Document, and the PEBP Enrollment and Eligibility Master Plan Document. These documents are available at ~~www.pebp.state.nv.us~~<https://pebp.nv.gov/> or by calling 775-684-7000, 702-486-3100, or 1-800-326-5496.

Master Plan Documents are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted in the Active Employee Health and Welfare Plan Document and Retiree Health and Welfare Wrap Plan Document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the *Participant Contact Guide*.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,

Public Employees' Benefits Program

Introduction

This Master Plan Document describes the ~~Low-Deductible~~ PPO Plan (also referred to as the ~~LD~~Low Deductible ~~-PPO Plan~~ or LD PPO Plan). The ~~LD~~ PPO Plan offers In-Network and Out-of-Network benefits and is a self-funded plan administered by PEBP and governed by the State of Nevada. The Plan is available to eligible employees, retirees, and their eligible dependents participating in the Public Employees' Benefits Program (PEBP).

The benefits offered with the ~~LD~~ PPO Plan include medically necessary medical, behavioral health, prescription drug, vision, and dental coverage. Additional benefits include basic life insurance for active employees and eligible retirees. The medical, behavioral health, prescription drug and vision benefits are described in this document. For information regarding the dental and life insurance benefits, refer to the PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document.

An independent ~~T~~hird~~-p~~arty Claims Administrator pays the claims for the medical, dental and vision benefits. An independent pharmacy benefit manager pays the claims for prescription drug benefits.

~~The Plan and t~~This document is intended to comply with the [Nevada Revised Statutes \(NRS\) Chapter 287](#), and the [Nevada Administrative Code \(NAC\) 287](#) and all other applicable provisions of Nevada Law. Additionally, PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the the Health Insurance Portability and Accountability Act (HIPAA) as amended and certain provisions of [NRS 695G](#) and [NRS 689B](#). The Plan Sponsor certifies that this Article incorporates the provisions set forth in [45 CFR Section 164.504\(f\)\(2\)\(ii\)](#) and the Plan Sponsor agrees to such provisions in accordance with [45 CFR Section 164.504\(f\)\(2\)\(ii\)](#).

The Plan described in this document is effective ~~July 1, 2023~~4, and unless stated differently, replaces other ~~LD~~ PPO Plan ~~medical and prescription drug benefit plan~~ documents/summary plan descriptions previously provided to you.

Provisions of this document contain important information. It will help you understand and use the benefits provided by this Plan. You should review it and show it to members of your family who are or will be covered by the Plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan. Be sure to read the ~~[Benefit Limitations and Explanations](#)~~[Benefit Limitations and Explanations](#), ~~[Benefit Limitations and Exclusions](#)~~[Benefit Limitations and Exclusions](#), and ~~[Key Terms and Definitions](#)~~[Key Terms and Definitions](#) sections. Remember, not every expense you incur for health care is covered by this Plan.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. Members should keep informed of this document as the Plan is amended from time to time. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later

information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Per NRS 287.0485 no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.

Suggestions for Using this Document:

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The *Table of Contents* provides you with an outline of the sections.
- The *Participant Contact Guide* helps you become familiar with PEBP vendors and the services they provide.
- The *Participant Rights* section describes your rights and responsibilities as a participant of this Plan.
- The *Key Terms and Definitions* section explains many technical, medical, and legal terms that appear in the text.
- The *Eligible Medical Expenses* and *Non-Eligible Medical Expenses, Summary of the Low Deductible PPO Plan Components, Schedule of ~~Medical~~ Benefits, Key Terms and Definitions*, and *Benefit Limitations and Exclusions* sections describe your benefits in more detail.
- The *Schedule of ~~Medical~~ Benefits* section provides wellness information that can help you proactively manage your health.
- The *Utilization Management* section provides information on what health care services require prior authorization and the process to request prior authorization.
- The *Claims Administration* section describes how benefits are paid and how to file a claim.
- The *Appeals ~~Procedure~~* section describes how to request a review (appeal) if you are dissatisfied with a claim decision.
- The *Coordination of Benefits* section describes situations where you have coverage under more than one health care plan, including Medicare.

Accessing Other Benefit Information:

You will also want to access the following documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, Consolidated Omnibus Budget Reconciliation Act (COBRA), third-party liability and subrogation, Health Insurance Portability and Accountability Act (HIPAA) and Privacy and Security and mandatory notices. These documents are available at ~~www.pebp.state.nv.us~~<https://pebp.nv.gov/>.

- ~~State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document~~
- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document

- ~~Consumer Driven Health Plan Master Plan Document and Summary of Benefits and Coverage for Individual and Family~~
- Consumer Driven Health Plan Master Plan Document and Summary of Benefits and Coverage for Individual and Family
- ~~Low Deductible PPO Plan Master Plan Document~~ Low Deductible PPO Plan Master Plan Document
- ~~Low Deductible~~ PPO Plan Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- EPO Plan Master Plan Document and EPO Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description
- Health Reimbursement Arrangement Master Plan Document

Participant Rights

You have the right to:

- Participate with your health care professionals in your health care decisions and have your health care professionals give you information about your condition and your treatment options.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with State and Federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and providers and your rights.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's participants' rights and responsibilities policies.
- Express respectfully and professionally any concerns you may have about PEBP or any benefit or coverage decisions the Plan, or the Plan's designated administrator, makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing future treatment and be informed by your physician(s) of the medical consequences.

Summary of the ~~LD~~ PPO Components

Highlights of the Plan

The ~~Low-Deductible~~ PPO Plan is a PEBP administered preferred provider organization (PPO) ~~low deductible~~ plan which provides both In-Network and Out-of-Network benefits. As a member, you receive coverage for many medically necessary services and supplies, subject to any Plan *Benefit Limitations and Exclusions*. This is an open access PPO Plan and does not require a referral to see a specialist.

The Plan includes:

- Coverage for participants residing nationwide (in-and outside of Nevada).
- In-and Out-of-Network benefits.
- Reimbursement for *Eligible Medical Expenses* described in this document (and as determined by the Plan Administrator) for participants residing permanently, part time, or while traveling outside of the United States. Refer to the *Out-of-Country Medical, Prescription Drug, and Vision Purchases* section for more information.
- Coverage for eligible preventive care services at 100% when using In-Network providers. Refer to the *Schedule of ~~Medical~~ Benefits* section for more information.
- Health care resources and tools to assist you in making informed decisions about your and your family's health care services. For more information log in to your E-PEBP member portal account at ~~www.pebp.state.nv.us~~<https://pebp.nv.gov/>.

Plan Year Deductibles and Out-of-Pocket Maximums				
	In-Network Deductible	In-Network Out-of-Pocket Maximum	Out-of-Network Deductible	Out-of-Network Out-of-Pocket Maximum
Individual (self-only coverage)	\$0	\$4,000	\$500	\$10,600
Family	Family: \$0 Individual family member: None	Family: \$8,000 Individual family Member: \$4,000	Family: \$1,000 Individual family member: \$500	\$21,200
In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums are not interchangeable. The Deductibles and Out-of-Pocket Maximums accumulate separately for In-Network and Out-of-Network provider expenses. See Family Deductible explanation below.				

Deductibles

The Plan Year Deductibles (combined medical and prescription drug) includes two tiers:

- **Individual Deductible:** Applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible:** Applies when two or more individuals are covered on the same Plan (e.g., Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductible may be met through a combination of *Eligible Medical Expenses* from covered family members. The In-Network Family Deductible includes an “Individual Family Member” embedded Deductible. This means one single member of the family is only required to meet the Individual Family Member Deductible before the Plan starts to pay Coinsurance for that member.

The Individual and Family Deductibles start July 1st (the first day of the Plan Year) and reset the following Plan Year on July 1st. This Plan does not include a Deductible carryover or rollover provision.

During the Plan Year, you are responsible for paying for your eligible medical and prescription drug expenses (except eligible Preventive Services provided In-Network), including amounts exceeding the Plan’s reference-based pricing for hip and knee replacement, preauthorization penalties, and other out of pocket costs.

In-Network Individual Deductible

The In-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible is **\$0**. Participants are responsible for paying Out-of-Pocket for eligible medical and prescription drug expenses that are subject to the Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Out-of-Network Individual Deductible

The Out-of-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible for Eligible Medical Expenses received Out-of-Network is **\$500**. Participants are responsible for paying Out-of-Pocket for eligible medical (prescription drugs are not covered Out-of-Network) expenses up to the Plan Year Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

In-Network Family Deductible

The In-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **\$0** and includes a **\$0** embedded “Individual Family Member” Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible In-Network medical and prescription drug expenses for the entire family after the **\$0** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **\$0** “Individual Family Member” Deductible (under no circumstances will one single family member be required to pay more than **\$0** toward the **\$0** Family Deductible). The **\$0** In-Network Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including “Individual Family Member” Deductible) accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Out-of-Network Family Deductible

The Out-of-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **\$1,000** and includes a **\$500** “Individual Family Member” Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible Out-of-Network medical and vision (prescription drugs are not covered Out-of-Network) expenses for the entire family after the **\$1,000** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **\$500** “Individual Family Member” Deductible (under no circumstances will one single family member be required to pay more than **\$500** toward the **\$1,000** Out-of-Network Family Deductible). The **\$1,000** Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including “Individual Family Member” Deductible) accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Coinsurance

Coinsurance is the percentage of costs that generally you and the Plan pay for Eligible Medical Expenses, after your Deductible is met. If you receive covered health care services using a health care provider who is a participating provider of this Plan’s PPO network, you will be paying less money out of your pocket. This Plan generally pays **80%** of the In-Network provider’s contract rate and you are responsible for paying the remaining **20%**. If you use an Out-of-Network provider (a non-participating provider, meaning the provider is not contracted with the PPO network), the Plan benefit may be reduced to **50%** of the Maximum Allowable Charge, and you are responsible for paying the remaining **50%**. Out-of-Network providers can also bill you directly for any difference between their billed charges and the Maximum Allowable Charge allowed by this Plan, except where prohibited by law.

Copayments

Copayments apply as specifically stated in this document and are payable by the covered participant. Copayments do not apply towards the Deductible but do apply towards the Out-of-Pocket Maximum.

Out-of-Pocket Maximums

In-Network Out-of-Pocket Maximums

The In-Network Out-of-Pocket Maximum (~~OOP Maximum~~OOPM) is the maximum amount you will pay for In-Network eligible medical and prescription drug expenses during the Plan Year. ~~Member cost share~~The Out of Pocket costs you pay toward your (Deductible, copayments, and /or Coinsurance for Eligible Medical Expenses accumulate toward your ~~OOP Maximum~~OOPM. The ~~OOP Maximum~~OOPM for:

- An Individual (covered as self-only) is **\$4,000**
- Family coverage (participant plus one or more covered dependents) is **\$8,000**
 - The Family ~~OOP Maximum~~OOPM includes a **\$4,000** embedded “Individual Family Member” ~~OOP Maximum~~OOPM. An Individual Family Member ~~OOP Maximum~~OOPM means one single family member will not pay more than **\$4,000** in the Plan Year for Eligible Medical Expenses.

Once an Individual or Family satisfies the ~~OOP Maximum~~OOPM, the Plan will pay 100% of eligible medical and prescription drug expenses for the remainder of the Plan Year. The ~~OOP Maximum~~OOPM accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year. The accumulation of Eligible Medical Expenses toward the ~~OOP Maximum~~OOPM is based on the date the medical or prescription drug expense is received by the Plan and not on the date of services.

Only Eligible Medical Expenses that are subject to cost-sharing (Deductible, Copayments, and Coinsurance) will apply to the ~~OOP Maximum~~OOPM. The ~~OOP Maximum~~OOPM does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges, preauthorization penalties, amounts exceeding the Plan’s allowable charge for hip and knee replacement and amounts that Out-of-Network providers bill and are payable that are greater than this Plan’s Maximum Allowable Charge. This list is not all-inclusive and may not include certain services and supplies that are not listed here.

For this section only, references to the ~~OOP Maximum~~OOPM, Eligible Medical Expenses, Deductible and Coinsurance are specific to In-Network benefits.

Out-of-Network Out-of-Pocket Maximum

The Out-of-Network Out-of-Pocket Maximum (~~OOP Maximum~~OOPM) is the maximum amount you will pay for Eligible Medical Expenses (excluding prescription drugs) during the Plan Year. The Out-of-Pocket costs you pay toward your Deductible and Coinsurance for Eligible Medical Expenses accumulate toward your ~~OOP Maximum~~OOPM. The ~~OOP Maximum~~OOPM for:

- Individual (covered as self-only) is **\$10,600**.
- Family coverage (participant plus one or more covered dependents) is **\$21,200**.
(The Family coverage tier does not include an embedded Individual Family Member ~~OOP Maximum~~OOPM.)

Once the ~~OOP Maximum~~OOPM is met, the Plan will pay 100% of Eligible Medical Expenses (excluding Out-of-Network prescription drug expenses) for the remainder of the Plan Year. The ~~OOP Maximum~~OOPM accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year.

The accumulation of Eligible Medical Expenses toward the ~~OOP Maximum~~OOPM is based on the date the medical expense is received by the plan and not on the date of services.

The Family ~~OOP Maximum~~OOPM (for Out-of-Network services only) can be met by one person or by a combination of Out-of-Pocket Eligible Medical Expenses from covered family members.

Only Eligible Medical Expenses that are subject to cost-sharing (Deductible, Copayments, and Coinsurance) will apply to the ~~OOP Maximum~~OOPM. The ~~OOP Maximum~~OOPM does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges, preauthorization penalties, amounts exceeding the Plan's allowable charge for hip and knee replacement, and any amount that Out-of-Network providers bill and are payable that are greater than this Plan's Maximum Allowable Charge. This list is not all-inclusive and may not include certain services and supplies that are not listed here.

References to the Out-of-Network, ~~OOP Maximum~~OOPM, Eligible Medical Expenses, Deductible and Coinsurance in this section are specific to Out-of-Network benefits.

In- and Out-of-Network Maximums are not interchangeable and cannot be combined to reach your Plan Year ~~OOP Maximum~~OOPM.

Description of In-Network and Out-of-Network

Provider Network

PEBP leases a network of preferred providers (PPO) through a contract with a vendor who maintains such a network.~~The Plan or its designee arranges for providers to participate in a PPO network.~~ For more information, see the Participant Contact Guide section of this document. In-Network providers are hospitals, physicians, medical laboratories, and other health care providers located within a service area who have agreed to provide health care services and supplies at negotiated discount fees. Network providers are not the Plan's employees or employees of any Plan designee.

The contracted PPO Network is responsible for credentialing providers by confirming public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the network status of a provider. A provider's status may change.~~You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another In-Network provider.~~ You can verify the provider's status by calling the third-party administrator or on the PEBP website in the Find a Provider section. The provider listing is maintained and updated by the contracted network.

The provider network is subject to change. It is possible that you might not be able to obtain specific services from an In-Network provider.~~The provider network is subject to change.~~ Or you might find that an In-Network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available, you must choose another In-Network provider to get In-Network benefits.

Do not assume that an In-Network provider's agreement includes all Eligible Medical Expenses. Some In-Network providers agree to provide only certain covered expenses, but not all covered expenses. Some In-Network providers choose to be an In-Network provider for only some products and services. You may contact the third-party administrator for assistance in choosing a provider or with questions about a provider's network participation.

Pursuant to NRS 695G.164, if a member is receiving medical treatment from a provider whose In-Network status changes during the course of treatment, the member may continue to receive treatment with that provider at In-Network rates under certain circumstances. See more detailed explanation in PPO Network Health Care Provider Services section.

In-Network Provider Benefits

The Plan provides In-Network benefits when the services are provided by an In-Network provider and generally pays at a higher amount than Out-of-Network benefits. In-Network benefits are payable for covered Eligible Medical Expenses.

When a participant uses the services of a PPO network (In-Network) health care provider, the participant is responsible for paying the applicable cost-share (–Copay, Deductible, and/or Coinsurance) on the discounted fees for medically necessary services or supplies, subject to the Plan's coverage, limitations, and exclusions.

If you receive medically necessary services or supplies from an In-Network provider, you will pay a lower Coinsurance-cost than if you received those services or supplies from a health care provider who is not in the PPO network (Out-of-Network). In-Network providers have agreed to accept the Plan's payment (plus any applicable Coinsurance-cost-share you are responsible for paying) as payment in full. The In-Network health care provider generally deals with the Plan or its designee directly for any additional amount due.

Out-of-Network Provider Benefits

Out-of-Network Eligible Medical Expenses are subject to applicable cost-share (Copayments , Deductibles, and a Coinsurance rate of 50%) of eligible billed charges and subject to the Plan's Maximum Allowable Charge, except when prohibited by law

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 (as defined in the Key Terms and Definitions) on non-discounted medically necessary services or supplies, subject to the Plan's cost-share (Copays , Deductibles, and /or Coinsurance). With exception of 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). Balance billing for Eligible Medical Expenses can be avoided by using In-Network Providers.

Other Providers

If you have a medical condition that the third-party administrator or the utilization management company believes needs special services, they may direct you to a provider identified by them. If you require certain complex covered services for which expertise is limited, the third-party administrator or the utilization management company may direct you to an Out-of-Network provider. In both cases, benefits will only be paid at the In-Network benefit level (subject to the Maximum Allowable Charge) if your covered expenses for that condition are provided by or arranged by the other provider as chosen by third-party claims administrator or the utilization management company.

Participants may obtain health care services from In-Network or Out-of-Network health care providers. Because providers are added and dropped from the PPO network periodically throughout the year, it is the participant's responsibility to verify provider participation before receiving services by contacting the third-party claims administrator at the telephone number or by visiting the provider network's website located at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Out-of-Network Benefit Exceptions

If there is no In-Network provider within 50-miles of your home, you may be eligible to receive benefits for certain Eligible Medical Expenses paid at the In-Network level, subject to the Plan's Maximum Allowable Charge (with exception of services subject to the No Surprises Act). Benefits that fall under this category must be approved prior to receipt of the care and are subject to ~~any~~ Plan limitations or exclusions set forth in this MPD.

If you are traveling outside your network and you need medical care, you should contact the third-party administrator at the telephone number appearing on your medical identification card for assistance in locating the nearest In-Network provider. There is an exception for emergency care. ~~If you need emergency care, however, go ahead and get the care you need. The Plan will pay your claim for Eligible Medical Expenses at the In-Network provider level.~~

Emergency Care

The Plan provides benefits for emergency care when required for stabilization and initiation of treatment as provided by or under the direction of a health care provider. Eligible Medical Expenses that are provided as a result of Emergent care provided by In-Network providers are paid at the In-Network benefit level. Out-of-Network Emergent care for Eligible Medical Expenses is paid at the In-Network benefit level.

Confinement in an Out-of-Network Hospital Following an Emergency

If you are confined in an Out-of-Network hospital after you receive emergency services, the utilization management company must be notified within two business days or on the same day of admission if reasonably possible. The UM company may elect to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the utilization management company decides a transfer is medically appropriate, and the provider obtains informed consent, and you receive the required notice as required under the No Surprises Act, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service.

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the Eligible Medical Expenses at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge. Services subject to the No Surprises Act are subject to the Recognized Amount.

When Out-of-Network Providers May be Paid as In-Network Providers

When a participant uses the services of an Out-of-Network provider for Eligible Medical Expenses in the circumstances defined below, charges by the Out-of-Network provider will be subject to the Plan's Maximum Allowable Charge (as defined in the *Key Terms and Definitions* section). Out-

of-Network providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing).

- If a participant traveling to an area serviced by an In-Network provider experiences an urgent but not life-threatening situation and cannot access an In-Network provider, benefits may be paid at the In-Network benefit level for use of an Out-of-Network urgent care facility.
- In the event of a life-threatening emergency in which a participant uses an Out-of-Network urgent care.
- For medically necessary services or supplies when such services or supplies are not available from an In-Network provider within 50 driving miles of the participant's residence. This includes services provided for wellness/preventive, or a second opinion.
- Participant travels to an area not serviced by an In-Network provider within 50 miles.
- If a participant travels to an area serviced by an In-Network provider, the participant must use an In-Network provider to receive benefits at the In-Network benefit level.
- If there is a specialty not available inside the participant's eligible PPO network, benefits may be paid as In-Network.

Preferred Provider Organizations (PPO Network)

A preferred provider organization (PPO) network is a list of the doctors, other health care providers, and hospitals that the Plan has a contract with to provide medical care for Plan members. These providers are called "network providers" or "In-Network providers."

This Plan includes a PPO network for members residing in-and outside-of Nevada. To locate an In-Network provider visit the PEBP website at www.pebp.state.nv.us <https://pebp.nv.gov/> or contact the third-party claims administrator. Information regarding the PPO network is also available in the *Participant Contact Guide* section of this document.

Service Area

A "Service Area" is a geographic area serviced by In-Network health care providers. If you and or your covered dependent(s) live more than 50 driving miles from the nearest In-Network health care provider whose services or supplies are determined by the Plan Administrator or its designee as being appropriate for the condition being treated, the Plan will consider that you live outside the service area. In that case, your claim for medically necessary services or supplies from an Out-of-Network health care provider will be treated as if the services or supplies were provided In-Network, subject to the Maximum Allowable Charge.

Directories of Network Providers

Participants are encouraged to confirm the In-Network participation status of a provider prior to receiving services.

A list of PPO providers is available to you without charge by visiting [your member website from the Third-Party Administrator's website](#) or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

[The online provider directory updates are made seven \(7\) days a week for Sierra HealthCare Options \(SHO\), United Healthcare Choice Plus, and Behavioral Healthcare Options \(BHO\) networks. Providers are available in the Find Care and Cost tool available 24/7.](#) The list of PPO providers is maintained and updated by the contracted network [based on information supplied by Providers](#).

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services, and supplies. The expenses for which you are covered are called eligible medical expenses. Eligible medical expenses are limited to the covered benefits specified in the *Schedule of ~~Medical~~ Benefits* and are:

- Determined by the Plan Administrator or its designee to be medically necessary (unless otherwise stated in this Plan), but only to the extent that the charges are usual and customary (U&C), provided in-network, and/or do not exceed the Plan's Maximum Allowable Charge, costs that do not exceed the Plan's reference based pricing for services performed at exclusive facilities; (as those terms are defined in the *Key Terms and Definitions* section of this document);
- Not services or supplies that are excluded from coverage (as provided in the *Benefit Limitations and Exclusions ~~Exclusions~~* section).
- Charges for services or supplies that do not exceed the Plan Year maximum benefits as shown in the Schedule of ~~Medical~~ Benefits.

Generally, the Plan will not reimburse you for all eligible medical expenses. Usually, you will have to pay some portion of costs, known as cost-sharing such as Copayments, Deductibles, or Coinsurance toward the amounts you incur that are eligible medical expenses. However, you are only required to pay copayments and coinsurance for eligible medical expenses up to the Plan year individual or family out-of-pocket maximum.

The above is not all-inclusive. For more information regarding eligible medical expenses, see the Summary of ~~Medical~~ Benefits, *Schedule of ~~Medical~~ Benefits*, Key Terms and Definitions, Benefit Limitations and Exclusions sections.

A Person Whose Status Changes from Employee/Retiree to Dependent or from Dependent to Employee

A person who is continuously covered on this Plan before, during, and after a change in status, will be given credit for portions of the medical, prescription drug and dental Deductibles previously met in the same Plan Year, including the benefit maximum accumulators (e.g., medical Out-of-Pocket Maximums, dental frequency maximums and annual benefit maximum) will continue without interruption.

Non-Eligible Medical Expenses

Non-eligible medical expenses are expenses that are excluded from the Plan and do not accumulate towards your Deductible and Out-of-Pocket Maximum.

This Plan does not pay benefits equal to all the medical expenses you may incur. You are responsible for paying the full cost of all expenses that are not Eligible Medical Expenses, including expenses that are:

- Not determined to be medically necessary (unless otherwise stated in this Plan).
- Determined to be in excess of the usual and customary charges.
- Determined to be in excess of the Plan's Maximum Allowable Charge.
- Expenses for medical services or supplies that are not covered by the Plan, including but not limited to, expenses that exceed the PPO provider contract rate, excluded benefits as listed in the ~~Benefit Limitations and Exclusions~~Benefit Limitations and Exclusions section, and dental expenses.
- Benefits exceeding those services or supplies subject to limited overall maximums for each covered individual for certain Eligible Medical Expenses.
- Additional amounts you are required to pay because of a penalty for failure to comply with the Plan's utilization management requirements described in the *Utilization Management* section of this document. If you fail to follow certain requirements of the Plan's utilization management program, the Plan may pay a smaller percentage of the cost of those services, and you may have to pay a greater percentage of those costs. The additional amount you may have to pay is in addition to your Deductible or Out-of-Pocket Maximum.
- Preventive Care/Wellness benefits that are paid by the Plan at 100% do not accumulate towards the Out-of-Pocket Maximum.

This list is not all-inclusive and may not include certain services and supplies that are not listed above.

Non-Eligible Medical Expenses do not accumulate toward the Plan Year Deductible or Out-of-Pocket Maximum as determined by the Plan Administrator for your specific coverage tier. You are responsible for paying these expenses out of your own pocket.

For more information regarding Non-Eligible Medical Expenses, see the Benefit Limitations and Exclusions section.

PPO Network Health Care Provider Services

If you receive medical services or supplies from an In-Network PPO provider, you will be responsible for paying less money out-of-pocket. Health care providers who are participating providers of the PPO network have agreed to accept the PPO network negotiated amounts in place of their standard charges for covered services. You are responsible for any applicable Plan

Copayment, Deductible, and or Coinsurance requirements as outlined in this document and are described in more detail in the ~~*Schedule of Medical Benefits*~~*Schedule of Benefits*.

With exception of services subject to the No Surprises Act, Out-of-network providers may bill you their standard charges and any balance that may be due after the Plan payment. It is the participant's responsibility to verify the In-Network status of a chosen provider.

NOTE: In accordance with [NRS 695G.164](#), if you are seeing a provider that is In-Network and that provider leaves the network, and you are actively undergoing a medically necessary course of treatment, and you and your provider agree that a disruption to your current care may not be in your best interest or if continuity of care is not possible immediately with another In-Network provider, PEBP will pay that provider at the same level they were being paid while contracted with PEBP's PPO network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- The 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 90th day after:
 - The date of delivery; or
 - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Out-of-Country Medical, Prescription and Vision Purchases

This Plan provides you with coverage worldwide. Whether you reside in the United States and travel to a foreign country, or if you reside outside of the United States permanently or on a part-time basis, and require medical, prescription drug, or vision care services, you may be eligible for reimbursement of the cost.

Please contact this Plan's third-party claims administrator and pharmacy benefit manager before traveling or moving to another country to discuss any criteria that may apply to a medical, prescription drug, or vision service reimbursement request.

Typically, providers in foreign countries do not accept payment directly from the Plan. You may be required to pay for medical and vision care services and submit your receipts to this Plan's third-party claims administrator for possible reimbursement. Medical and vision services received outside of the United States are subject to Plan provisions, coverage, limitations, exclusions, clinical review, if necessary, determination of medical necessity, and the Plan's Maximum Allowable Charge. ~~The review may include application of pertinent Food and Drug Administration (FDA) regulations~~*The review may include regulations determined by the FDA.* Out-of-country medication purchases are only eligible for reimbursement while traveling outside of the United States.

The third-party claims administrator may require a written notice from you or your designated representative explaining why you received the medical services from an out of country provider and why you were unable to travel to the United States for these services. This provision applies to elective and emergency services.

Prior to submitting receipts from a foreign country to this Plan's third-party claims administrator, you must complete the following:

- Proof of payment from you to the provider of service (typically your credit card invoice).
- Itemized bill to include complete description of the services rendered and admitting diagnosis(es).
- Itemized bill must be translated to English.
- Reimbursement request converted to United States dollars.
- Foreign purchases of medical care and services are subject to Plan limitations such as:
 - Benefit coverage
 - Coinsurance and deductibles
 - Frequency maximums
 - Annual benefit maximums
 - Medical necessity
 - FDA approval
 - Usual and Customary or this Plan's Maximum Allowable Charge

The Plan Administrator and the third-party claims administrator reserve the right to request additional information. If the provider will accept payment directly from the third-party claim's administrator, you must also provide the following:

- Assignment of benefits signed by you or an individual with the authority to sign on your behalf such as a legal guardian or Power of Attorney (POA).

Once payment is made to you or to the out-of-country provider, the Plan Administrator and its vendors are released from any further liability for the out-of-country claim. The Plan Administrator has the exclusive authority to determine the eligibility of medical services rendered by an out-of-country provider. The Plan Administrator may or may not authorize payment to you or to the out-of-country provider if requirements of these provisions are not satisfied.

This Plan may provide certain benefits for travel assistance back to the United States.

This Plan may provide benefits for the purposes of emergency medical transportation only. For more information, contact this Plan's third-party claims administrator listed in the *Participant Contact Guide*.

Health Reimbursement Arrangement (HRA)

PEBP and its vendor require direct deposit for HRA reimbursements. PEBP's HRA benefits are subject to the provisions explained in IRS Publication 969. Also see PEBP HRA Summary Plan Document on PEBP's website.

Active Employees and Retirees

This section provides summary information only. For more detailed information regarding this important benefit, see Internal Revenue Service (IRS) Publication 502 or contact the HRA third-party claims administrator listed in the *Participant Contact Guide*.

PEBP will be funding an HRA for active employees enrolled in a qualifying PEBP plan for Plan Year 20254. **This is a one-time event.**

Funds in the HRA account may be used to pay for qualified medical expenses as defined by the IRS (see [IRS Publication 502](#)), other than premiums, including payment of Copay, Deductibles, Coinsurance, and other Out-of-Pocket qualifying healthcare expenses not covered by this Plan.

The HRA may only be used to pay or reimburse qualified Out-of-Pocket health care expenses incurred by the following individuals enrolled in this Plan (or other non-HRA group health coverage providing minimum value):

- the participant; or
- the participant's spouse; or
- participant's dependent(s) who could be claimed on the participant's annual tax return.

HRA funds may not be used for a person who does not meet the IRS definition of a qualified tax dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether PEBP provides coverage for the dependent.

The entire PEBP one-time contribution for **Plan Year 20245** will be available for use at the beginning of the Plan Year on or about **July 1, 20243** (subject to certain limitations). Participants who initially elect PEBP coverage after **July 1, 20243**, will receive a pro-rated base contribution for the participant based upon the coverage effective date and the months remaining in the Plan Year. Participants cannot contribute to an HRA. If the annual funds in the HRA are exhausted, neither PEBP nor the participant will contribute any additional funds.

Any funds remaining in the HRA at the end of the Plan Year will carryover (i.e., will not be forfeited) and will be available for use in the following Plan Year as long as the member maintains the same Plan.

Participants are allowed the option annually, and at termination in the plan, to permanently opt-out of the HRA, and thereby forfeit any unused balance.

Unlike a Flexible Spending Account (FSA), participants cannot be reimbursed from funds that are not yet available in the HRA. Any reimbursement from the HRA will be the lesser of the available HRA balance or the claim amount paid to the provider.

HRA funds are not portable between different plan types; participants cannot use HRA funds if they are no longer covered by the initial Plan with an HRA. If a participant terminates their coverage, the remaining balance in the HRA account will revert to PEBP, unless the qualified beneficiary elects COBRA. Participants enrolled with an HRA who change plans during the Open Enrollment period or during a Qualifying Life Event to a plan with an HSA and retirees who transition coverage to the Medicare Exchange will forfeit any remaining funds in the HRA account.

Active employees who retire and who are not Medicare age (typically at age 65 years) can maintain the balance of their HRA account at retirement if:

- They are eligible to enroll in and continue coverage under a PEBP plan; or
- Continued coverage under COBRA.
 - If a participant elects COBRA coverage, the HRA account will remain in place until COBRA coverage is terminated.

In the case of a retroactive coverage termination, any funds used from the HRA for expenses that are incurred after the date of coverage termination will be recovered by PEBP through the collection process.

Retirees who have a HRA balance and who transition to the Medicare Exchange will forfeit any remaining funds in the HRA on the last day of coverage under this Plan.

The death of an active employee or retiree will cause any remaining funds in the HRA to be forfeited on the first day following the date of death.

Timely Filing of HRA Claims

In accordance with [NAC 287.610](#), claim requests must be submitted to the third-party claims administrator within one year (12-months) from the date of service that the claim is incurred. No plan benefits will be paid for any claim requests submitted after this period.

When your HRA-eligible coverage ends, you will have one year (12-months) from the date your coverage ends to file a claim for reimbursement from your HRA for eligible claims incurred during your coverage period in accordance with [NAC 287.610](#)~~NAC 287.610~~. HRA funds may not be used to pay premiums.

HRA Contributions for Eligible State Active Employees	
Tier	One-Time Contribution
~~PEBP Funded Contribution~~	
~~State Active Employee Only~~	~~\$300~~
~~State Active Employee + Spouse/Domestic Partner~~	~~\$300~~
~~State Active Employee + Child(ren)~~	~~\$300~~
~~State Active Employee + Family~~	~~\$300~~
Legislature Appropriated One-Time Contribution	
State Active Employee Only	\$300
State Active Employee + Spouse/Domestic Partner	\$400
State Active Employee + Child(ren)	\$400
State Active Employee + Family	\$500

* One-time contribution provided to eligible active, State employees enrolled in this Plan on **July 1, 2024~~3~~**. State employees who initially elect PEBP coverage after **July 1, 2024~~3~~**, will receive a pro-rated base contribution based on the tier and the coverage effective date and the months remaining in the Plan Year.

Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing plans.

Legislatively approved enhancements, such as HSA/HRA funding and enhanced basic life insurance amounts may be subject to change in subsequent plan years.

Utilization Management

The Plan is designed to provide you and your eligible dependents with financial protection from significant health care expenses. To enable the Plan to provide coverage in a cost-effective way, it has a Utilization Management (UM) program designed to help control increasing health care costs by avoiding unnecessary services, directing participants to more cost-effective treatments capable of achieving the same or better results and managing new medical technology and procedures. If you follow the procedures of the Plan's UM program, you may avoid some Out-of-Pocket costs. However, if you do not follow these procedures, Plan benefits may be reduced, and you will be responsible for paying more out of pocket.

The Plan's UM program is administered by an independent professional UM company operating under a contract with the Plan. The name, address and telephone number of UM company appears in the *Participant Contact Guide* section. The health care professionals at the UM company focus their review on the medical necessity of hospital stays and the medical necessity, appropriateness, and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM company has been given discretionary authority by the Plan administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of the Plan.

The UM program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document, PEBP's *Employee Health and Welfare Wrap Plan*, and *Retiree Health and Welfare Wrap Plan* documents. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered, either in whole or in part, by an exclusion in the Plan.

~~Regardless of whether~~ Even if your physician recommends surgery, hospitalization, confinement in a skilled nursing or sub-acute facility, or your physician or other provider proposes or provides any medical service or supply ~~does not mean~~ the recommended services or supplies are not automatically considered medically necessary for purposes of ~~will be considered medically necessary for~~ determining coverage under the Plan.

Benefits payable by the Plan may be affected by the determination of the UM company if:

- the UM company does not authorize a proposed surgery or other proposed medical treatment as medically necessary; or
- The Plan will not pay regular benefits for a hospitalization or confinement in a skilled nursing or sub-acute facility because the UM company does not authorize a proposed confinement.

PEBP, the third-party claim administrator, and the UM company are not engaged in the practice of medicine and are not responsible for the outcomes of health care services rendered (even if the health care services have been authorized by the UM company as medically necessary), or

for the outcomes if the patient chooses not to receive health care services that have not been authorized by the UM company as medically necessary.

When reviewing services for appropriateness of care and medical necessity, the UM company uses guidelines and criteria published by nationally recognized organizations, along with medical judgement of licensed health care professionals.

Delivery of Services

You are entitled to receive medically necessary medical care and services as specified in this Plan's *Summary of ~~Medical~~ Benefits* and *Schedule of ~~Medical~~ Benefits*. These include medical, mental health, behavioral health, surgical, diagnostic, therapeutic, and preventive services. If a precertification is required and you do not obtain the required precertification, the service may not be covered, even if the service is medically necessary. These services, although not all-inclusive are those that generally:

- Are provided In-Network and Out-of-Network,
- Are performed or ordered by a participating provider,
- Require a precertification according to the utilization management and quality assurance protocols, if applicable.

Concurrent Review

Concurrent Review (continued stay) is the ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or skilled nursing or sub-acute facility. When you are receiving medical services in a hospital or other inpatient facility, the UM company monitors your stay by contacting your physician or other providers to assure that continuation of medical services in the facility is medically necessary. The UM company will also help coordinate your medical care with other healthcare benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services, and or advising your physician or other providers of various options and alternatives for your medical care available under this Plan.

If at any point, your stay is found not to be medically necessary and care could be safely and effectively delivered in another environment (such as through home health care or in another type of health care facility), you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, expenses incurred after the notification will be your responsibility. If your hospital stay is determined not to be medically necessary, no benefits will be paid on any related hospital, medical or surgical expense. You may also appeal the determination (refer to the *Appealing a UM Utilization Management determination* section).

Retrospective Review

Retrospective Review is the review of health care services after they have been provided to determine if those services were medically necessary. The Plan will pay benefits only for those

days or treatments that would have been authorized under the utilization management program; and case management: The process whereby the patient, the patient's family, physician, or other providers work together with the Plan Administrator or its designee under the guidance of the UM company to coordinate a quality, timely and cost-effective treatment plan.

Case Management

Case management is a voluntary process administered by the UM company. Its ~~medical~~ professionals work with the patient, the patient's family, caregivers, providers, the third-party claims administrator, and the Plan Administrator or its designee to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly and/or high-technology services, or when assistance is needed to guide the patient through a maze of potential providers. Case management is available for individuals diagnosed with sickle cell ~~or and~~ its variants, ~~among other conditions~~ ([NRS 695G.174](#), ~~among other conditions~~). Case management is also available for a disability resulting from a mental health or substance use disorder diagnosis.

The case manager will work directly with your physician, hospital, and/or other provider to review proposed treatment plans and to assist in coordinating services and obtaining discounts from providers as needed. From time to time, the case manager may confer with your physician or other providers and may contact you or your family to assist in making plans for continued health care services or obtaining information to facilitate those services.

You, your family, or your physician may call the case manager at any time to ask questions, make suggestions or offer information. The case manager can be reached by calling the UM company at the telephone number shown in the *Participant Contact Guide* section or on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Precertification (Prior Authorization) Process

Precertification prior authorization review is a procedure administered by the UM company to assure health care services meet or exceed accepted standards of care. In certain cases, as set forth below, for a benefit to be covered, the UM company must approve and/or pre-certify the service. **If a precertification is required and you do not obtain the required precertification, benefits may be reduced, even if the service is medically necessary.** The UM company uses nationally recognized guidelines and criteria as standard measurement tools to determine whether benefits are approved and/or pre-certified.

Precertification also includes the determination of whether the admission and length of stay in a hospital or skilled nursing or sub-acute facility, surgery or other health care services are medically necessary and if the location of service is high quality and lowest cost.

A precertification is required for referrals to physicians and providers for certain services. Benefits listed in this Plan may be subject to precertification requirements and concurrent or retrospective review depending upon the circumstances associated with the services. Refer to the Services Requiring Precertification section below for more information.

Failure to obtain precertification may result in your benefits being reduced or denied (see the Failure to Follow Required Utilization Management Procedures in this section).

Services Requiring Precertification (Prior Authorization)

Inpatient Admissions

- Acute inpatient or observation
- Long-Term Acute Care
- Rehabilitation
- Behavioral Health
- Transplant including ~~all~~ pre-transplant related expenses
- Skilled Nursing facility and sub-acute facility
- Residential Treatment Facility, ~~including outpatient partial hospitalization programs,~~ and partial residential treatment programs
- Hospice (inpatient/outpatient) exceeding six (6) months.
- Obstetric – (precertification only required if days exceed 48 hours for vaginal delivery or 96 hours for a C-section)
- Intraoperative Neuro Monitoring
- Surgeries to treat Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery.

Outpatient and Physician – Surgery

When outpatient and physician surgery is performed at an In-Network, contracted ambulatory surgical center (ASC) by an In-Network, contracted physician, prior authorizations is not required.

However, when services are not performed at an In-Network, contracted ASC, procedures will require prior authorization. This is commonly referred to as Site of Service. Examples of services that require prior authorization include, but are not limited to:

- Back Surgeries and hardware related to surgery
- Total and remaining Hip and Knee Surgeries
- Biopsies (excluding skin, colonoscopy and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Oophorectomy, unilateral and bilateral
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Surgeries to treat Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery

- Sleep apnea related surgeries, limited to:
 - Radiofrequency ablation (Coblation, Somnoplasty)
 - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic) and reconstruction surgery
- Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Varicose vein surgery/sclerotherapy
- Any procedure deemed to be Experimental and/or Investigational (provider must indicate on the pre-certification request that the service/procedure is Experimental and/or Investigational and/or part of a clinical trial)
- Intraoperative Neuro Monitoring
- Prophylactic surgery

Outpatient and Physician – Diagnostic Services

- CT, PET, SPEC, and MRI
- Capsule endoscopy
- Genetic Testing, including:
 - BRCA
 - Biomarker Testing (Assembly Bill 155 from the 82nd Legislative Session in 2023)

Outpatient and Physician – Continuing Care Services

- Applied Behavior Analysis (ABA) Therapy for Medical, Mental Health, and Substance Use Disorder
- ~~Dialysis~~
- Electroconvulsive Therapy (ECT)
- Chemotherapy
 - Oral Chemotherapy to be reviewed by Pharmacy Benefit Manager
- Radiation Therapy
- Oncology and transplant related injections, infusions, and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric Oxygen
- Home Health Care
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Durable Medical Equipment exceeding \$1,000
 - Prior authorization is based on overall cost to the plan and/or purchase price, not the amount billed for monthly rental. DME rental to purchase in accordance with Medicare guidelines.
- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables and infusions excluding services reviewed by the PBM

- ~~Behavioral Health~~ Intensive Outpatient programs, including partial hospitalization programs
- ~~Sickle Cell Disease~~
- ~~_____~~
- ~~Vein Therapy~~
- ~~_____~~
- Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a combined visit limit of 90 visits between the types of therapy per Plan Year.
 - Visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder.

Services Not Requiring Precertification (Prior Authorization)

Prior authorization is not required for medically necessary emergency services when a medical condition that manifests itself by symptoms of such severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the participant.
- Serious jeopardy to the health of an unborn child.
- Serious impairment of a bodily function; or
- Serious dysfunction of any bodily organ or part.

The UM company must be notified of an emergency hospital admission within one business day so the UM company can conduct a *concurrent review*. Your physician or the hospital should call the UM company to initiate the concurrent review. Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding UM, such as concurrent review.

How to Request Precertification (Prior Authorization)

It is your responsibility to ensure that precertification occurs when it is required by the Plan. Any penalty or denial of benefits for failure to obtain precertification is your responsibility, not the provider's. ~~You or your~~ Your physician must call the UM company at the telephone number shown in the *Participant Contact Guide* to request precertification. Calls for elective services should be made at least 15 calendar days before the expected date of service or may be subject to the benefit reduction listed in the *Utilization Management* section. The UM company will require the following information:

- The employer's name.
- Employee's name.
- Patient's name, address, phone number and Social Security Number or PEBP unique ID.
- Physician's name, phone number or address.
- The name of any hospital or outpatient facility or any other provider that will be providing services.
- The reason for the health care services or supplies; and

- The proposed date for performing the services or providing the supplies.

The UM company will review the information and provide a determination to you, your physician, the hospital or other provider, and the third-party claims administrator as to whether the proposed health care services have been determined to be medically necessary. Additionally, the UM company may approve medical necessity but not site of care. In these circumstances, the UM company will provide approved alternate locations to the caller. While industry and accreditation standards require a preauthorization determination within 15 calendar days for a non-urgent case, the UM company will usually respond to your physician or other provider by telephone within (5) five business days of receipt of the request. The determination will then be confirmed in writing.

If your hospital admission or medical service is determined not to be medically necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal (refer to the *Appealing a UM Determination* section).

Second Opinion

The utilization management company may authorize a second opinion upon your request in accordance with this Plan. Examples of instances where a second opinion may be appropriate include:

- Your physician has recommended a procedure and you are unsure whether the procedure is necessary or reasonable.
- You have questions about a diagnosis or plan or care for a condition that threatens substantial impairment or loss of life, or bodily functions.
- You are unclear about the clinical indications about your condition.
- A diagnosis is in doubt due to conflicting test results.
- Your physician is unable to diagnose your condition; and a treatment plan in progress is not improving your medical condition within a reasonable period.

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in Services Requiring Precertification (Prior Authorization).

2nd.MD

2nd.MD is PEBP's preferred second opinion Service. See benefits in the Schedule of Benefits, below, for additional information

Hospital Admission

You are responsible for ensuring the UM company is notified at least 5 (five) business days before an inpatient admission to obtain pre-certification.

Your physician or other provider may notify the UM company, but it is ultimately your responsibility to make sure they are notified. The UM company will review the

physician/provider's recommendation and treatment plan to determine the level of care and place of service. If the UM company denies the precertification for hospital admission as not covered or they determine that the services do not meet the UM company's medical necessity criteria, the Plan's third-party administrator will only pay benefits for inpatient that has been pre-certified.

You are required to obtain a precertification before you obtain services for inpatient elective surgeries. If you do not follow the required UM process, benefits for the elective surgeries may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network surgery expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum, if applicable.

Emergency and Urgent Hospital Admission

This Emergency and Urgent Hospital Admissions includes complications of pregnancy.

You are not required to obtain a precertification before you obtain services for a medical emergency. However, the UM company must still be notified within 24 hours, the next business day, or as soon as reasonable after admission so the UM company can conduct a concurrent review. If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times, they must receive notification as soon as reasonably possible after the admission or you may be subject to reduction or denial of benefits as provided by the Plan.

- Emergency Hospital Admission: Admission for hospital confinement that results from a sudden and unexpected onset of a condition that requires medical or surgical care. In the absence of such care, you could reasonably be expected to suffer serious bodily injury or death. Examples of emergency hospital admission include, but are not limited to, admissions, for heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal injuries, and other acute conditions.
- An urgent hospital admission means an admission for a medical condition resulting from injury or serious illness that is less severe than an emergency hospital admission but requires care within a short time, including complications of pregnancy.

Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding utilization management, such as concurrent review.

If you do not follow the required UM process, benefits payable for the services may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network medical expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum.

Confinement in an Out-of-Network Hospital Following an Emergency Admission

Please refer to the No Surprises Act section of this document for claims subject to that Act. For other confinements, if you are confined in an Out-of-Network hospital after you receive emergency services, the UM company must be notified within 24 hours, the next business day, or as soon as reasonable after admission. The UM company may determine it is appropriate to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the UM company decides a transfer is medically appropriate, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service.

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the Eligible Medical Expenses at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge.

Elective Knee and Hip Joint Replacement – Nevada Exclusive Hospitals and Outpatient Surgery Centers

Precertification is required; the UM company will review the request based on surgery type, medical necessity, covered benefits, provider quality, cost, and provider location.

Due to cost variations for elective knee and hip joint replacement performed in Nevada, the third-party claims administrator has identified exclusive providers who meet the Plan's cost threshold for routine knee and hip replacement procedures. The exclusive provider list can be found on the PEBP website.

If you choose a provider on the exclusive list, you will potentially reduce your out-of-pocket costs in accordance with the standard plan benefits.

However, if you choose to use a non-exclusive provider, the Plan will pay benefits in accordance with its cost threshold or Maximum Allowable Charge. You may be subject to balance billing for any amount exceeding this Plan's cost threshold. Amounts exceeding the Plan's established threshold will not apply to your Deductible (if applicable) or Out-of-Pocket Maximum.

Inpatient or Outpatient Surgery

You are responsible for ensuring that the UM company is notified at least 5 (five) business days before elective inpatient or outpatient surgery is performed to ensure that it is covered.

Your physician or other provider may notify the UM company, but it is your responsibility to make sure they are notified. The UM company will review the physician's recommended course of treatment to ensure the requested treatment meets established medical necessity criteria and protocols.

The claims administrator will only pay benefits for inpatient or outpatient surgery that is pre-certified, and the services/supplies are a covered benefit.

Outpatient Infusion Services

Precertification is required for outpatient infusion services. The UM company will review the request based on covered benefits, medical necessity, provider quality, cost, and location. If you choose to receive your infusion at a non-exclusive hospital or infusion center, you will be responsible for any amount that exceeds this Plan's Maximum Allowable Charge. Amounts exceeding this Plan's established cost threshold will not apply to your annual Deductible or Out-of-Pocket Maximum.

Air Ambulance Services

This Plan provides coverage for emergency air ambulance and inter-facility patient air transport if there is a life-threatening situation, or the service is deemed medically necessary by the UM company. The air ambulance services are subject ~~to the Plan cost-share~~ (-Deductible, Copay, or Coinsurance), if applicable, then the Plan will pay the lower of the PPO allowable for In-Network air ambulance providers, or for Out-of-Network providers, the Plan will pay up to the Recognized Amount.

See the Utilization Management section for air ambulance precertification requirements.

Air/Flight Schedule Inter-Facility Transfer

Inter-facility transport services require precertification. The UM company may discuss with the physician and/or hospital/facility the diagnosis and the need for inter-facility patient transport versus alternatives. Failure to obtain a precertification may result in a reduction or denial of benefits for charges arising from or related to flight-based inter-facility transfers. Non-compliance penalties imposed for failure to obtain a precertification will not be included as part of the annual out-of-pocket maximum.

Inter-facility transport may occur if there is a life-threatening situation, ~~or~~ if the transport is deemed medically necessary. The following conditions apply:

- Services via any form of air/flight for inter-facility transfers must be pre-certified before transport of the participant to another hospital or facility, and the participant is in a hospital or other health care facility under the care or supervision of a licensed health care provider; and
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

Emergency Air Ambulance

This Plan provides coverage for emergency air ambulance transportation for participants whose medical condition at the time of pick-up requires immediate and rapid transport due to the

nature and/or severity of the illness/injury. Air ambulance transportation must meet the following criteria:

- Services via any form of air/flight for emergency air ambulance; and
- The patient's destination is an acute care hospital; and
- The patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health; or
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

See *Air Ambulance Services* [and the No Surprises Act](#) for details on plan benefits and coverage.

Gender Dysphoria

The participant or their physician should contact the UM company to begin the process toward surgical intervention ~~of~~ [to treat](#) gender dysphoria. The initial contact will include:

- Notification to the participant that the precertification process begins with the initial contact to the UM company.
- Advising participants of providers who specialize in this type of treatment.

This service is provided by the UM company and will be initiated upon the first call for a precertification. Case management services are particularly helpful for a participant or their covered dependent who is receiving complex medical services for medical conditions such as gender dysphoria. Your assigned case manager nurse will provide you with assistance addressing any concerns you may have about issues such as continuity of care or finding providers or a provider who specializes in gender dysphoria.

In accordance with [Senate Bill 163](#) from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include [consideration of the most](#) recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

Health Care Services and Supplies Review

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in *Services Requiring Precertification (Prior Authorization)*.

Non-participating providers may not know to notify the UM company to obtain precertification for services. In such a case, you must confirm that the UM company pre-certified the service to assure that it is covered.

The Plan will pay for covered health care services and supplies only if authorized as outlined above. The Plan will not pay for any health care services or supplies that are not covered services or do not meet medically necessary criteria and protocols.

Failure to Follow Required UM Procedures

If you do not follow the required precertification review process described in this section, benefits payable for the services you failed to receive a precertification may be reduced by 50% of the Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network *Eligible Medical Expenses*. Expenses related to the penalty will not apply to your Plan Year Deductible or Out-of-Pocket Maximum. If you wish to appeal an adverse benefit decision made by the UM company, refer to the *Appealing a UM Determination* section.

Summary of ~~Medical~~ Benefits

To determine the benefit limitations for any health care service or supply, review the Summary and Schedule of ~~Medical~~ Benefits listed below.

To determine precertification requirements, refer to the *Utilization Management* section.

Copay applies to Primary Care Physician (PCP) and Specialist office visits for evaluation and management services only; imaging, surgery, and other services provided during a PCP or Specialist office visit are subject to the Plan Year Deductible and Coinsurance.

Benefit Description	In-Network	Out-of-Network
Physician Office Visits		
Primary Care Physician (PCP) Office Visit	\$30 Copay	Plan pays 50% after Deductible
Specialist Services (including Allergy Services)	\$50 Copay	Plan pays 50% after Deductible
<i>No referral is required for these visits. Imaging, surgery, and other services provided in an office setting subject to Deductible and Coinsurance.</i>		

Benefit Description	In-Network	Out-of-Network
ACA Wellness/Preventive Office Visits and Preventive Screenings The Plan covers recommended preventive care services without participant cost-sharing when services are received by In-Network providers. For more details see <i>Preventive Services</i> in the Summary of ~~Medical~~ Benefits.		
Primary Care Wellness Visit	\$0 Copay	Not Covered
Obstetrics and Gynecology ACA Services	\$0 Copay	Not Covered
Prenatal and Postnatal Office Visit	\$0 Copay	Not Covered
<i>No referral is required for these visits. Imaging, surgery, and other services provided in an office setting subject to Deductible and Coinsurance</i>		

Benefit Description	In-Network	Out-of-Network
Wellness/Preventive Office Visits and Preventive Screenings		
Mammography screening	\$0 Copay	Not Covered
<i>Limit: One 2D or 3D mammogram screening per Plan Year for women aged 40 years and older.</i>		
Papanicolaou (Pap) test	\$0 Copay	Not Covered
Prostate Specific Antigen (PSA) screening	\$0 Copay	Not Covered
Colorectal screening	\$0 Copay	Not Covered
<i>Colorectal Screening: Starting at age 45 in accordance with the American Cancer Society's screening guidelines.</i>		
Counseling for sexually transmitted infections (STI), HIV counseling and testing	\$0 Copay	Not Covered
Breastfeeding support, supplies, and counseling	\$0 Copay	Not Covered
<i>Contact the third-party claims administrator for the purchase of covered breast pumps. Rental for heavy duty electrical (hospital grade) covered only when medically necessary and only during the newborn's inpatient hospital stay.</i>		
Screening for interpersonal and domestic violence	\$0 Copay	Not Covered
Contraceptives/In-office counseling	\$0 Copay	Not Covered
<i>FDA approved injections, implants, and contraceptive devices not covered under the pharmacy benefits.</i>		
Screening for Gestational Diabetes	\$0 Copay	Not Covered
Real Appeal	\$0 Copay	Not Covered
High-risk Human Papillomavirus (HPV) testing	\$0 Copay	Not Covered
<i>For more information, refer to the Preventive Services in the Schedule of ~~Medical~~ Benefits section. An office visit copay may apply if services provided during the visit include additional services that are not preventive services.</i>		

Benefit Description	In-Network	Out-of-Network
Hospital Facility Services		
Inpatient Hospital Admission	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Inpatient Delivery Postpartum/Newborn Care Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Outpatient Observation	\$500 Copay	Plan pays 50% after Deductible
<i>Outpatient Observation period lasting more than 23 hours will be considered and paid as an inpatient confinement.</i>		
Outpatient Surgery	\$500 Copay	Plan pays 50% after Deductible
<i>Other services, related to and during the outpatient surgery on that date, are not subject to the deductible and coinsurance.</i>		
Skilled Nursing Facility Limit: 100 days per Plan Year	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Rehabilitation, Habilitation Facility ** ~~(Limited to 60 days per Plan Year)~~	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>Hospital facility services require precertification. In emergencies in which a member is admitted to hospital for an inpatient stay, the UM company must be notified with 24 hours, the next business day following the admission.</i> <i>*See the Utilization Management section for precertification requirements, including emergency hospital admissions.</i> <i>**Rehabilitation, Habilitation Facility services are limited to 60 days per Plan Year; however, visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder.</i>		

Benefit Description	In-Network	Out-of-Network
Urgent Care and Emergency Services		
Urgent Care Services*	\$80 Copay	\$80 Copay, subject to the Plan's Maximum Allowable Charge

Emergency Room Services**	\$750 Copay	\$750 Copay *
<i>*When using Out-of-Network urgent care services, you are responsible for paying this Plan's copayment amount, plus any amounts exceeding the Plan's Maximum Allowable Charge. See Key Terms and Definitions for more information.</i> <i>**Emergency Room services: If admitted to the hospital, the ER Copay is waived and the Inpatient Hospital Copay applies.</i>		
Urgent and Emergency Services		
Ambulance (ground/water)*	Plan pays 80% after Deductible	Plan pays 80% after Deductible, subject to the Maximum Allowable Charge
Ambulance (air)	Plan pays 80% after Deductible	Plan Pays 80% after Deductible *
<i>*When using Out-of-Network ambulance providers you are responsible for paying your Deductible and Coinsurance. See the Utilization Management and Schedule of ~~Medical~~ Benefits.</i> *see also NRS 695G.170 for medically necessary emergency services at any hospital in Nevada.		

Benefit Description	In-Network	Out-of-Network
Outpatient Specialty Imaging and Diagnostic Testing		
Computer Tomography (CT) Scan	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Positron Emission Tomography (PET) Scan	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Magnetic Resonance Imaging (MRI/MRA)	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Nuclear Medicine	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Angiogram and Myelogram	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>Outpatient Specialty Imaging and Diagnostic testing: When performed Out-of-Network, you are responsible for the Plan's cost-share and any amount exceeding the Plan's Maximum Allowable Charge. See the Utilization Management section for precertification requirements.</i>		

Benefit Description	In-Network	Out-of-Network
Non-Specialty Imaging and Diagnostic Testing (Including X-rays and Ultrasounds; except Specialty Imaging and Diagnostic Testing)		
Services provided in a Primary Care Physician Office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Services provided in a Specialty Care Physician's Office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Services provided in a hospital outpatient setting	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Diagnostic Mammography	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>Non-Specialty Imaging and Diagnostic testing: When performed Out-of-Network, you are responsible for the Plan's cost-share and amounts exceeding the Plan's Maximum Allowable Charge.</i>		

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		
General Laboratory Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Routine/Preventive Lab Testing*	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Routine and Preventive Lab Services <i>* Routine/preventive lab services must be performed at a freestanding, non-hospital-based lab facility.</i> - Medically necessary routine labs when ordered by a physician as part of comprehensive medical care. - Preventive laboratory services such as basic metabolic panel, lipid <u>panel</u>, ~~or general health panel~~<u>etc.</u> - Routine/preventive lab tests performed at an outpatient hospital or hospital-based free-standing lab facility/draw station are not covered.		

Pre-admission Lab Testing Services**	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Pre-Admission Lab Testing Services **Pre-admission lab testing performed on an outpatient basis at a hospital-based lab or free-standing hospital-based lab draw station within 7 days prior to a scheduled hospital admission or outpatient surgery. Testing must be related to the sickness or injury for which admission or surgery is planned.		
Outpatient ~~Short-Term~~ Rehabilitation and Habilitative Therapy Services Outpatient Speech, Occupational, and Physical Therapy		
Speech Therapy	\$50 Copay per Visit	Plan pays 50% after Deductible
Occupational Therapy	\$50 Copay per Visit	Plan pays 50% after Deductible
Physical Therapy	\$50 Copay per Visit	Plan pays 50% after Deductible
<u>Outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) is subject to copay for each therapy type.</u> <u>Precertification required; speech, occupational, and physical therapy visits are limited to a combined 90 visits based on distinct visit-types per Plan Year. Visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder..</u>		

Benefit Description	In-Network	Out-of-Network
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and Pulmonary rehabilitation	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<u>Limited to medically necessary services; 60 visits per Plan Year for all modalities combined.</u>		
Dialysis	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Wound Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Chemotherapy Treatment	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Radiation therapy (Outpatient hospital/facility, or physician's office)	Plan pays 80% after Deductible	Plan pays 50% after Deductible

Infusion Therapy (home/outpatient, including specialty drugs)	Plan pays 70% after Deductible	Plan pays 50% after Deductible
<i>See the Utilization Management section for precertification requirements.</i>		

Benefit Description	In-Network	Out-of-Network
Hinge Health		
Digital Musculoskeletal (MSK) Care	\$0 copay; not subject to deductible	Not Covered

Benefit Description	In-Network	Out-of-Network
Surgical Services		
Performed in a Primary Care Physician's office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Performed in a Specialty Care Physician's office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Performed in same-day surgery facility or Ambulatory Surgery Center (ASC)	\$500 Copay	Plan pays 50% after Deductible
<i>See the Utilization Management section for surgical services requiring precertification.</i>		

Benefit Description	In-Network	Out-of-Network
Medical Supplies, Equipment, and Prosthetics		
Durable Medical Equipment	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>Durable Medical Equipment (DME): Limited to one purchase, repair, or replacement of a specific item of DME every 3 years. DME rental to purchase in accordance with Medicare guidelines. The purchase or rental of DME, including oxygen related equipment in excess of \$1,000 requires precertification.</i>		
Orthopedic and prosthetic devices	Plan pays 80% after Deductible	Plan pays 50% after Deductible

<i>Orthopedic and prosthetic devices: Limited to a single purchase of a type of prosthetic device, including repair and replacement, every 3 years. Orthopedic and prosthetic devices in excess of \$1,000 require precertification.</i>		
Hearing Aids	\$50 Copay per Device	\$50 Copay per Device
<i>Hearing Aids: Coverage for medically necessary, FDA approved air conduction hearing aids. Subject to a \$50 Copay per device, Maximum benefit \$1,500 per device, per each ear, every 3 years.</i>		
Special Food Product	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>Special Food Product: ~~\$2,500 maximum benefit per Plan Year for Special Food Products for the treatment of a person with inherited metabolic diseases.~~ See Enteral Formulas and Special Food Products in the Schedule of ~~Medical~~ Benefits.</i>		
Enteral Formula	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>Enteral Formula for the treatment of inherited metabolic disease. See Enteral Formulas and Special Food Products in the Schedule of ~~Medical~~ Benefits.</i>		

Mental/Behavioral Health Treatment		
Inpatient/Residential Rehabilitation	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Intensive Outpatient Treatment Program	~~Plan pays 100% after Deductible~~ ~~\$30 Copay per Visit~~	Plan pays 50% after Deductible
Partial Hospitalization Program	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Applied Behavioral Therapy	~~Plan pays 100% after Deductible~~ ~~\$30 Copay per Visit~~	Plan pays 50% after Deductible
Outpatient treatment	~~Plan pays 100% after Deductible~~ ~~\$30 Copay per Visit~~	Plan pays 50% after Deductible
Psychological testing	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>Refer to the Utilization Management section for precertification requirements.</i>		

Benefit Description	In-Network	Out-of-Network
Other Medical Services – Doctor on Demand, Telehealth, 2nd.MD		

Doctor on Demand		
Telemedicine Visit		
Medical Visit	\$10 Copay per Visit	Not Covered
Psychology Visit (25-minutes)	\$20 Copay per Visit	Not Covered
Psychologist Visit (50 -minutes)	\$30 Copay per Visit	Not Covered
Psychiatrist Visit (45 minutes/initial visit)	\$30 Copay per Visit	Not Covered
Psychiatry Visit (15-minute follow-up visit)	\$20 Copay per Visit	Not Covered
Telehealth Visit		
Primary Care Visit	\$30 Copay per Visit	Plan pays 50% after Deductible
Specialist Care Visit	\$50 Copay per Visit	Plan pays 50% after Deductible
2nd.MD (Second Opinion Services)		
2nd.MD (Second Opinion Services)	\$0 Copay per Visit	Not Covered

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Chiropractic (Spinal manipulation services)	\$50 Copay per Visit	Plan pays 50% after Deductible
<i>Chiropractic and spinal manipulation services: Limited to 20 office visits per Plan Year.</i>		
Acupuncture, Acupressure services	\$50 Copay per Visit	Plan pays 50% after Deductible
<i>Acupuncture and acupressure services: Limited to 20 visits (combined) per Plan Year, 100 visits (combined) per lifetime.</i>		

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Home Health Care	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>Home Health Care: Limited to 60 visits per Plan year; may provide for private duty nursing in the home; requires precertification. Additional visits are subject to preauthorization by the UM company.</i>		
Office-based infertility services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility for a covered individual (limited to one diagnostic evaluation for infertility every Plan Year, and up to three (3) per lifetime, and up to six (6) artificial inseminations per lifetime. See exclusions in the Benefit Limitations and Exclusions. These limits and exclusions apply to both office-based and non-office-based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in the Summary of Medical Benefits</i>		
Temporomandibular Joint (TMJ) Disorder Services*		
Office-based services (excluding surgical services)	Specialist Visit: \$50 Copay Other office-based services: Plan pays 80% after Deductible	Plan pays 50% after Deductible
TMJ Surgical Services (including surgical services)	Outpatient Surgery: \$500 Copay Inpatient: Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>TMJ disorder and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Limited to two (2) surgeries in a lifetime.</i>		

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Hospice	Plan pays 80% after Deductible	Plan pays 50% after Deductible
<i>The hospice care program administers palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill patients with a life expectancy of</i>		

6 months or less as certified by patient's medical physician. For outpatient bereavement counseling services, see Hospice Services in the Schedule of ~~Medical~~ Benefits. Precertification is required for both inpatient and outpatient hospice services exceeding six (6) months. For a description of the hospice care benefits, see Hospice Services in the Schedule of ~~Medical~~ Benefits.

Benefit Description	In-Network	Out-of-Network
Obesity Care Management (OCM) Program (Disease Management Program)		
Weight Loss Medication	*Preferred -Retail 30-Day Supply	Home Delivery 90-Day Supply*
Preferred/Formulary Generic	\$0 Copay	\$0 Copay
Preferred/Formulary Brand	\$20 Copay	\$40 Copay
Non-Preferred/Non-Formulary Brand	\$75 Copay	\$150 Copay
*Preferred Retail Network Pharmacies: Copayments apply if you fill your prescription at a Preferred Retail Network retail pharmacy. If you fill your prescription at a non-Preferred Retail Network retail pharmacy, you will pay an additional \$10 per prescription. If you currently use a non-Preferred Retail Network pharmacy and you want to avoid the \$10 upcharge, call a Preferred Retail Network pharmacy to transfer your prescription. See the Schedule of Pharmacy Benefits for instructions on how to find a Preferred Retail Network pharmacy. Certain weight loss medications may not be available in 90-day supply. Contact Express Scripts for information about your prescribed medication. * Retail 90-day Supply is three (3) times the copay for the 30-day supply		

Benefit Description	In-Network	Out-of-Network
Obesity Care Management (OCM) Program (Disease Management Program)		
Office Visit (OCM weight loss provider)	\$0 Copay	Not Covered
Laboratory test	\$0 Copay	Not Covered
<i>Outpatient laboratory test services as determined by your weight loss provider (and as covered under this Plan). Outpatient laboratory tests must be performed at an in-network, free-standing, non-hospital-based lab facility such as Lab Corp or Quest. See Outpatient Laboratory Services for more information.</i>		
Nutritional Counseling Services	\$0 Copay	Not Covered
<i>Nutritional Counseling Services are covered for enrolled OCM participants who are actively engaged in the program. Nutritional counseling services must be provided by a registered dietician or nutritionist. The frequency of the nutritional counseling services will be determined by the third-party claims administrator and will be based on medical necessity and engagement in the OCM program.</i>		
<i>OCM benefits subject to requirements/compliance with the OCM program as indicated in the Schedule of ~~Medical~~ Benefits Section.</i>		

Benefit Description	In-Network	Out-of-Network
Vision Care Services		
Vision <u>Screening</u> Exam (preventative)	\$10 Copay	\$10 Copay
<i>Limited to one, <u>preventative</u> exam per Plan Year, per covered individual. The maximum benefit this Plan will pay per Plan Year, per covered individual is \$100.</i>		
Prescription <u>eyeglasses</u><u>eyewear</u>	\$10 Copay	\$10 Copay
<i>Single vision, bifocal and trifocal lenses, and prescription contact lenses. Eyeglasses, or contact lenses in lieu of eyeglasses, limited to \$100 every 24 months.</i>		

Prescription Drug Benefits			
In-Network Pharmacy Benefits			
	Preferred Retail Network Pharmacies* (30-Day Supply)	Smart90 Retail Pharmacies (90-Day Supply)	Home Delivery Express Scripts Pharmacy (90-Day Supply)
Preferred Formulary Generic	\$10 Copay	\$20 Copay	\$20 Copay
Preferred Formulary Brand	\$40 Copay	\$80 Copay	\$80 Copay
Non-Preferred/Non-Formulary Brand	\$75 Copay	\$150 Copay	\$150 Copay
Specialty Drugs			
Specialty Drugs Accredo Specialty Mail Order Pharmacy	N/A	N/A	You pay 30% after Deductible <u>for drugs on the SaveOnSP program.</u> <u>OR</u> <u>Copay limit of \$100 min and \$250 max applies</u> (30-Day Supply)
*Preferred Retail Network Pharmacies: Copayments apply if you fill your prescription at a Preferred Retail Network retail pharmacy. If you fill your prescription at a non-Preferred Retail Network retail pharmacy, you will pay an additional \$10 per prescription. If you currently use a non-Preferred Retail Network pharmacy and you want to avoid the \$10 upcharge, call a Preferred Retail Network pharmacy to transfer your prescription. Prescription drugs are not covered when purchased from Out-of-Network pharmacies. See the Schedule of ~~Medical~~ Benefits in this document for important information related to pharmacy benefits, including how to find a Preferred Retail Network and Smart90 pharmacy.			

Schedule of ~~Medical~~ Benefits

The *Schedule of ~~Medical~~ Benefits* provides a description of benefits, including certain limitations under this Plan. Covered services must be medically necessary and are subject to exclusions and limitations as described herein. Precertification is required for many services, plan benefit limitations apply to certain benefit categories, and out-of-network charges are not covered unless otherwise specified in this document.

When the Plan Administrator determines that two or more courses of treatment are substantially equivalent, the Plan Administrator reserves the right to substitute less costly services or benefits for those that this Plan would otherwise cover.

Example: If both inpatient care in a skilled nursing facility and intermittent, part-time nursing care in the home would be medically appropriate, and if inpatient nursing care would be less costly, this Plan could limit coverage to the inpatient care. This Plan could limit coverage to inpatient care even if this means extending the inpatient benefit beyond the quantity provided in the Summary of Medical Benefits or Schedule of ~~Medical~~ Benefits.

The fact that a participating provider prescribed, ordered, recommended, or approved a service, treatment, or supply does not necessarily make it a covered service or medically necessary.

The *Summary of Medical Benefits and Schedule of ~~Medical~~ Benefits* should be read in conjunction with the *Benefit Limitations and Exclusions* and *Key Definitions Terms and Definitions*. The Explanations and Limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any precertification requirements), ~~Exclusions~~Benefit Limitations and Exclusions, *Key Terms and Definitions* and other sections that may apply to a specific benefit.

Claims must be submitted within twelve (12) months of the date of service to be considered for payment.

Acupuncture and Acupressure Services

Acupuncture and acupressure are covered under this Plan if performed by a licensed health care provider acting within the scope of that license. Acupuncture and acupressure services must be provided by In-Network and are limited to 20 visits per Plan Year, maximum 100 visits per lifetime.

Maintenance services are not a covered benefit.

Alcohol and Substance Abuse Services (inpatient and outpatient)

Medically necessary inpatient and outpatient alcohol and substance abuse services will be provided under the same terms as medical and surgical benefits, with no additional financial or treatment limitations. Substance abuse care benefits are for acute medical detoxification and for substance abuse rehabilitation and counseling. The main purpose of medical detoxification is to rid the body of toxins, monitor heart rate, blood pressure and other vital signs, manage withdrawal symptoms and administer medications as needed.

Inpatient and outpatient programs for alcohol and substance abuse treatment require precertification. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require precertification.

Allergy Testing and Treatment

Coverage is provided for medically necessary allergy testing, preparation of serum, serum, and administration of injections. For allergy treatment only, the participant will be responsible for the lesser of the primary care or specialist office visit copay or the cost of the serum/injection.

Ambulance Services

Ambulance services are covered if the services are medically necessary, and they are:

- Provided in an emergency; or
- Provided in a non-emergency setting when prior authorized by the UM company.

Autism Spectrum Disorders

This Plan provides coverage for autism spectrum disorder per [NRS 695G.1645](#) including coverage of screening for and diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders for covered dependents individuals.

~~Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription drug care, psychiatric care, psychological care, behavioral therapy, or therapeutic care that is:~~

- ~~• Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and~~
- ~~• Provided for a person diagnosed with an autism spectrum disorder by a licensed psychologist, licensed behavior analyst or other provider that is acting within the scope of their license.~~

Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

~~Terms in the Autism Spectrum Disorders section of NRS have the definitions assigned to them in [NRS 695G.1645](#) and not necessarily the definitions in this MPD.~~

Bariatric/Weight Loss Surgery

Covered services include medically necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese *with* associated illnesses. These services may have a reduced benefit unless you receive precertification.

Bariatric weight loss surgery benefits, pre-and post-surgery, are available only when performed at an in-network Bariatric Surgery Center of Excellence facility, by an in-network surgeon and ancillary providers. The third-party Claims Administrator will determine the in-network Bariatric Surgery Center of Excellence facility. It is the participant's responsibility to ensure that bariatric surgery services providers are in-network and facility chosen to provide services are in-network.

There is no payment if services are provided at an out-of-network facility or out-of-network surgeon, or other ancillary providers are used.

Participants are limited to one obesity related surgical procedure of any type in an individual's lifetime while covered under this Plan or any PEBP self-funded Plan. For example, a participant cannot have lap band surgery and subsequently seek benefits for gastric bypass. The first service related to surgical weight loss will be considered payable under this Plan, any others will not. If a participant had coverage under a different plan (any other plan other than a PEBP self-funded Plan) previously and subsequently had a bariatric surgery, they are still eligible to have one bariatric procedure paid for under the Plan, provided that precertification criteria are met.

For lap band adjustments, the Plan will consider any adjustments made in the 12 months following surgery if the participant remains compliant with their post-surgical agreement as verified by the UM company. Any adjustments to the lap band after the first 12 months post-surgery will be subject to precertification.

It is the responsibility of the participant to ensure that their providers and facilities chosen to provide these services are in-network for benefits to be paid. Participants can verify the network status of any provider (including a facility) by calling the Claims Administrator located in the *Participant Contact Guide*.

Participants must receive treatment in a Bariatric Surgery Center of Excellence which has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

- Behavior modification program supervised by a qualified professional.
- Consultation with a dietician or nutritionist.

- Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen.
- Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise therapist or other qualified professional.
- Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
- Reduced-calorie diet program supervised by dietician or nutritionist.

If a participant has started any type of program to meet the pre-surgery criteria outlined below with an out-of-network provider (including a facility), those services will NOT be considered part of the Plan's mandatory precertification requirements. For the Plan to consider your bariatric surgery a covered benefit under this Plan; you will have to begin the precertification process again with the appropriate providers.

Services, pre- and post-surgery must be at an in-network facility, with in-network providers AND be at a certified Center of Excellence for bariatric weight loss.

Precertification/Pre-Surgery Criteria for Weight Loss Surgery

The participant or their physician must contact the UM company to begin the process toward surgical intervention for obesity. The initial contact will include:

- Notifying the participant that the precertification process begins with the initial contact to UM company.
- Notifying the participant that precertification requests presented to the UM company before the clinical criteria listed below has been completed will be denied. A precertification request may be reconsidered upon completion of the clinical criteria.
- Informing the participant of the requirement to access and participate in a weight management and nutrition program.
- Documenting participant completion of the associated assessments required to be considered for the procedure.
- Educating the participant on how to access wellness/preventive services and how to proceed with meeting the clinical indications listed below; and
- Advising participants of Centers of Excellence in bariatric surgery provider in their geographic area.

Clinical Criteria for Weight Loss Surgeries is managed by the UM Company.

Surgical or invasive treatments for obesity or morbid obesity including but not limited to bariatric weight/loss services, reversals, and treatments to resolve complications are generally excluded.

Travel Expenses:

This Plan provides reimbursement of certain costs associated with travel and ~~lodging hotel~~ accommodations for the member and one additional person (spouse/domestic partner, family member or friend) when associated with bariatric/weight loss surgery and performed at a Center of Excellence that is located 50 or more miles from the member's residence. For travel expense benefits, refer to the Travel Expenses benefit section.

Expenses incurred for travel and ~~lodging hotel~~ accommodations for bariatric/weight loss surgery not performed at a Center of Excellence are not covered.

Blood Services for Surgery

Medically necessary blood and related supplies provided during a surgical or other procedure that requires blood replacement are covered services.

Chemotherapy

Chemotherapy and other drug therapies that are medically necessary to treat cancers and other diseases and conditions are covered services. Covered when ordered by a physician; chemotherapy must be pre-certified by the UM company.

See prescription benefits for orally administered chemotherapy drugs:

Patients undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year (excluding sales tax).

Chiropractic Services

(Spinal Manipulation (non-surgical))

Coverage is provided for up to 20 visits per Plan Year for medically necessary spinal manipulations and adjustments.

Maintenance services are not a covered benefit.

Clinical Trials

A clinical trial is the process for testing new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases.

Coverage for certain treatment received as part of a clinical trial or study for treatment of cancer or chronic fatigue syndrome will be provided subject to the requirements and limitations set forth in NRS 695G.173.

~~The routine medical treatment costs, including items and services that are otherwise generally available to Plan participants, received as part of a clinical trial or study, may be covered under NRS 695G.173.~~

Diabetic Services for Type 1, Type 2, and Gestational Diabetes

Coverage is provided for the medically necessary management and treatment of diabetes, including infusion pumps and related supplies, medication, equipment, supplies, and appliances for the treatment of diabetes.

Coverage is provided for the medically necessary self-management of diabetes for training and education provided after you are diagnosed with diabetes for the care and management of diabetes, including, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.

Durable Medical Equipment (DME)

Coverage is provided for the purchase, rental, repair, or maintenance of durable medical equipment prescribed by a provider for a medically necessary condition other than kidney dialysis. **DME is limited to one purchase, repair, or replacement of a specific item of DME every 3 years.** Rental of DME ~~will be subject to to cover~~ Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME of more than \$1,000 requires precertification from the UM company.

To help determine what durable medical equipment is covered, see the definition of "Durable Medical Equipment" in the Key Terms and Definitions section, below ~~Durable medical equipment is equipment that:~~

~~Can withstand repeated use.~~

~~Is not disposable.~~

~~Is appropriate for use in the home.~~

~~Is not useful in the absence of an illness or injury.~~

~~Is prescribed by a physician.~~

~~Meets CMS guidelines for coverage; and~~

~~Is not primarily for convenience or comfort but serves a medical purpose.~~

~~Durable medical equipment includes, but is not limited to, the following:~~

~~Oxygen equipment (oxygen and oxygen-related equipment, except for oxygen while traveling on an airline).~~

~~Wheelchairs.~~

~~Hospital beds.~~

~~Insulin pumps and supplies.~~

~~Glucose monitors; and~~

~~Warning or monitoring devices for infants (defined as a child 24 months old or less) suffering from recurrent apnea.~~

Coverage will be based on an amount equal to the generally accepted cost of durable medical equipment that provides the medically necessary level of care at the lowest cost.

Items not covered under this benefit include, but are not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, and any other primarily non-medical equipment, except as otherwise covered and described within this *Schedule of ~~Medical~~ Benefits* and the *Benefit Limitations and Exclusions* sections.

Also excluded are exercising equipment, vibratory or negative gravity equipment, swimming or therapy pools, spas, and whirlpools (even if recommended by your medical provider to treat a medical condition).

Enteral Formulas and Special Food Products

Enteral Formulas and Special Food Products are covered in accordance with [NRS 689B.0353](#).

There is a \$2,500 maximum benefit per Plan Year for Special Food Products for the treatment of a person with inherited metabolic diseases or for Medically Necessary treatment of a mental health diagnosis. The maximum will not apply to Medically Necessary treatment of a mental health disorder.

Inherited metabolic diseases is characterized under NRS 689B.0353 as the following:

- deficient metabolism, or
 - malabsorption originating from congenital defects, or
 - defects arising shortly after birth,
- for amino acid, organic acid, carbohydrate or fat.

Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception

Medical or surgical treatment for sexual dysfunction: There are some limits on sexual dysfunction drugs such as Viagra or Muse and are subject to the Plan Year Deductible. For more information, contact the pharmacy benefit manager.

Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility for a covered individual (limited to one diagnostic evaluation for infertility every Plan Year, and up to three (3) per lifetime, and up to six (6) artificial inseminations per lifetime. See exclusions in the Benefit Limitations and Exclusions. These limits and exclusions apply to both office-

based and non-office-based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in the Summary of Medical Benefits

Contact the Utilization Management company for prior authorization for procedures related to sexual dysfunction.

Coverage is provided for vasectomies and tubal ligations. Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals are excluded.

Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility are covered for one workup per Plan Year up to three (3) evaluations per lifetime. For infertility services that are not covered under this Plan, see the *Benefit Limitations and Exclusions* section.

Gender Dysphoria

This Plan provides benefits to individuals seeking medical services for the treatment of gender dysphoria.

Procedures, services, and supplies related to surgery and sex hormones associated with gender affirmation/confirmation should be reviewed by the UM Company for medical necessity.

In accordance with [Senate Bill 163](#) from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

This plan does not discriminate on the basis of gender identity or expression. Claim or coverage appeal shall include a consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment. The plan does not provide coverage cosmetic benefits as defined by Senate Bill 163.

Cosmetic Surgery under the bill means:

- Means a surgical procedure that:
 - Does not meaningfully promote the proper function of the body
 - Does not prevent or treat illness or disease; and
 - Is primarily directed at improving the appearance of a person.
- This Includes, without limitation, cosmetic surgery directed at preserving beauty.

Genetic Counseling/Testing

Covered services include medically necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the

presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests solely for research, or for the benefit of individuals not covered under the Plan.

Covered services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk, and review testing options, where available.

Genetic testing may only be done after consultation with an appropriately certified genetic counselor and/or, in our discretion, as approved by a physician that we may designate to review the utilization, medical necessity, clinical appropriateness, and quality of such genetic testing. Medically necessary genetic counseling will be covered in connection with pregnancy management with respect to the following individuals:

- Expenses for genetic tests, except where otherwise noted in this document, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities, or genetically transmitted characteristics including:
- Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents; and
- Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder, except that payment is made for fluid or tissue samples obtained through amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), fetoscopy and alpha fetoprotein (AFP) analysis in pregnant women.
- Participants should contact the Plan's Claims Administrator to determine if proposed genetic testing is covered or excluded and the UM company for precertification requirements. See also the exclusions related to prophylactic surgery or treatment later in this section.

Genetic Counseling except as related to covered genetic testing as listed in the Genetic Testing and Counseling and the Preventive Covered services include genetic testing of heritable disorders as medically necessary when the following conditions are met:

- The results will directly impact clinical decision-making and/or clinical outcome for the individual.
- The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and
- One of the following conditions is met:

- The participant demonstrates signs/symptoms of a genetically linked heritable disease, or
- The participant or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

Additional genetic testing/counseling will be covered in accordance with federal or state mandates.

Biomarker testing: In accordance with [Assembly Bill 155](#) from the 82nd Legislative Session in 2023, the Plan provides benefits for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.

In the absence of specific information regarding advances in the knowledge of mutation characteristics for a disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the member.

Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology or mandated by federal or state law.

Hearing Aids

Air conduction hearing aids are considered medically necessary when one or more of the following hearing loss criteria are met *in either or both ears*:

- Hearing thresholds 40 dB HL or greater at two or more of these frequencies: 500, 1000, 2000, 3000, 4000 Hz; or
- Hearing thresholds 26 dB HL or greater at three of these frequencies; or
- For high frequency hearing loss, defined as loss occurring only above 2000 Hz:
 - a. Hearing thresholds of 26 dB HL or greater at three or more of these frequencies: 2000, 3000, 4000, 6000 or 8000 Hz
- Speech recognition is less than 80 percent in either or both ears regardless of hearing threshold level.

Participants who meet the above hearing loss criteria: Each air conduction hearing aid is subject to a \$50 copay (per device, per each ear), with maximum plan benefit of \$1,500 per device every three (3) years.

Participants may submit a copy of their hearing aid payment receipt from the hearing aid provider to the third-party claims administrator to request reimbursement for the hearing aid benefit, less applicable copayment(s), and deductibles to receive credit towards the Out-of-Pocket Maximum.

Over the Counter hearing aids are excluded from the Plan.

Hinge Health Digital Musculoskeletal (MSK) Care

Hinge Health's Digital MSK Program is offered through the Pharmacy Benefit Manager and is designed to help members with Musculoskeletal Care using digital technology. The program offers qualifying participants virtual physical therapy focusing on prevention, acute injury, chronic and surgical care programs via digital physical therapy plus additional physical and behavioral support through a full clinical-care team. Members will also have access to other services, such as pelvic floor therapy, advanced wearable technology for electrical nerve stimulation and pain relief, expert medical opinion consultation, health education, etc.

Members will complete a screener to assess which Digital MSK Clinic™ programs is right for them. The questionnaire screener leverages data analytics combined with a dedicated clinical care team review to match each member's personal needs with the right program tools and resources. This program is managed by Express Scripts and is provided at no cost to members.

Home Health Care

Medically necessary home health care is covered if such care is provided by an organization or professional licensed by the state to render home health services. Such care will not be available if it is substantially or primarily for the participant's convenience or the convenience of a caregiver. Home care is covered in the home only on a part-time and temporary basis and to the extent that such care is performed by a licensed or registered nurse or other appropriate therapist or provider acting within the scope of their license.

Home health care covered includes skilled nursing care, therapies, and other health related services provided in the home environment for other than convenience for patient or patient's family, personal assistance, or maintenance of activities of daily living or housekeeping. Covered home health care services under this part include home health care provided by a professional as the nature of the illness dictates.

Excluded from coverage as home health care are:

- Personal care, custodial care, domiciliary care, or homemaker services.
- In-home services provided by a licensed provider acting within the scope of their license.
- Over-the-counter medical equipment, over-the-counter supplies, or any prescription drugs, except to the extent that they are covered elsewhere in this *Schedule of ~~Medical~~ Benefits*.

Hospice Services

The following hospice care services are covered for members with a terminally ill, limited life expectancy of six months. Additional days would have to be preauthorized by the UM Company.

- Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week

- Outpatient bereavement counseling of the participant and his or her immediate family (limited to 6 visits for family members combined if they are not otherwise eligible for mental health benefits under their specific plan). Counseling must be provided by:
 - A psychiatrist.
 - A psychologist; or
 - A licensed, master's level clinician.
- Respite care providing nursing care for a maximum of 8 inpatient respite care days per Plan Year and 37 hours per Plan Year for outpatient respite care services. Inpatient respite care will be provided only when the UM company determines that home respite care is not appropriate or practical.

Hospital, Skilled Nursing Care, and Services in an Outpatient Surgical Center

Inpatient Care

Medically necessary inpatient hospital care is covered. Services include, but are not limited to:

- Services for medical conditions treated in an acute care hospital inpatient environment.
- Semi-private room and board (private room when medically necessary).
- General nursing care facilities, services, and supplies on an inpatient basis.
- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility. For related covered services refer to Other Services and Supplies in the *Schedule of ~~Medical~~ Benefits* section.
- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthesiologist or anesthesiologist together with preoperative and postoperative care.
- Maternity and newborn care for up to 48 hours of inpatient care for a mother and her newborn child following a vaginal delivery and up to 96 hours of inpatient care for a mother and her newborn child following a cesarean delivery. The time-periods will commence at the time of the delivery. Any decision to shorten the length of inpatient stay to less than those time-periods will be made by the attending physician after conferring with the mother.
- Inpatient, short-term rehabilitative services, limited to treatment of conditions that are subject to significant clinical improvement over a continuous 30-day period from the date inpatient therapy commences in a distinct rehabilitation unit of a hospital, skilled nursing facility, or other facility approved by us (limited to 100 days per Plan Year).
- Inpatient alcohol and substance abuse rehabilitation services in a hospital, residential treatment facility, or day treatment program; and
- Inpatient mental health services.

Inpatient services to treat mental illness conditions are subject to medical necessity. Provider visits received during a covered admission are also covered. Benefits are provided for medically

necessary inpatient care, outpatient care, partial hospitalization, and provider office services for the diagnosis, crisis intervention and treatment of severe mental illness conditions and substance abuse conditions as noted in the *Schedule of ~~Medical~~ Benefits*.

Inpatient services must be provided by a licensed hospital, psychiatric hospital, alcoholism treatment center, or residential treatment center.

The member should contact the UM company to determine medical necessity, appropriate treatment levels and appropriate settings. Inpatient services are subject to precertification notification guidelines to avoid potential penalties related to non-notification of services.

If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times in the UM section, above, the UM Company must receive notification as soon as reasonably possible after the admission or you may be subject to reduced benefits as provided in this Plan.

Medically necessary care at a skilled nursing facility (limited to 100 days per Plan Year) for non-custodial care is covered. A skilled nursing facility is a facility that is duly licensed by the state and/or federal government and that provides inpatient skilled nursing care, rehabilitation services, or other related health services that are not custodial or convenience in nature. Skilled nursing care includes medically necessary services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse. This Plan does not cover skilled nursing care that is not covered by CMS. Prior care in a hospital is not required before being eligible for coverage for care in a skilled nursing facility.

Outpatient Care

Medically necessary outpatient hospital or outpatient surgical center care is covered. Services furnished in a hospital or outpatient surgical center premises are covered, including use of a bed and periodic monitoring by a hospital's nursing or other staff that are medically necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital. If a hospital intends to keep a patient in observation status for more than 48 hours, observation status will become an inpatient admission for administration of benefits.

Coverage for the following benefits is dependent upon the benefits described in the *Schedule of ~~Medical~~ Benefits* for this Plan. Mental health and substance abuse outpatient services include, but are not limited to:

- Services for medical conditions treated in an acute care hospital outpatient environment.
- Semi-private room and board (private room when medically necessary) if patient is in observation status.
- General nursing care facilities, services, and supplies on an outpatient basis.

- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility.
- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Outpatient, short-term rehabilitative services.
- Outpatient alcohol and substance abuse rehabilitation services in a hospital, hospital residential treatment facility, or day treatment program; and
- Outpatient mental health services.

Medically necessary short-term outpatient habilitative and rehabilitative services are covered for:

- Short-term speech, physical, and occupational habilitative and rehabilitative therapy for acute conditions that are subject to significant clinical improvement over a 90-day period, as determined by the UM company, from the date outpatient therapy commences or to maintain function in an individual. Precertification required for habilitative and rehabilitative therapy exceeding a combined visit limit of 90 visits per Plan Year (visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder); and
- Services for cardiac rehabilitation and pulmonary rehabilitation (limited to 60 visits/sessions per Plan Year for each type of therapy).

Medically necessary services such as radiation therapy and chemotherapy (including chemotherapy drugs), are covered to the extent that such services are delivered in the most appropriate clinical manner and setting as part of a treatment plan.

Services that are not covered under this benefit include:

- Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution.
- Private duty nursing and private rooms in an inpatient setting.
- Personal, beautification, or comfort items for use while in a hospital or skilled nursing facility; and
- Services related to psychosocial rehabilitation or care received as a custodial inpatient.

Lab and Diagnostic Services

Coverage is provided for medically necessary laboratory and diagnostic procedures, services, and materials, including:

- Diagnostic x-rays.
- Fluoroscopy.
- Electrocardiograms; and
- Laboratory tests.

Coverage is also provided for other laboratory and diagnostic screenings as well as provider services related to interpreting such tests.

Outpatient laboratory services are covered for pre-admission testing, urgent care, or emergency room. Pre-admission testing must be performed within 7 days of a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Outpatient laboratory services for routine/preventive lab testing must be performed at a non-hospital-based, freestanding laboratory such as Lab Corp or Quest.

If a freestanding, non-hospital-based laboratory facility is not available within 50 miles of your residence, you may use an in-network outpatient hospital facility or hospital-based lab draw station.

Routine lab services from independent labs may not be paid as wellness unless the TPA system finds a corresponding wellness office visit within a reasonable number of days prior or after lab date to validate wellness diagnosis.

Mastectomy and Reconstructive Surgery

Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. Subject to the terms and conditions of this *Schedule of ~~Medical~~ Benefits*, if a covered mastectomy or other breast cancer treatment is performed, we will also provide coverage for:

All stages of reconstruction of the breast on which the mastectomy has been performed.

- Surgery and reconstruction of the other breast to produce a symmetrical structure.
- Prostheses; and
- Physical complications for stages of mastectomy, including lymphedemas.

If reconstructive surgery occurs within three years after a mastectomy, the amount of the benefits for that surgery will equal the amounts provided for in the Plan at the time of the mastectomy. If the surgery occurs more than three years after the mastectomy, the benefits provided are subject to the terms, conditions, and exclusions contained in the Plan at the time of reconstructive surgery.

This Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA) Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. For any covered individual who is receiving mastectomy-related benefits, coverage will be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- External prostheses (breast forms that fit into your bra) that are need before or during reconstruction; and Treatment of physical complications of stages of the mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery).

Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy as mandated by the Women's Health and Cancer Rights Act.

Participants should use the Plan's precertification procedure to determine if a proposed surgery or service will be considered cosmetic surgery or medically necessary reconstructive services.

Maternity and Newborn Services

Medically necessary maternity services for pregnant participants are covered, including prenatal and postpartum care, related delivery room and ancillary services and newborn care. Newborn care includes care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of newborn to and from the nearest facility staffed and equipped to treat the newborn's condition. Newborn care is subject to the eligibility requirements as defined in the *Schedule of ~~Medical~~ Benefits*.

Notwithstanding anything in this *Schedule of ~~Medical~~ Benefits* to the contrary, participant does not need precertification from the UM company to obtain access to obstetrical or gynecological care from a professional in this Plan's network who specializes in obstetrics or gynecology. The provider, however, may be required to comply with certain procedures, including obtaining precertification for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating providers who specialize in obstetrics or gynecology, refer to the Low Deductible PPO Plan network at <https://pebp.nv.gov/>.

Notwithstanding anything in this *Schedule of ~~Medical~~ Benefits* to the contrary, in the case of a person who has a child enrolled in coverage, this Plan will permit such person to designate any pediatrician as a primary care physician if such pediatrician is a participating provider.

When the member has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days ([NRS 689B.033](#)). Individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.

Services that are not covered include:

- Amniocentesis to the extent that it is performed to determine the sex of the child.

- Non-newborn circumcisions after eight weeks of age unless medically necessary and provided a precertification.

Medical Care

Medically necessary medical care and services, performed by a physician or other professional on an inpatient and outpatient basis, are covered, including:

- Office visits and consultations.
- Hospital and skilled nursing facility services.
- Ambulatory surgical center services.
- Home health care services.
- Surgery; and
- Other professional services.

Note: The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the Surgery/Surgeries definition in the *Key Terms and Definitions* section.

Assistant surgeon fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. See Certified Surgical Assistant in the *Key Terms and Definitions* section.

Mental Health Services

Medically necessary mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other qualified mental health care professional are covered according to the limits provided in the *Schedule of ~~Medical~~ Benefits* sections.

Outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require precertification. This Plan provides mental health benefits in accordance with the MHPAEA.

No Surprises Act

The federal No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from a Non-PPO provider at an in-network facility. Beneficiaries receiving these services will only be responsible for paying their in-network cost sharing and cannot be balance billed by the provider or facility for emergency services.

Emergency Services

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities;
- Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO provider or a PPO emergency facility;
- By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by a PPO provider or a PPO emergency facility.

Your cost sharing amount for Emergency Services from Non-PPO Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount (QPA).

* In addition to the No Surprises Act, the Plan complies with the requirements of NRS 695G.170 with respect to coverage for medically necessary emergency services at any hospital~~see also NRS 695G.170 for medically necessary emergency services at any hospital in Nevada.~~

Post Stabilization Services

Emergency Services furnished by a Non-PPO Provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; and
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the nonparticipating provider, acknowledging that the participant or beneficiary

understands that continued treatment by the nonparticipating provider may result in greater cost to the participant or beneficiary.

Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-PPO provider at a PPO facility, the items or services are covered by the plan:

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such Non-PPO provider were equal to the Recognized Amount for the items and services.
- By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a PPO provider,
- Non-emergency items or services performed by a Non-PPO provider at a PPO facility will be covered based your out-of-network coverage if:
 - At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
 - The participant or dependent gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.
- The notice and consent exception does not apply to Ancillary services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-PPO provider satisfied the notice and consent criteria, and therefore these services will be covered:
 - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,
 - With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and

- With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a PPO provider.

Your cost sharing amount for Non-emergency Services at PPO Facilities by Non-PPO Providers will be based on the lesser of billed charges from the provider or the Qualifying Payment Amount.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from a non-PPO provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from a Non-PPO provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a PPO provider.
- In general, you cannot be balanced billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a PPO provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your Network (PPO) deductible and Network (PPO) out-of-pocket maximum in the same manner as those received from a PPO provider.

Payments to non-PPO Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-PPO provider. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the non-PPO provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a non-PPO provider at a PPO facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review. Please see the External Review procedures in the SPD for further information.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

Per [NRS 695G.164](#), the Plan provides coverage for continued medical treatment for a medical condition from a provider of health care whose contract with the insurer is terminated during active medically necessary treatment. Unless excepted, this is until the later of:

- The 12^{0th} day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 4^{5th} day after:
 - The date of delivery; or
 - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Incorrect PPO Provider Information

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

Continued Coverage Following Termination of a Provider Contract

For serious health conditions not covered by the No Surprises Act, if a participant is receiving a medically necessary course of treatment from an in-network provider and that provider leaves the network (except for termination due to medical incompetence or professional misconduct), and the participant and the provider agree that a disruption to the participant's current care may not be in the best interest or if continuity of care is not possible immediately with another in-network provider, this Plan will pay that provider at the same level they were being paid while contracted with this Plan's network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- Such treatment is no longer medically necessary or no later than the 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 90th day after:
 - The date of delivery; or
 - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Obesity Care Management Program

The Obesity Care Management (OCM) Program is open to participants who have been diagnosed as obese by their physician and who meet the criteria set out in this section.

Participants who opt-in to the OCM Program may be eligible for enhanced benefits. These benefits include:

- Services provided by an in-network provider certified by the American Board of Bariatric Medicine (ABBM) and specializes in weight loss services or if there is no certified provider within 50 miles of a participant's residence, services may be provided by any in-network provider.
- Laboratory tests provided by an in-network free-standing, non-hospital-based outpatient laboratory facility such as Lab Corp or Quest.
- Nutritional counseling services, when provided in-network, frequency is determined by the Claims Administrator and is based on medical necessity.

Weight Loss Medications:

- The Plan covers certain only short-term use obesity/weight loss generic medications as identified by the Plan's Pharmacy Benefits Manager. Contact the Pharmacy Benefit Manager or refer to the Plan's prescription drug formulary to determine what weight loss medications are covered by the enhanced benefit. Long-term weight loss medications are excluded.
- This Plan does not coordinate prescription drug plan benefits.

Medications purchased at non-participating pharmacies are not covered under this Plan.

Gym memberships, exercise equipment, and bariatric restrictive weight loss surgery ARE not included in the OCM benefits. Refer to the *Summary of Medical Benefits* section for more information.

For enrollment information, please contact the Claims Administrator as listed in this document under the *Participant Contact Guide*. When you enroll in the program, your effective date will typically be the 1st of the month following your enrollment in the program. The effective date will be determined by PEBP.

The information described in this section provides a summary of the Program's functions. For more detailed information, please contact the Claims Administrator.

The Obesity Care Management Program is optional and considered an "opt-in" Program. To be eligible for the enhanced wellness benefits, participants must meet certain criteria and adhere to certain participation requirements.

Once you have met your final weight loss goal as determined by your weight loss provider at the onset of your participation in a medically supervised weight loss program, benefits under the Obesity Care Management Program will end. This Plan does not provide benefits for ongoing

maintenance care. If you choose to receive ongoing maintenance care, you will be responsible for the cost of receiving the services.

The Claims Administrator provides an Obesity Care Management Participant Program navigation guide available through the PEBP Member Portal, see the *Participant Contact Guide* for more information.

The Obesity Care Management Program is administrated by the Claims Administrator.

Engagement in the Program

You must remain actively engaged in a medically supervised weight loss program.

Monitoring Engagement

The Claims Administrator will assist your weight loss provider with completing monthly progress reports. The initial report should include your weight and BMI or waist circumferences, and a description of your treatment plan to include weekly weight loss goals, final weight loss goal, exercise regimen, diet, and nutrition instructions. Subsequent monthly reports should provide information regarding your weight loss progress and adherence to the treatment plan. Submission of these reports will be a requirement for payment under the enhanced wellness benefits. If your monthly weight loss reports are not received by the Claims Administrator, your benefits under this program will end, and your coverage will return to the standard LD PPO Plan benefits where other Plan limitations will apply. The effective date of the return to the standard Low Deductible PPO Plan benefits will be the first day of the month following the non-compliance notification received from the Claims Administrator.

How to Enroll in the Obesity Care Management Program

- Contact the Claims Administrator for a list of in-network weight loss providers. This information is located on the Claims Administrator's website by logging into the E-PEBP Portal.
- Make an appointment with an in-network weight loss provider. The Claims Administrator can also help you identify which in-network provider may best meet your needs, based on geography or other specialized needs you may have.
- When you make an appointment with your in-network weight loss provider, before you go, be sure to take an Obesity Care Management Program Enrollment form with you. This form is located on the Claims Administrator's website under forms.
- Have your in-network weight loss provider complete the enrollment form and submit (by mail or fax) the completed form to the Claims Administrator. Their name, address and fax number are provided on the enrollment form.
- The Claims Administrator will review the information submitted by your provider and if the information indicates that you meet the criteria for the weight loss program benefits, the Claims Administrator will enroll you in the program. The Claims Administrator will notify PEBP and the Pharmacy Benefit Manager of your

enrollment. If you do not meet the criteria for weight loss benefits, the Claims Administrator will notify you of the denial of benefits.

- Engagement in the Program.

Benefits under the Obesity Care Management Program

The following benefits are included, many at no cost to you, when provided under this program subject to the limits in the *Summary of Medical Benefits* section:

- Office Visits.
- Laboratory tests.
- Nutritional counseling.
- Meal replacement therapy; and
- Certain medications under the prescription drug component of the Plan.

Oral Surgery, Dental Services, and Temporomandibular Joint Disorder

Medically necessary oral surgery procedures are covered (inpatient or outpatient) related to the following:

- Accidental injury to the jaw bones or surrounding tissues when the injury occurs, and the repair must commence within 90 days after the accidental injury, regardless of date enrolled in the plan. Services that commence after 90 days are not covered unless determined to be medically appropriate.
- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
- Non-dental surgical procedures and hospitalization required for newly born and children placed for adoption or newly adopted to treat congenital defects, such as cleft lip and cleft palate.
- Repair and restoration of teeth from injuries that arise from non-gustatory trauma.
- Extraction of teeth when related to radiation therapy or in advance of an organ transplant (other than a corneal transplant).
- Medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including treatment of fractures.
- Under certain circumstances (listed below) the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services:
 - Dental general anesthesia for a beneficiary when services are rendered in a hospital or outpatient surgical facility, when enrolled individual is being referred because, in the opinion of the dentist, the individual:
 - Is under age 18 and has a physical, mental, or medically compromising condition; or

- Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy; or
- Patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient.
- Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.
- No payment is extended toward the dentist or the assistant dental provider under this Plan. Refer to the dental benefits described in the PEBP Self-funded PPO Dental Plan Master Plan Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Temporomandibular Joint Disorder (TMJ) and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. TMJ surgeries are covered under the medical benefits based on medical necessity and are limited to an annual maximum of one surgery and a lifetime maximum of two (2) surgeries.

Precertification is required for dental general anesthesia in a hospital or outpatient surgical facility. Dental anesthesiology services are covered only for procedures performed by a qualified specialist in pediatric dentistry, a dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

Only the services and supplies described above are covered, even if the condition is due to a genetic, congenital, or acquired characteristic. Exclusions include:

- Except as described above as an inclusion, services involving treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; and repairs and restorations except for appliances that are medically necessary to stabilize or repair sound and natural teeth after an injury as set forth above;
- Dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth above.
- Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and near the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and

- Other supplies and services including but are not limited to cosmetic restorations, veneers, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthopedic Devices and Prosthetic Devices

Coverage for orthopedic devices is limited to medically necessary braces for problems requiring complete immobilization or for support, or if the braces are custom fitted or have rigid bar or flat steel supports and stays, splints, devices for congenital disorders, post, and pre-operative devices.

One medically necessary prosthetic device, approved by the Centers for Medicare & Medicaid Services (CMS), is covered for each missing or non-functioning body part or organ every three years. Coverage is limited to:

- Devices that are required to substitute for the missing or non-functioning body part or organ.
- Adjustment of initial prosthetic device; and
- The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.
- Repair and replacement of prosthetic devices is not covered except in limited situations involving mastectomy reconstructive surgery.

Orthopedic shoes, foot orthotics or other supportive devices of the feet are excluded, except when such devices are:

- An integral part of a covered leg brace and its expense is included as part of the cost of the brace;
- For diabetes mellitus and for foot deformity, history of pre-ulcerative calluses, history of previous ulceration, peripheral neuropathy with evidence of callus formation, poor circulation or previous amputation of the foot or part of the foot;
- For rehabilitation prescribed as part of post-surgical or post-traumatic casting care; or
- Prosthetic shoes for members with a partial foot.

Ostomy Care Supplies

Coverage is provided for medically necessary care and supplies after colon, ileum, or bladder surgery to assist in carrying on normal activities with a minimum of inconvenience.

Outpatient Rehabilitative and Habilitative Therapy Services

Coverage is provided for medically necessary physical, speech, occupational, cardiac, and pulmonary therapy habilitative and rehabilitation services that are performed by a physician or by a therapy provider licensed in accordance with state regulations for that therapy discipline.

Coverage for these services is available for acute conditions arising from illness or injury, as well as chronic or developmental conditions up to the benefit limits as defined in the benefit Plan.

- Outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) and is subject to cost-share for each therapy type.
- Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year (limit not applied to therapy treating a behavioral health condition).
- There is no limit for Cardiac Rehabilitation services.

PEBP also offers participants access to Hinge Health Digital Musculoskeletal (MSK) Care program for virtual therapy focusing on prevention, acute injury, chronic and surgical care programs. See Hinge Health, above, for more information.

Partial Hospitalization Services

Partial hospitalization services are covered for mental illness and substance abuse according to the benefits listed in the *Schedule of ~~Medical~~ Benefits*. The same services covered for inpatient services are also covered for partial hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One partial treatment day is defined as no less than three and no more than 12 hours of therapy per day. Partial day treatment is covered only when the member receives care through a day treatment program.

Podiatry Services

Podiatry services are covered for the medically necessary treatment of acute conditions of the foot such as infections, inflammation, or injury and other foot care that is disease related.

The following services are not covered:

- Non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and routine foot care.

Preventive Services

Notwithstanding anything to the contrary in this ~~Summary of Medical Benefits~~*Summary of Medical Benefits*, the following preventive services will be covered without any participant cost-sharing if such services are provided by a participating provider:

- Periodic physical examinations and routine immunizations.
- Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination.
- ~~Screening mammograms every 1-2 years for women 40 years of age or older.~~

- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics.
- Colorectal cancer screening starting at age 45 years in accordance with:
 - The guidelines published by the American Cancer Society; or
 - Other guidelines or reports concerning such screening that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data.
- Immunizations, including COVID-19, influenza, pneumococcal, Haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, measles, diphtheria, human papillomavirus (HPV), pertussis (whooping cough), poliovirus, rotavirus, varicella (chickenpox), shingles (herpes zoster) and tetanus, if such immunizations have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (Note: Immunizations related to foreign travel or employment are excluded.);
- Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.
- Evidence-based items or services that have an “A” or “B” Recommendation by the [United States Preventive Services Task Force \(USPSTF\)](#) and [Section 2713\(a\)\(5\) of the Public Health Service Act](#) and Section 9(h)(v) (229) of the 2015 Consolidated Appropriations Act.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services guidelines including the American Academy of Pediatrics Bright Futures guidelines; and
- With respect to women, such additional preventive care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Human Papillomavirus testing and vaccination ~~under~~ [pursuant to NRS 695G.171](#).

[Women's ~~Contraceptives~~ Preventive Services](#)

This Plan covers FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity. The FDA requires the services to be “prescribed” by a physician even for over-the-counter methods. ~~†This Plan complies with the coverage requirements for contraception and related health services set forth in NRS 695G.1715~~ [his Plan also adheres to NRS 695G.1715](#).

In accordance with [Senate Bill 280](#) from the 82nd Legislative Session in 2023, the Plan provides benefits for contraceptive injection or the insertion of a device at a hospital immediately after an insured gives birth.

Colorectal Cancer Screening

Colorectal screening tests are covered at 100% when provided in-network for adults aged 45 years and older who are at average risk of colorectal cancer in accordance with the [American Cancer Society](#)'s qualified recommendations; or beginning at age 40 for members with a high-risk of colorectal cancer. For more information regarding colorectal screening guidelines, contact the Claim's Administrator.

Screening Mammograms

Preventative mammograms are covered at 100% for women aged 40 years and older under the [Affordable Care Act](#) and [USPSTF](#), or beginning at age 35 for members with a high-risk of breast cancer, when performed in-network.

[Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions](#)

Healthy Diet/Physical Activity Counseling and Obesity Screening/Counseling for adults aged 18 years and older are covered under the Wellness/Preventive Care Benefit when the Participant or covered dependent is referred by a primary care practitioner; for those who are obese; and have additional cardiovascular disease (CVD) risk factors. This wellness/preventive benefit is limited to twelve (12) Healthy Diet/Physical Activity Counseling or Obesity Screening/Counseling sessions according to recommendations from the [USPSTF](#). Additional visits are subject to a specialist visit copay, deductible, or coinsurance where applicable.

Prostate Cancer Screening

Limited to 1 preventative per plan year and offered in accordance with [NRS 695G.177](#), which includes reference to the [American Cancer Society](#) guidelines.

Smoking/Tobacco Cessation

- Prescription and over-the-counter smoking/tobacco cessation products are covered under the prescription drug program. Over-the-counter smoking cessation products must be accompanied by a prescription written by a physician.
 - Some examples of cessation products eligible to be paid at 100% include Chantix (by prescription only), nicotine gum, nicotine patches, and nicotine lozenges.
 - Some limitations on quantity may apply and are at the discretion of the Pharmacy Benefit Manager and your physician.
- Benefits for over-the-counter products are limited to those that are FDA approved and recommendations by the Surgeon General.
- Over-the-counter smoking/tobacco cessation products may be obtained by presenting your physician's written prescription to an In-Network pharmacy, or you can submit your purchase receipt for the product with your physician's written prescription attached to the Prescription Drug Reimbursement Claim Form (this form is located at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/)).
- Second-line therapies such as clonidine hydrochloride and nortriptyline hydrochloride are sometimes used in the management of smoking/tobacco-cessation; however, due to the lack of an FDA-approved indication for smoking cessation, as well as undesirable side effect

profiles, currently prohibit these agents from achieving first-line classification and therefore, not covered under the *Preventive Care/Wellness Services* Benefit.

- The Plan does not cover electronic cigarettes.

For more information, please visit:

Preventive Services for Adults and Families: Visit the U.S. Preventive Task Force at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>

Preventive Services for Women, Including Pregnant Women: Visit Human Resources & Services Administration (HRSA) at <https://www.hrsa.gov/womens-guidelines/index.html>

Vaccines for infants, children, and teens: Visit the U.S. Department of Health & Human Services at <https://www.hhs.gov/vaccines/index.html>

Vaccines & Immunizations: Visit the Centers for Disease Control and Prevention at <https://www.cdc.gov/vaccines/index.html>

Preventive Health Services: Visit HealthCare.gov at <https://www.healthcare.gov/coverage/preventive-care-benefits/>

Preventive care services identified through the above links are recommended services. It is up to the participant and their physician or provider of care to determine which services to provide. The Plan Administrator has the authority to determine which services and quantity limits will be covered at the 100% wellness benefit; unless otherwise mandated by the Affordable Care Act or mandated in accordance with applicable Nevada Revised Statutes.

~~Note: This Plan complies with NRS 695G as related to contraceptive methods, utilization management, step therapy, prior authorization, categorization of prescription drugs (meaning Preferred Generic, Preferred Brand and Non-Preferred Brands), and cost sharing.~~

Radiation Therapy

The Plan covers medically necessary specialty radiology when ordered by a physician or health care practitioner acting within the scope of their license, including, but not limited to, MRI, MRA, MRS MRT, PET, SPEC, and CT scan. See the *Utilization Management* (Prior Authorization) section for precertification requirements.

The Plan covers technical and professional fees associated with:

- diagnostic and curative services, including radiation therapy, and
- pre-admission testing: Outpatient radiology tests performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Real Appeal

Nevada Public Employees' Benefits Program has partnered with UMR's Real Appeal program. Real Appeal provides eligible members a benefit for virtual weight loss and weight management coaching sessions. Sessions are covered under the preventive care benefit resulting in no cost-sharing to members. Real Appeal supports members eighteen (18) years of age and older.

This support includes, but not limited to, one-on-one coaching and online group sessions with supporting video content delivered by a virtual coach.

A qualified enrolled member will receive:

- Access to a coaches who will guide you through the program and develop a custom plan that fits your needs, preferences, and goals.
- 24/7 access to digital tools and dashboards.
- A Real Appeal kit containing health weight management tools that may include fitness guides, recipes, digital food and weight scales
- Support from online group classes with a coach and other members who share what's helped them achieve success.

For more information, contact the Plan's third-party claims administrator listed in the Participant Contact Guide.

Skin Lesions

Coverage is provided for medically necessary removal of skin lesions and related pathological analysis of such lesions. Coverage is provided for the removal of port wine lesions.

Transplant Services ~~(Organ and Tissue)~~

Medically necessary organ transplants at an approved Center of Excellence are covered when you are the organ recipient in the following cases:

- Bone marrow.
- Cornea.
- Heart.
- Heart and lung.
- Intestinal and liver.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Pancreas and kidney; and
- Stem cell.

Centers of Excellence are facilities that meet vigorous credentialing requirements for the specific type of organ transplant. A facility that is designated as a Center of Excellence for one type of

organ transplant may not be designated as a Center of Excellence for another type of organ transplant. Designation as a Center of Excellence is at the UM company's sole discretion.

Organ transplants are only covered where the organ donor's suitability meets the OPTN/UNOS (Organ Procurement and Transplantation Network/United Network for Organ Sharing) donor evaluation and guideline criteria, when applicable.

Coverage for related transplant services is limited to:

- Tests necessary to identify an organ donor.
- The reasonable expense of acquiring the donor organ.
- Transportation of the donor organ (but not the donor), and life support where such support is for the sole purpose of removing the donor organ.
- Storage costs of an organ, but only as part of an authorized treatment protocol; and
- Follow-up care.

The following services are excluded from coverage:

- Services provided at a facility that has not been designated as an approved Center of Excellence.
- Services provided to an organ donor unless otherwise specified elsewhere in this document.
- Services provided in connection with purchasing or selling organs.
- Transplants utilizing any animal organs.
- Any transportation of the donor (as opposed to transportation of the donor organ only) is excluded, except as otherwise covered under the *Travel Expense* section for transplant services.
- Any expenses associated with an organ transplant where an alternative remedy is available are excluded.
- Artificial heart implantation is excluded.
- Services for which government funding or other insurance coverage is available are excluded.
- Tissue transplants (whether natural or artificial replacement materials or devices are used) or oral implants, including the treatment for complications arising from tissue or organ transplants or replacement are excluded, except as described above.

2nd.MD Opinion

2nd.MD provides eligible members with direct access to elite specialists across the county for expert second opinions. Specialists answer questions about disease, cancer, chronic conditions, surgery or procedure, medications, and treatment plans. Specialists are board certified, leaders in research, and pioneers in medicine. To learn more visit www.2nd.MD/PEBP or call 1-866-841-2575.

Telemedicine or Telehealth (Doctor on Demand)

Telemedicine (virtual medicine) is available through Doctor on Demand. Participants can register with Doctor on Demand and connect face-to-face with a board-certified doctor, therapist or licensed psychologist on a smartphone, tablet, or computer through live video. Some of the medical and behavioral health conditions that may be treated include cold and flu, bronchitis, sinus issues, urinary tract infection, anxiety, depression, etc. Doctor on Demand providers can also prescribe medications (except controlled substances). For more information, visit [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) or the ~~Summary of Medical Benefits~~[Summary of Medical Benefits](#).

Services available include:

- Medical visit
- Psychologist visit
- Psychiatry visit

You may receive services from a provider who is in a different location using information and audio-visual communication technology. Telemedicine does not include communication through telephone, facsimile, or email.

Doctor on Demand physicians do not prescribe DEA controlled substances and may elect not to treat or prescribe other medications based on what is clinically appropriate. In a true medical emergency, such as chest pains, shortness of breath or broken bones, dial 911 or seek immediate medical attention as appropriate.

Alternatively, telemedicine may be available from in-network providers and is covered on the same basis as in-person services. It is your responsibility to ensure the providers you use are in-network providers. Failure to use in-network providers will result in a denial of benefits and higher cost to you.

~~This Plan adheres to the provisions of NRS 695G.162 regarding coverage for services provided through telehealth. This Plan also adheres to the provisions of NRS 695G.162 regarding telehealth.~~

Transplants (Organ and Tissue)

Organ, bone marrow and tissue transplant coverage are provided only for eligible services related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.

This Plan will provide coverage for the donor when the recipient is a participant under this Plan. Coverage is provided for organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his/her Plan will pay first and benefits under this Plan will be reduced by the amount payable under the donor's Plan.

Transplantation-related services require precertification (see the *Utilization Management* section of this document for details).

See the specific exclusions related to experimental and investigational services and transplants in the *Benefit Limitations and Exclusions* section.

This Plan provides for reimbursement of certain costs associated with travel and ~~lodging hotel~~ accommodations for the patient and one additional person when the travels are associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to *Transplant Services* section for additional information. Expenses incurred for travel and ~~lodging hotel~~ accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.

This Plan does not provide advance payment for travel expenses related to organ or tissue transplants.

See the specific exclusions related to experimental and investigational services and transplants in the *Benefit Limitations and Exclusions* section.

This Plan provides for reimbursement of certain costs associated with travel and ~~lodging hotel~~ accommodations for the patient and one additional person when the travels are associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to *Schedule of ~~Medical~~ Benefits* section for additional information. Expenses incurred for travel and ~~lodging hotel~~ accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.

This Plan does not provide advance payment for travel expenses related to organ or tissue transplants.

Use of Centers of Excellence for Transplant and Gastric (Bariatric) Procedures

This Plan requires participants to use an in-network Center of Excellence for transplant and bariatric weight/loss surgery. An appropriate Center of Excellence facility will be identified by the Plan's UM company and third-party Claims Administrator.

Travel

This Plan allows for the reimbursement of travel and hotel accommodation expenses permitted under [IRS Regulation 213\(d\)](#) and [IRS Publication 502](#) for qualified medical expenses when the expenses are associated with the following services and have been pre-certified by the UM company:

- Organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence; or
- Elective surgeries performed at exclusive hospitals/ambulatory facilities; and
- Outpatient infusion services if the UM company requires you to travel more than 50 miles one way for a service subject to precertification.

- Travel for a participant located in a State with restricted access to abortion to the nearest care center for abortion services covered under this Plan.

Participants are required to use the least expensive method of transportation. Participants who use their personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center will be compensated for mileage from the participant's residence to and from the Center of Excellence or exclusive hospital/ambulatory surgical facility or outpatient infusion facility (based on an objective source such as Google Maps) at the standard mileage reimbursement rate for medical travel.

This Plan incorporates the travel expense reimbursement guidelines established in [IRS Regulation 213\(d\)](#) and [IRS Publication 502](#).

NOTE: The Plan Administrator or its designee has full authority to approve or deny all or part of your travel expenses. The denial of travel expenses cannot be appealed.

Excluded Travel Expenses:

The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved):

- Alcoholic beverages.
- Car maintenance.
- Vehicle insurance.
- Flight insurance.
- Cards, stationery, stamps.
- Clothing.
- Dry cleaning.
- Entertainment (cable televisions, books, magazines, movie rentals).
- Flowers.
- Household products.
- Household utilities, including cell phone charges, house cleaner, baby-sitter, or day care services.
- Kennel fees.
- Laundry services.
- Meals (inasmuch as it is excluded under the IRS Publication 502 and Regulations under 213(d)).
- Security deposits.
- Toiletries.
- Travel expenses related to a facility or provider that is not a certified Center of Excellence, exclusive hospital/ambulatory surgical facility, or outpatient infusion facility; and
- Travel expenses incurred on or after one year following surgery are not eligible for reimbursement.
- Travel expenses are subject to the annual cost sharing requirements.

Note: PEBP will not reimburse travel or any other expense to any participant covered under PEBP's ~~EPO~~Exclusive Provider Organization (EPO) Plan, the self-funded Consumer Driven Health Plan (CDHP), or the Low Deductible PPO Plan twice for any service or event.

PEBP does not provide advance payment for travel expenses.

Pre-Approval of your Travel Expenses

Unless there are extenuating circumstances, travel expenses must be pre-approved by PEBP or its designee. Travel expenses not pre-approved by PEBP or its designee will not be eligible for reimbursement.

If the participant is unable to obtain pre-approval by PEBP or its designee because the organ or tissue transplant required immediate travel, the participant may submit associated travel costs to PEBP or its designee after the transplant surgery for consideration. The participant should designate someone to notify PEBP or its designee regarding the emergency travel and the circumstances surrounding such travel. Travel claims must be submitted within 12 months of the date of surgery to be considered eligible. Other requests for travel expenses require pre-approval.

Pre-approval will provide an approximation of your travel reimbursement. Final reimbursement will be based on actual expenses using the actual number of days and travel times and may differ from the pre-approved approximation. The Pre-approval Travel Expense Request form is available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Submitting your Travel Expense Receipts

A claim for travel expense reimbursement must be submitted to PEBP on a Travel Expense Reimbursement claim form. Relevant sections of the form must be completed including the start and end times, destination, and purpose of trip. The claimant should sign the travel expense claim form attesting to the accuracy of the claim.

Travel expense reimbursement claims should be accompanied by original itemized receipts which include the name(s) of the person(s) incurring the expense.

Reimbursement of eligible travel expenses, including any eligible travel expenses relating to a travel companion, will be payable to the primary participant (employee or retiree) and not to the service vendor (credit card company, hotel, hospital, etc.).

Vision Care Services

Vision Screening Exam (preventative)

One annual preventive vision screening exam including refractive error testing per Plan Year.

PEBP does not maintain a network specific to vision care; however, the PPO network does have a list of some vision providers.

Prescription eyewear

Single vision, bifocal and trifocal lenses, and prescription contact lenses.

Eyeglasses, or contact lenses in lieu of eyeglasses, limited to \$100 every 24 months.

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Schedule of Prescription Drug Benefits

Benefits for prescription drugs are provided through the prescription drug plan administered by the Pharmacy Benefit Manager, Express Scripts ("ESI"). Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the U. S. Food and Drug Administration (FDA) as requiring a prescription and FDA approval for the condition, dose, route, duration, and frequency, if prescribed by a physician or other practitioner.

Some over the counter (OTC) drugs and prescription drugs are eligible to be covered under the Plan's Preventive Care Services benefit in accordance with the Affordable Care Act; whereby, the Plan will waive the Copay and Deductible and products are paid at 100%. Examples include aspirin, folic acid, smoking cessation products and female oral contraceptives. Please contact Express Scripts for more information.

Certain OTC female contraception products are covered when presented with a prescription from your physician to your pharmacy. These types of products include the female condom, sponges, and spermicides. Refer to the *Women's Preventive Care* section for more information or call Express Scripts, whose contact information is in the *Participant Contact Guide*.

Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. Contact the pharmacy benefit manager listed in the *Participant Contact Guide* or visit www.express-scripts.com to check vaccine coverage and locate your nearest in-network pharmacy.

Coverage is also provided for, but not limited to:

- COVID-19 vaccinations and medications.
- Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (tetanus, diphtheria, and pertussis -whooping cough)
- Prenatal & pediatric prescription vitamins
- Prescription female oral contraceptives
- Insulin, diabetic supplies (such as lancets, syringes, test strips), insulin pumps, and insulin pump supplies
 - Insulin pumps and supplies are covered under the pharmacy benefit's base day and quantity limits, subject to copayments, deductibles, or coinsurance.
- Orally Administered Chemotherapy (NRS 695G.167): The Copayment or Coinsurance amount for orally administered chemotherapy drugs will be consistent with the drug's formulary tier for retail, home delivery and Specialty pharmacy; and in accordance with NRS 695G.167, the cost will not exceed \$100 per prescription. For more information, see *Key Terms and Definitions* section.
- ~~Prescription drugs irregularly dispensed for purposes of synchronization of chronic medication pursuant to the provisions of NRS 695G.1665~~ Chronic medication synchronization per NRS 695G.1665.
- Topical Ophthalmic Products See also NRS 695G.172. Refills of topical ophthalmic products will be covered when medically necessary, including when requested: (a)

After 21 days or more but before 30 days after receiving any 30-day supply of the product; (b) After 42 days or more but before 60 days after receiving any 60-day supply of the product; or (c) After 63 days or more but before 90 days after receiving any 90-day supply of the product.

- Medically necessary prescription drugs to treat sickle cell disease and its variants pursuant to the provisions of ~~{NRS 695G.174.}~~
- Human Papillomavirus testing and vaccination under NRS 695G.171.
- In accordance with Assembly Bill 156 from the 82nd 82nd~~82nd~~ Legislative Session in 2023, the Plan provides benefits for substance use disorder including coverage for all drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.
- In accordance with Senate Bill 167 from the 82nd 82nd~~82nd~~ Legislative Session in 2023, the Plan provides prescription benefits for psychiatric conditions for drugs that are approved by the Food and Drug Administration or the use of a drug to treat a psychiatric condition that is supported by medical or scientific evidence when prescribed by a Provider acting within the scope of their license. These prescription drugs are not subject to medical management techniques, such as step therapy.

For helpful tools such as “Price a Medication” see the *Participant Contact Guide* section or go to the PEBP website at ~~www.pebp.state.nv.us~~https://pebp.nv.gov/.

Preventive Drug Benefit Program

The Preventive Drug Benefit Program 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 logging on to ~~www.pebp.state.nv.us~~https://pebp.nv.gov/ or by contacting Express Scripts located in the *Participant Contact Guide* section.

The plan adheres to NRS 695G.1715 regarding contraception and related health services.

Specialty Prescription Drugs

Specialty drugs are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, etc. Specialty drugs and prescriptions are limited to a 30-day supply. Specialty drugs must be filled through Accredo, an Express Scripts Specialty Pharmacy (see the *Participant Contact Guide*). ~~Plan participants are encouraged to~~

~~register with the Accredo Specialty Pharmacy before filling their first prescription for a specialty drug. Check with Express Scripts to determine if your prescription is considered specialty.~~

~~Certain drugs fall into a category called specialty drugs. Specialty drugs are available only through the Specialty Pharmacy listed in the *Participant Contact Guide* section, and prescriptions are limited to a 30-day supply.~~ Plan participants are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. Contact Express Scripts to determine if your prescription is considered specialty.

Special pharmaceuticals, which include injectables, oral medications, and medications given by other routes of delivery, may be delivered in any setting. Special pharmaceuticals are pharmaceuticals that typically have:

- Limited access.
- Treat complex medical conditions.
- Complicated treatment regimens.
- Compliance issues.
- Special storage requirements; or
- Manufacturer reporting requirements.

This Plan's Pharmacy Benefit Manager maintains a list of special drugs classified as special pharmaceuticals. For information regarding special pharmaceuticals, contact ~~the Pharmacy Benefit Manager~~ Express Scripts listed in the *Participant Contact Guide*.

For Specialty Drugs part of the SaveOnSP program, the coinsurance applies. For Specialty Drugs not part of the SaveOnSP program, the respective coinsurance applies with a copay limitation of \$100 minimum and a maximum of \$250.



Copayment assistance (manufacturer-funded patient assistance) for specialty drugs will not apply toward your Deductible and Out-of-Pocket Maximum.

Preferred Retail Pharmacy Network

For short-term prescriptions, such as antibiotics, use a Preferred Retail Pharmacy (for lower copays) or a Non-Preferred Retail Pharmacy (where you will pay \$10 extra for each short-term prescription). Your Preferred Retail Pharmacy Network has more than 34,000 pharmacies consisting of approximately 50% independent pharmacies in addition to grocers and other stores. To find a preferred pharmacy near you, register or log in to express-scripts.com/findapharmacy or call Express Scripts' Member Services at 855-889-7708.

Smart90 Retail and Home Delivery Program

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 both a 90-day supply and to either a participating retail pharmacy or Express Scripts Home Delivery Pharmacy. 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.

Smart90 Retail Pharmacy

To locate a participating Smart90 Retail Pharmacy or a Preferred Retail Network Pharmacy, log in to the E-PEBP Portal located at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) and select Express Scripts. You can also get pharmacy information by calling Express Scripts' Member Services at 855-889-7708. You can transfer your medications easily in-store, by phone or online.

Express Scripts Home Delivery

You may use home delivery through the Express Scripts Home Delivery Pharmacy to receive a 90-day supply of your maintenance medications and have them mailed to you with free standard shipping. Not all drugs are available via mail order. Check with Express Scripts for further information on the availability of your prescription medication. Enrolling in home delivery is easy! First, log in to express-scripts.com.

If you are enrolling a new prescription in home delivery:

- **Contact your doctor** and ask them to e-prescribe a 90-day prescription directly to Express Scripts.
- **OR send a request** [through Express Scripts' website](https://express-scripts.com) by selecting "Forms" or "Forms & Cards" from the "Benefits" menu, print and mail-order form and follow the mailing instructions.
- **OR call Express Scripts' Member Services** at 855-889-77058 and they will contact your doctor for you if you are enrolling a current prescription:

Transfer retail prescriptions to home delivery by clicking **"Add to Cart"** for eligible prescriptions and check out. You can also refill and renew prescriptions. Express Scripts will contact your doctor and take care of the rest.

Check **Order Status** to track the shipping of your prescriptions. After we receive your prescription from your doctor, you will receive your medication within 7 days. Please keep in mind, longer delivery times may be due to additional correspondence need with prescribers, medication availability and/or delivery times from the shipping vendor.

Generics Preferred Program

When your doctor prescribes a brand-name drug and a generic substitute is available, you will automatically receive the generic drug unless:

- Your doctor writes “dispense as written” (DAW) on the prescription; or
- You request the brand-name drug at the time you fill your prescription.

If you choose generic medicines, you get safe medicines at lower cost. Your copayment for the generic drug will be less than the copayment for the brand-name drug.

If a generic is available, but you or your doctor request the brand-name drug, you will pay the applicable brand copayment, plus the full difference in cost between the brand-name drug and the generic equivalent. This difference in cost is referred to as the ancillary fee. The ancillary fee is in addition to the copayment, so the cost could exceed the copayment maximum.

SaveonSP Program

As part of your prescription drug plan, ~~Nevada Public Employees’ Benefits Program~~ PEBP has partnered with an Express Scripts’ copay assistance program, SaveonSP, to help save money on certain specialty medications. Through the SaveonSP Program, manufacturer-funded assistance is available to help assisting members with the cost of the Program drug(s) is reimbursed by the manufacturer at no cost to the participant.

The medications included in the SaveonSP Program are classified as Non-Essential Health Benefits under the Affordable Care Act. The cost of these drugs will not be applied towards satisfying your deductible or out-of-pocket maximum.

Members currently taking a medication or those who will be taking a medication that is on the Non-Essential Benefit Specialty Drug List, are eligible to participate in the program.

- Select medications on the *Non-Essential Benefit Specialty Drug List* will be free of charge (\$0) to members who participate.
- Prescriptions must be filled through Accredo Specialty Pharmacy.
- The medications and associated copays included in this program are subject to the Pharmacy Benefit Manager’s clinical rules.
- If the medication you are taking is on the *SaveOnSP Non-Essential Benefit Specialty Drug List* and you wish to participate, call SaveOnSP at 1-800-683-1074.
- The SaveonSP Program drug list can be found at www.saveonsp.com/pebp



Participation in the SaveOnSP Program is voluntary; however, if you are taking or will be taking a medication that is on the Non-Essential Benefit Specialty Drug List, and you choose not to participate in the SaveOnSP Program, you will be responsible for the copay outlined in the SaveonSP Program Drug List and that cost will not apply toward your Deductible or Out-of-Pocket Maximum.

Diabetes Care Value

Express Scripts offers a program that supports members with diabetes (type 1 and 2) pre-diabetes, and even common comorbidities like obesity. ESI's digital diabetes prevention and obesity solution offers a personalized coaching and weight loss program, including an app-connected scale, to help patients avoid type 2 diabetes. The Diabetes Care Value is administered by Express Scripts and qualifying participants will receive a personal invitation, with instructions, to join the program.

Extended Absence Benefit

If you are going to be away from your home for an extended period, either in the country or outside of the country, you may obtain an additional fill (30 or 90-day supply) of your prescription drugs from your local retail or mail order pharmacy. This limited benefit must be requested in advance by the participant to the pharmacy benefit manager listed in the *Participant Contact Guide*. A maximum of two (2) early refills are allowed every 180 days. You may be required to obtain a new written prescription from your physician and any necessary prior authorizations.

Out-of-Country Emergency Medication Purchases

This Plan may cover emergency prescription drugs purchased if you reside in the United States and travel to a foreign country. You will need to pay for the drug at the time of purchase and later submit for reimbursement from ~~Express Scripts~~the Pharmacy Benefit Manager. Prescription drug purchases made outside of the United States are subject to Plan provisions, *Benefit Limitations and Exclusions*~~, limitations and exclusions~~, clinical review, and determination of medical necessity. The review may include application of pertinent Food and Drug Administration (FDA) regulations~~The review will also include regulations determined by the FDA~~. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the United States.

If your purchase is eligible for reimbursement, you must use the Direct Claim Form available from the prescription drug plan administrator. Direct Claim Forms may be requested from the prescription drug plan or obtained by logging in to www.express-scripts.com. In addition to the Direct Claim Form, you are required to provide:

- A legitimate, legible copy of the written prescription completed by your physician.
- Proof of payment from you to the provider of service (typically your credit card invoice).
- Prescription and receipt must be translated to English and include the American equivalent National Drug Code for the prescription purchased.
- Reimbursement request must be converted to United States dollars.

The claim will be processed based on the American equivalent National Drug Code and charged based upon that drug copay tier. If an American equivalent National Drug Code does not exist, the claim will be denied.

Any foreign purchases of prescription medications will be subject to Plan limitations such as:

- Benefits and coverage
- Deductibles
- Coinsurance
- Dispensing maximums
- Annual benefit maximums
- Medical Necessity
- Usual and Customary (U&C) or prescription drug pharmacy benefit manager contracted allowable
- FDA approval
- Plan prior authorization requirements

Contact the Express Scripts before traveling or moving to another country to discuss any criteria that may apply to a prescription drug reimbursement request.

Out-of-Network Pharmacy Benefit

Prescriptions filled at a domestic (inside the United States) out-of-network pharmacy location, are not authorized for reimbursement under the prescription drug Plan. Prescription drugs must be filled at a participating in-network pharmacy location.

Other Limitations

- This Plan does not coordinate prescription drug plan benefits with other prescription drug plans. It is the participant's responsibility to use the appropriate primary and secondary (if applicable) prescription plan.
- See exclusions related to medications in the [Benefit Limitations and Exclusions Exclusions](#) section of this document.
- The formulary is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

Benefit Limitations and Exclusions

This Plan does not cover certain services. This chapter lists the general medical and pharmacy benefit exclusions of this Plan. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum. Additional exclusions that apply to only a service or benefit are listed in the description of that service or benefit in the *Summary of Medical Benefits* and *Schedule of ~~Medical~~ Benefits* sections. This list is not all-inclusive; if you have questions about a service or supply, contact the Claims Administrator listed in the *Participant Contact Guide*.

Expenses That Do Not Accumulate Toward Your Out-of-Pocket Maximum

The following services do not accumulate toward the out-of-pocket maximum, and you will be responsible for paying these expenses out of your own pocket.

- Expenses for medical and pharmacy services and supplies that are not covered by the Plan, to include but not limited to, expenses that exceed the LD network contract rate, services listed in the *Benefit Limitations and Exclusions* section.
- Charges in excess of the usual and customary charge determined by the Plan Administrator.
- Any additional amounts you must pay because you failed to comply with the utilization management requirements described in the *Utilization Management* section.
- Benefits exceeding those services or supplies subject to maximum individual or lifetime limit(s) for certain eligible medical expenses as listed in the *Schedule of ~~Medical~~ Benefits*; and
- Certain wellness or preventive services that are paid by this Plan at 100% do not accumulate towards the out-of-pocket maximum.

This list is not all-inclusive and may not include certain services and supplies that are not listed above.

Benefit Limitations

In addition to the exclusions listed below, refer to the *Summary of ~~Medical~~ Benefits* and *Schedule of ~~Medical~~ Benefits* sections for the maximum individual or lifetime limit(s) and any Plan Year limit applicable to certain covered expenses. Plan Year limits are met by days, hours, visits, or dollar limits paid under components of the Plan.

Lifetime Maximum

This Plan imposes a lifetime maximum on some health care services and procedures. For information on the lifetime maximums, refer to the *Summary of Medical Benefits* and *Schedule of ~~Medical~~ Benefits* sections.

Exclusions Under the ~~Medical~~ Plan

The following is a list of services and supplies or expenses not covered by this Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and terms of the Plan and determines eligibility and entitlement to Plan benefits. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum.

Abortion: Termination of pregnancy is excluded, other than medically indicated abortions that are medically necessary to save the life of the mother and complications of such abortions.

This plan provides abortion benefits in accordance with [NRS 422.250](#).

Alternative/Complimentary Health Care: Expenses for chelation therapy, except as may be medically necessary for treatment of mental health, acute arsenic, gold, mercury, or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron. Expenses for prayer, religious or spiritual healing or counseling. Expenses for homeopathic treatments/supplies that are not FDA approved. See the *Summary of Medical Benefits* and *Schedule of ~~Medical~~ Benefits* for benefit limitations and copayments and cost-sharing.

Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.

Bariatric and Overweight Surgery: The Plan's individual lifetime maximum is one (1) bariatric surgery while covered under any current or previous PEBP self-funded health plan.

Bariatric and Overweight Surgery not Performed at a Center of Excellence Provider: Benefits are excluded for bariatric/weight loss surgery performed at an out-of-network facility, out-of-network surgeon, or out-of-network ancillary provider are used, unless covered under the No Surprises Act. PEBP or its designee will determine the in-network Center of Excellence facility.

Behavioral (Mental) Health Services

- ~~• Expenses for hypnosis and hypnotherapy.~~
- Expenses for behavioral health care services related to:
 - adoption counseling;
 - non medically necessary court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws);
 - custody counseling;
 - dance/poetry/art therapy,
 - developmental disabilities;
 - dyslexia,
 - learning disorders;
 - ~~attention deficit disorders (with or without hyperactivity, except when the services are for diagnosis, the prescription of medication as prescribed by a physician or other health care practitioner, or when accompanied by a~~

~~treatment plan as submitted to the Plan or its designee) or the treatment is related to the management of ADD/ADHD without prescription drugs and is approved by the Plan or its designee;~~

- family planning counseling;
- marriage and/or couples counseling (the exclusion for marriage/couples counseling will not limit individual mental health counseling for an otherwise covered mental health condition)/~~and/or sex counseling~~;
- intellectual disability;
- pregnancy counseling;
- vocational disabilities, and
- organic and non-organic therapies
 - including (but not limited to) crystal healing/EST/primal therapy/L-Tryptophan/vitamin therapy, religious/spiritual, etc.
- Expenses for tests to determine the presence of or degree of a person's dyslexia or learning disorder unless the visit meets the criteria for benefits payable for the diagnosis or treatment of autism spectrum disorder.

Complications of a non-covered service: Expenses for care, services or treatment required because of complications from treatment or medications are not covered under this Plan, except complications from an abortion.

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge medical practice to have access to the medical services provided by the concierge medical practice.

Controlled Substance or Intoxicated: Services/treatment which involve an injury to which a contributing cause was the insured's commission of or attempt to commit a felony, except if a result of a medical or behavioral health condition, or domestic violence, even if the condition was not diagnosed at the time of the injury. See [NRS 695G.405](#).

Corrective Appliance, Orthotic Device Expenses, and Appliances: Any items that are not

- corrective appliances,
- orthotic devices or orthotic braces that straighten or change the shape of a body part,
- prosthetic appliances, or
- durable medical equipment (as each of those terms is defined in the *Key Terms and Definitions* section)

This ~~includes~~, but not limited to, ~~personal comfort items like:~~

- air purifiers,
- humidifiers,
- electric heating units,
- swimming pools,
- spas,
- saunas,

- escalators,
- lifts,
- motorized modes of transportation determined to be not medically necessary,
- pillows,
- orthopedic mattresses,
- water beds, and
- air conditioners are excluded.

Expenses for cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome.

Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment are not covered.

Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.

Cosmetic Services and Surgery: The Plan excludes expenses for cosmetic services and surgery or any drugs used for cosmetic purposes, including but not limited to health and beauty aids unless explicitly noted in the Covered Services section.

Complications resulting from Cosmetic Services or Surgery are not covered.

~~There is no coverage for travel costs.~~

*Breast augmentation/augmentation mammoplasty excluded, except as otherwise covered and described above.

Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken/missed appointments, general telephone calls not including telehealth, or photocopying fees.

Court-Ordered Treatment: Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, laboratory and other diagnostic testing and other services including hospitalizations or partial hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless the Plan Administrator or its designee determines that such services are independently medically necessary.

Custodial Care: Expenses for custodial care as defined in the Key Terms and Definitions section, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, including any service that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Services required to be performed by physicians, nurses or other skilled health care providers are not considered to be provided for custodial care services and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Dental Services: Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness, or injury affecting the mouth or another part of the body.

Except as described as an inclusion in the *Schedule of ~~Medical~~ Benefits*, services involving

- treatment to the teeth;
- extraction of teeth;
- repair of injured teeth;
- general dental services;
- treatment of dental abscesses or granulomas;
- treatment of gingival tissues (other than for tumors);
- dental examinations;
- restoration of the mouth, teeth, or jaws because of injuries from
 - biting, chewing, or accidents;
- artificial implanted devices;
- braces;
- periodontal care or surgery;
- teeth prosthetics and bone grafts regardless of etiology of the disease process; and
- repairs and restorations except for
 - appliances that are medically necessary to stabilize or repair sound and natural teeth after an injury;
 - dental and or medical care including mandibular or maxillary surgery,
 - orthodontia treatment,
 - oral surgery,
 - pre-prosthetic surgery,
 - any procedure involving osteotomy to the jaw, and
 - any other dental product or service except as set forth in the *Schedule of ~~Medical~~ Benefits*.

Coverage for dental services as the result of an injury to teeth may be extended under the medical Plan to a maximum of two (2) years following the date of the injury. Restorations past the two-year time frame will be considered under the dental benefits described in the PEBP Self-Funded Dental PPO Plan Master Plan Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other

dental orthosis or prosthesis, including the replacement of metal dental fillings; and other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthodontia is a specific Plan exclusion.

Drugs, Medicines, Nutrition or Devices Exclusions:

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been prescribed for a medically necessary indication or are experimental and/or investigational (as defined in the *Key Terms and Definitions* section of this document).
- Non-Prescription (non-legend or over the counter) drugs or medicines (except as preventive care medications required by the Affordable Care Act).
- Foods and nutritional/dietary supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs, and minerals (whether they can be purchased over the counter or require a prescription), except when provided during hospitalization; prenatal vitamins or minerals requiring a prescription.
- Special Food Product (as defined in the Key Terms and Definitions section), except for the benefit described as covered under Special Food Product in the Schedule of ~~Medical~~ Benefits section or elsewhere in this document
- Naturopathic, Naprapathic, or homeopathic treatments/substances.
- Weight control or anorexiant (phentermine, Xenical, HCG, including the OTC weight loss products), except those anorexiant used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy.
- Compounded prescriptions in which there is not at least one ingredient that is a Legend Drug requiring a prescription, as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, or other health care facility.
- Vaccinations, immunizations, inoculations, or preventive injections that are not covered under the *Summary of* ~~Medical~~ Benefits section.
- Marijuana and any derivative, including CBD, THC, edibles, etc. are not a covered benefit under this Plan.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the *Prescription Drug Program*.
- Drugs to enhance athletic performance such as anabolic steroids (including off-labeled growth hormone). Coverage for human growth hormone or equivalent is excluded unless specifically covered and described in the *Summary of* ~~Medical~~ Benefits.
- Non-prescription male contraceptives, e.g., condoms.
- Dental products such as topical fluoride preparations and products for periodontal disease, except as a preventive service required under the Affordable Care Act.
- Hair removal or hair growth products (*i.e.*, Propecia, Rogaine, Minoxidil, Vaniqa).
- Vitamin A derivatives (retinoids) for dermatologic use.

- Vitamin B-12 injections (except for treatment of Mental Health, pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (unless otherwise specified in the *Schedule of ~~Medical~~ Benefits*).
- Anti-aging treatments (even if FDA-Approved for other clinical indications).

Durable Medical Equipment Exclusions:

See the exclusions related to Corrective Appliance, Orthotic Device Expenses, and Appliances

Educational Services: Expenses for educational/vocational services, supplies or equipment including (but not limited to) computers, software, printers, books, tutoring, visual aids, auditory aides, and speech aides, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, or self-esteem, etc. (even if they are required because of an injury, illness, or disability of a covered individual).

Electronic cigarettes: The Plan does not cover electronic cigarettes.

Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by you or your covered dependents' employer; or for benefits otherwise provided under this Plan or any other Plan that PEBP contributes to or otherwise sponsors (e.g., HMOs).

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefit as described in this document.

Expenses Exceeding Usual and Customary Charges, Maximum Allowable Charge, Prevailing Rates and Plan Contracted Rates: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Plan's Maximum Allowable Charge, usual and customary charge, prevailing rates or Plan contracted rate as defined in the *Key Terms and Definitions* section, except as required by independent dispute resolution under the No Surprises Act .

Expenses for Which a Third Party Is Responsible: See "Third-Party Liability" of the Health and Welfare Wrap document that can be found on www.pebp.state.nv.us <https://pebp.nv.gov/> ([NAC 287.755](#)).

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided either before the patient became covered under the medical program or after the date the patient's coverage ends, except under those conditions described in COBRA.

Experimental and/or Investigational Services: Unless mandated by law, expenses for any medical services, supplies, drugs, or medicines that are determined by the Plan Administrator, UM company, or its designee to be experimental and/or investigational services.

Fertility and Infertility Services: Except as otherwise specified in the *Schedule of ~~Medical~~ Benefits* section, other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) except services directly related to artificial insemination services up to the maximum benefit limit are excluded. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy; the promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the participant's ability to become pregnant or to carry a pregnancy to term; and any payment made by or on behalf of a participant who is contemplating or has entered into a contract for surrogacy to a provider or individual related to any services potentially included in the scope of surrogacy services; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are also excluded.

Foot/Hand Care

Expenses for non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and expenses for routine foot care (including but not limited to: trimming of toenails, removal of corns and callouses, preventive care with assessment of pulses, skin condition and sensation) or hand care, (including manicure and skin conditioning), unless the Plan Administrator or its designee determines such care to be medically necessary.

Routine foot care from a podiatrist for treatment of foot problems such as corn, calluses, and toenails are payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

Gender Dysphoria and/or Gender Services: Certain procedures associated with gender dysphoria treatment and/or gender surgery found to be non-medically necessary in the Treatment for Gender Dysphoria section above and are not covered. The Plan provides benefits to individuals seeking services for the treatment of gender dysphoria and gender incongruence in accordance with [Senate Bill 163](#) from the ~~82nd~~ Legislative Session in 2023.

◆ ~~There is no coverage for travel costs.~~

Genetic Testing and Counseling: Coverage is not available for tests solely for research, or for the benefit of individuals not covered under this Plan.

Expenses for genetic testing and counseling are excluded, unless otherwise specified in this Plan's *Schedule of ~~Medical~~ Benefits*.

Gym Fees: Fees by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists, even if recommended by a professional to treat a medical condition.

Hair: Expenses for or related to hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Eflornithine; or for hair replacement devices, including (but not limited to) wigs, toupees and/or hairpieces or hair analysis. Patients undergoing chemotherapy may be able to receive benefits for some hair replacement devices, as listed above

Hearing Care: Special education and associated costs in conjunction with sign language education for a patient or family members.

Hearing Aids: Over the Counter hearing aids are excluded from the Plan.

Home Birth/Delivery: Planned birth/delivery at home and associated services are not covered by this Plan. Guidelines for Perinatal Care published by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG) that the hospital, including a birthing center within the hospital complex, or a freestanding birthing center, provides the safest setting for labor, delivery, and the postpartum period. The use of other settings is not covered by this Plan. Facilities providing obstetrical care should have the services listed as essential components of a Level 1 hospital.

Home Health Care:

- Expenses for any home health care services that are not medically necessary, other than part-time, intermittent skilled nursing services and supplies.
- Expenses for a homemaker, custodial care, childcare, adult care, or personal care attendant, except as provided under the Plan's hospice coverage.
- Expenses for any home health care services that is not provided by an organization or professional licensed by the state to render home health services.
- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the *Summary of ~~Medical~~ Benefits* and *Schedule of ~~Medical~~ Benefits*.
- Expenses for any services provided substantially or primarily for the participant's convenience or the convenience of a caregiver.

Hospital Employee, Medical Students, Interns or Residents: Expenses for the services of an employee of a hospital, skilled nursing facility or other health care facility, when the facility is obligated to pay that employee.

Hypnosis and Hypnotherapy: (As defined by CMS) an artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility.

Illegal Act: Expenses incurred by any covered participant for injuries resulting from commission (or attempted commission by the covered participant) of an illegal act the Plan Administrator determines involved violence or the threat of violence to another person, or in which any weapon or explosive is used by the covered participant, unless such injury is the result of a physical or mental health condition or domestic violence. The Plan Administrator's determination that this exclusion applies shall not be affected by any prosecution, or acquittal of (or failure to prosecute) the covered participant in connection with the acts involved.

Internet/Virtual Office Visit: Expenses related to an online internet consultation with an out-of-network physician or other health care practitioner (also called a virtual office visit/consultation), physician-patient web service or physician-patient e-mail service (including receipt of advice, treatment plan, prescription drugs or medical supplies obtained) from an online internet provider who is not a participating provider in the Plan network except as specifically provided.

Maternity/Family Planning:

- Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms.
- Termination of Pregnancy: Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies the health of the mother would be endangered if the fetus were carried to term, and complications of such termination.
- Childbirth courses.
- Expenses related to delivery associated with ~~a newborn~~the newborn of a pregnant dependent-child.
- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs.
- For nondurable supplies.
- Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.

Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary, as defined in the *Key Terms and Definitions* section.

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required because of an injury, illness, or disability of a participant, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc.)

No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

No Provider Recommendation or Order: Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician or other licensed provider acting within the scope of their license.

Non-Emergency Hospital admission: Care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.

Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses) of a health care provider, participant except where otherwise specified in the *Utilization Management* section for organ/tissue transplants and bariatric weight loss surgery or certain surgeries performed in a surgery center, inpatient hospital or outpatient setting as determined by the Plan Administrator or the UM company.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: Expenses incurred by you or any of your covered dependents arising out of or during employment if the injury, illness, or condition is subject to coverage, in whole or in part, under any Workers' Compensation, or occupational disease (or similar) law.

Orthodontia: Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an accident or medical condition.

Personal Comfort Items: Expenses for patient convenience, including (but not limited to) care of family members while the participant is confined to a hospital (or other health care facility, or to bed at home), guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

Private Room in a Hospital or Health Care Facility: The use of a private room in a hospital or other health care facility, unless the facility has only private room accommodations, or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

Prophylactic Surgery or Treatment: Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery (as defined in the *Key Terms and Definitions* section), when the services, procedures, Prescription of Drugs, or Prophylactic surgery is prescribed or performed for:

- Avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results, in certain circumstances; or
- Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder. Participants should use the Plan's UM company to assist in the determination of a proposed surgery to determine if it is or is not covered under this Plan.

NOTE: Some prophylactic surgeries may be covered under this Plan if certain criteria are met. Please refer to the *Schedule of ~~Medical~~-Benefits* section. For additional information, please contact this Plan's UM company or Claims Administrator.

Prophylactic drugs are excluded.

Rehabilitation Therapy (Inpatient or Outpatient):

- Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing, and related services.
- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
- Expenses for maintenance rehabilitation, as defined in the *Key Terms and Definitions* section.
- Expenses for speech therapy for functional purposes including (but not limited to) stuttering, and stammering ~~and conditions of psychoneurotic origin~~.
- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living or for Medically Necessary treatment of a mental health or substance use disorder diagnosis.
- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency.

Service Animals: Expenses for the purchase, training, or maintenance of any type of service animal, even if designated as medically necessary.

Smoking Cessation or Tobacco Withdrawal: Expenses for non-prescription (over the counter) tobacco/smoking cessation products such as nicotine gum or patches, unless prescribed by a physician. There are no benefits payable for the use of electronic cigarettes. Prescription smoking/tobacco cessation products are payable under the prescription drug benefit as described in the *Schedule of ~~Medical~~-Benefits* section.

Stand-By Physicians or Health Care Practitioners: Expenses for any physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the physician or health care practitioner was available on a stand-by basis.

Taxes: Sales taxes, unless specifically covered in the Plan. See also CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, Chapter 21, Section 2122.2.G.

Telephone Calls: Expenses for telephone calls between a physician or other health care provider and any patient, other health care provider, UM company or vendor; or any representative of this Plan for any purpose whatsoever.

Transplant (Organ and Tissue):

- Expenses for human organ and/or tissue transplants that are experimental and/or Investigational, including (but not limited to) donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post-operative services and drugs or medicines, and complications thereof, except those transplant services as described under Transplants in the *Schedule of ~~Medical~~ Benefits*.
- Expenses related to non-human (Engrafted) organ and/or tissue transplants or implants, except heart valves.
- Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this plan.

Travel Outside of the United States: Any services received outside the United States are excluded unless deemed to be urgent or emergency care.

Urgent Care: Any urgent care services that are received out-of-network are excluded unless the urgent care service is received out-of-area as defined in the *Key Terms and Definitions*.

Vision Care: Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery); and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded, except as otherwise specified in this Plan's *Summary of ~~Medical~~ Benefits* and *Schedule of ~~Medical~~ Benefits*.

War or Similar Event: Expenses incurred because of an injury or illness due to a participant's participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Weight Management and Physical Fitness:

- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs, and prescription drugs, except those services specified in the *Summary of ~~Medical~~ Benefits* and *Schedule of ~~Medical~~ Benefits*. Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Expenses for weight loss surgery performed without a precertification from the UM company will be denied.
- Expenses related to programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.

- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of an eating disorder (such as anorexia, bulimia, ~~or acute starvation~~ etc.). Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under any PEBP self-funded medical Plan (e.g., LD PPO Plan, CDHP, and EPO Plan).

Other Benefit Exclusions

- Stress reduction therapy or cognitive behavior therapy for sleep disorders.
 - The exclusion for cognitive therapy does not apply to Medically Necessary treatment of a mental health or substance use condition.
- Sleep therapy (except for central or obstructive apnea when medically necessary and when a precertification has been received from the UM company), behavioral training or therapy, milieu therapy (unless the care is otherwise medically necessary), biofeedback (unless included with psychotherapy), behavior modification, sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.
- ~~Charges that result from appetite control, food addictions, or any treatment of obesity, unless otherwise provided in the Summary of Medical Benefits and Schedule of Medical Benefits.~~
 - ~~Except as otherwise provided in the Summary of Medical Benefits and Schedule of Medical Benefits, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.~~
- Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (BEST), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.
- Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or Chiropractor's office, or at a retail location are excluded, unless otherwise specified in the *Summary of ~~Medical~~ Benefits and Schedule of ~~Medical~~ Benefits*.

Medical Claims Administration

How Medical Benefits are Paid

Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP's third-party claims administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or copayments apply, you are responsible for paying your share of these charges.

If services are provided through the PPO network, the PPO health care provider may submit the proof of claim directly to PEBP's third-party claims administrator; however, you will be responsible for the payment to the PPO health care provider for any applicable Deductible, Coinsurance, or copayments.

If a health care provider does not submit a claim directly to PEBP's third-party claims administrator and instead sends the bill to you, you should follow the steps outlined in this section regarding How to File a Claim. If, at the time you submit your claim, you furnish evidence acceptable to the Plan administrator or its designee (PEBP's third-party claims administrator) that you or your covered dependent paid some or all those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan Year Deductible and Coinsurance amounts are met.

How to File a Medical Claim

Claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

See also, [NAC 287.610](#).

Most providers send their bills directly to the PEBP's claims administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party claims administrator or PEBP's website (see the *Participant Contact Guide* in this document for details on address, phone, and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains the following information:

- A description of the services or supplies provided including appropriate procedure codes.
- Details of the charges for those services or supplies.
- Appropriate diagnosis code.
- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Claims Administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny Deductible and Out-of-Pocket Maximum credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list:

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- Providers such as hospitals and facilities that bill for single or bulk items such as orthopedic devices/implants or other types of biomaterials shall provide to the third-party claim's administrator a copy of the manufacturer's/organization's invoice (that directly supplied the device/implant/biomaterial to the healthcare provider). This Plan will deny payment for such medical devices until a copy of the invoice is provided to this Plan's Claims Administrator.

Claims are processed by the third-party claims administrator in the order that they are received.

It is your responsibility to maintain copies of the EOB documents provided to you by PEBP's third-party claims administrator or prescription drug administrator. Copies of EOB documents are available on the Claims Administrator's website but cannot be reproduced. PEBP and its third-

party claims administrator do not provide printed copies of EOB documents outside of the original mailing.

Where to Send the Claim Form

Send the completed claim form, the bill you received (retain a copy for your records) and any other required information to the Claims Administrator at the address listed in the Participant Contact Guide in this document.

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Appeals

You have the right to ask PEBP or its designees to reconsider a claim or Utilization Management Adverse Benefit Determination resulting in a denial, reduction, termination, failure to provide or make payments (in whole or in part) for a service or treatment, or rescission of coverage (retroactive cancellation).

Discretionary Authority of PEBP and Designee

In carrying out their respective responsibilities under the Plan, PEBP and its designees have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in this document.

Medical and Dental Claims Appeals

Written Notice of Adverse Benefit Determination

The Plan or its designee, the third-party administrator, will notify you in writing on an Explanation of Benefits (EOB) of an Adverse Claim Determination resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal.

You will be provided with:

- upon request and without charge, reasonable access to and copies of relevant documents, records, and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- a full and fair review that considers comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on

which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

Level 1 Claim Appeal

[NAC 287.670](#)

If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third-party administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause can be demonstrated. The written request for appeal must include:

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit your own comments in writing. The third-party administrator will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The third-party administrator will issue a decision of your Level 1 Claim Appeal in writing within 20 days after receipt of your request for appeal.

You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:

- information that is sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
- the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review (when external review is applicable);

- the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
- reference the specific Plan provision(s) on which the determination is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- an explanation of the Plan's appeal process and Level 2 appeal process and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol, or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
- disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

The notification will explain the steps necessary if you wish to proceed to a Level 2 Appeal if you are not satisfied with the response at Level 1.

Level 2 Claim Appeal

[NAC 287.680](#)

If you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request forms* are available at www.pebp.state.nv.us <https://pebp.nv.gov/> or by request by contacting PEBP Customer Service. Furthermore, you are welcome to submit Level 2 Claim Appeals online through a form that can be found under the subheading "Filing an Appeal" under PEBP's contact us web page. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal **must** include a copy of:

- Any document submitted with your Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use resources available to ensure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. A Level 2 Appeal determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.

External Claim Review

[NAC 287.690](#)

Standard Request

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. An *External Review Request Form* is available on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/). The OCHA will assign an independent external review organization within five (5) days after receiving the request. The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

A Request for External Claim Review must include:

- completed and signed External Review Request Form.
- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587, (888) 333-1597
Web:

[https://adsd.nv.gov/Programs/CHA/Office for Consumer Health Assistance \(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

Appealing a Utilization Management Determination

The utilization management (UM) company is staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer utilization review services. The review includes a process to determine the medical necessity, appropriateness, location, and cost effectiveness of health care services. Depending on the service, a review may occur before, during, or after the services are rendered, including, but not limited to precertification/pre-authorization; concurrent and/or continued stay review; discharge planning; retrospective review; and case management.

Pursuant to applicable [NRS 695G](#), you have the following appeal processes for any adverse benefit determination made during the precertification, concurrent review, retrospective review, or case management. An appeal may be initiated by the participant, treating provider, parent, legal guardian, or person authorized to make health care decisions by a power of attorney.

The UM company will utilize a physician (other than the physician who rendered the original decision) to review the appeal. This physician is Board Certified in the area under review and is in active practice. Refer to the *Participant Contact Guide* for the UM company's contact information.

Internal UM Appeal Review

Expedited Internal UM Appeal Review

You may request an expedited appeal review of a denied precertification of a hospital admission, availability of care, continued stay or health care service for which you received emergency services but have not been discharged from the facility providing the care; or if the physician certifies that failure to proceed in an expedited manner may jeopardize your life or health or the life or health of your covered dependent or the ability for you or your covered dependent to regain maximum function.

Requests for an expedited internal UM appeal review may be made by telephone or any other reasonable means to the UM company that will ensure the timely receipt of the information required to complete the appeal process. If your physician requests a consultation with the reviewing physician, this will occur within one business day. The UM company will decide on an expedited appeal within 72 hours of receipt of the information needed to complete the appeal. The results of the determination of an expedited appeal will be provided immediately to the managing physician by phone and in writing to the patient, managing physician, facility, and the third-party claim's administrator.

If the appeal review request is denied, the UM company will provide the member with an adverse benefit determination letter including the clinical rationale for the non-certification decision and the member may pursue an external appeal as described in [NRS 695G.241](#) - [NRS 695G.275](#).

Standard Internal UM Appeal Review

If you have a denied precertification request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue) and you do not qualify for an expedited appeal, you may request a standard appeal review. Requests for standard appeal review may be made by writing to the UM company.

Requests for standard appeal review must be made within 180 days of the date of the denial/non-certification. Actual medical records are encouraged to be provided to assist the reviewer. Standard appeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service treatment will be completed within 20 days of the receipt of the request. The results of the determination of a standard appeal will be provided in writing to the patient, managing physician, facility, and third-party claim's administrator.

A participant or their designee can choose to bypass the internal appeals process from adverse benefit determinations resulting from the UM company and request a review by an external review organization.

External UM Appeal Review

An external review may be requested by a participant and/or the participant's treating physician after you have exhausted the internal UM appeal review process. This means you may have the right to have the Plan Administrator or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgement as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

Expedited Request for External Review (Pre-Service Urgent UM Appeal) [NRS 287.04335](#)

For adverse benefit determinations resulting from the UM company, a participant or their designee can choose to bypass the internal UM appeal process and request a review by an external review organization.

Expedited external review is available only if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination and the patient's treating provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered individual or would jeopardize the covered individual's ability to regain maximum function. Pursuant to [NRS 695G.271](#), the Office for Consumer Health Assistance (OCHA) will approve or deny a request for an external review of an adverse determination not later than 72 hours after receipt from the provider. If OCHA determines the request qualifies for expedited review, a final of the external review will made by the external review organization within 72 hours of receipt and the provider and participant will be notified within 24 hours.

A participant may file a request for an expedited external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of

a notice of an adverse benefit determination or final internal adverse benefit determination. An expedited external review request form, which includes a certification of treating provider for expedited consideration can be found on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

The request must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587, (888) 333-1597
Web:

[https://adsd.nv.gov/Programs/CHA/Office for Consumer Health Assistance \(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office%20for%20Consumer%20Health%20Assistance%20(OCHA)/)

Standard Request for External UM Review

A standard request for external UM review may be filed with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. A standard external review request form can be found on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

A standard external review decision will be made within 45 days of OCHA's receipt of the request.

As with the expedited external review, a standard external review must be submitted to the Office for Consumer Health Assistance at the contact information listed above.

Experimental and/or Investigational Claim/UM External Review

If you received a denial for a service, durable medical equipment, procedure, or other therapy because the third-party administrator or the UM company determined it to be experimental and/or investigational, or subject to the No Surprises Act, or rescission of coverage, you may request an external review. To proceed with the experimental and/or investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.

A "Physician Certification of Experimental/Investigational /Denials" is located under "Forms" on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

After this form is completed by the treating physician, it should be attached to the Request for External Review" form and submitted to the Office for Consumer Health Assistance at:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587, (888) 333-1597

Web:

[https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_\(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

Prescription Drug Review and Appeals

A participant has the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. The Pharmacy Benefit Manager reviews both clinical and administrative coverage review requests, including those cases related to specialty drugs dispensed through Accredo specialty pharmacy.

Clinical Coverage Review

The initial clinical coverage review is a request for coverage or medication that is based on clinical conditions of coverage that are set by this Plan—for example, medications that require a prior authorization. To make an initial determination for a clinical coverage review request, the prescribing physician must submit specific information for review.

How to Request a Clinical Coverage Review

The preferred method to request an initial clinical review is for the prescribing physician to submit the prior authorization request electronically. Alternately, the participant's prescribing physician or pharmacist may call Express Scripts at 1-800-753-2851 or the prescriber may submit a request in writing using a Benefit Coverage Review Form, which can be obtained by calling Express Scripts Member Services at 1-855-889-7708. (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

Administrative Coverage Review

The initial administrative coverage review is a request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Administrative Coverage Review

To request an initial administrative coverage review, the participant must submit the request in writing to Express Scripts to the attention of the Benefit Coverage Review Department (see *Participant Contact Guide* section).

For an administrative coverage review request, the participant must submit information to the pharmacy benefits manager to support the request.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by calling Express Scripts at 1-800-753-2851.

If the necessary information is provided to Express Scripts so that a determination can be made, the initial determination and notification for a clinical coverage or administrative coverage review will be made within the timeframe below:

- Standard Pre-Service: 15 days for retail pharmacy and five (5) days for home delivery; and
- Standard Post-Service: 30 days.

Level 1 Appeal or Urgent Appeal

When an initial administrative or clinical coverage review request has been denied, a request for appeal of the denial may be submitted by the participant within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to Express Scripts' Benefit Coverage Review Department:

- Name of patient.
- Participant ID number.
- Phone number.
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the initial adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including physician/prescriber statements/letters, bills, or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone at 1-800-753-2851 or fax 1-877-852-4070 to Express Scripts. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are by Express Scripts' pharmacist, physician, panel of clinicians, trained prior authorization staff member, or an independent third-party prescription drug utilization management company.

Level 1 Appeal Decisions and Notifications

Express Scripts will render Level 1 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 20 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse benefit determination. Standard Post-Service: [NAC 287.670](#)

Level 2 Appeal

When a Level 1 Appeal has been denied, a request for a Level 2 Appeal may be submitted by the participant within 35 days from receipt of notice of the Level 1 Appeal denial. To initiate a Level 2 Appeal, you must request by mail or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department.

An urgent Level 2 Appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department (see the *Participant Contact Guide* section). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Level 2 Appeal Decisions and Notifications

Express Scripts will render Level 2 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 30 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. Standard Post-Service: [NAC 287.680](#).

External Reviews

The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental and investigation. Generally, internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to the independent review organization (see *Participant Contact Guide*) within 4 (four) months of the date of the Level 2

Appeal denial. (If the date that is 4 (four) months from that date is a Saturday, Sunday, or a holiday, the deadline will be the next business day).

Standard External Review: the pharmacy benefit manager will review the external review request within 5 (five) business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and the patient will be notified within 1 (one) business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO within 5 (five) business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgement or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the pharmacy benefit manager for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and the pharmacy benefit manager written notice of its decision. If the IRO has determined that the claim does not involve medical judgement or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regarding maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Coordination of Benefits

For detailed information, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

Which Benefits are Subject to Coordination?

When Participants have medical, dental or vision coverage from some other source, benefits are determined using Coordination of Benefits (COB). COB operates so that one of the plans (i.e., the primary plan) will pay its benefits first. The other plan or policy, (i.e., the secondary plan) may then provide additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

Participants must let the Plan Administrator, or its designee, know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and dental deductibles. This Plan’s prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.

For the purposes of this COB section, the word “plan” refers to any group or individual medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual either on an individual basis or as part of a group of employees, retirees or other individuals.

A Participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such fully insured plan and the rules and procedures described in such fully insured plan’s applicable Summary of Insurance.

A Participant in a self-insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures set forth in this Section 4.4. The PEBP delegates to the third-party administrator of such self-insured plan the duty to administer and interpret the provisions of this Section 4.4. and to adopt, document and communicate any rules and procedures necessary or appropriate to implement the COB procedures, as set forth herein:

Which Plan Pays First: Order of Benefit Determination Rules

PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any plan that does not use these same rules always pays its benefits first.

When two plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second).

If the first of the ~~following~~ rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

These rules are detailed in the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

Coordination with Medicare

Coordination with Medicare is not applicable for retirees and their dependents who are eligible for Medicare Part A and Medicare Part B and who are required to transition to the Medicare Exchange.

This Plan has coordination of benefits for Medicare as it relates to:

- Entitlement to Medicare Coverage,
- When the Participant Is Not Eligible for Premium Free Medicare Part A,
- Coverage Under Medicare and This Plan When a Participant has End-Stage Renal Disease (ESRD),
- How Much This Plan Pays When It Is Secondary to Medicare,
- When the Retiree or the Retiree’s Covered Spouse or Domestic Partner is Enrolled in Medicare Part B,
- When the Participant Enters Into a Medicare Private Contract

For details, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

Coordination with Other Government Programs

This Plan has coordination of benefits as it relates to:

- Medicaid,
- Medicare,
- Tricare,
- Veterans Affairs,
- Worker’s Compensation, and
- Medicare Disability.

For more details, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

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Subrogation and Third-Party Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the manner in which they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). Any and all claims made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. Any and all payments made by the Plan relating in any way to the Injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury. Refer to the separate *Health and Welfare Benefits Wrap Plan* document for more information regarding third party liability and subrogation.

The Participant must cooperate fully, at all times, and provide information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

- Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation.
- Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
- Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate Health and Welfare Benefits Wrap Plan document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) for more information regarding third party liability and subrogation.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) 3427 Goni Road, Ste 109 Carson City, NV 89706 Customer Service: (775) 684-7000, (702) 486-3100, or (800) 326-5496 Fax: (775) 684-7028 www.pebp.state.nv.ushttps://pebp.nv.gov/	Plan Administrator • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR <u>Claims Submission</u> P O Box 30541 Salt Lake City, UT 84130-0541 EDI #39026 <u>Appeal of Claims</u> P O Box 30546 Salt Lake City, UT 84130-0546 <u>Customer Service</u> (888) 763-8232 www.UMR.com	Third-party Claims Administrator/Third-party Administrator/PPO Network/ Disease Management Administrator • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Sierra Health-Care Options, Inc PO BOX 15645 Las Vegas, NV 89144-5648 Customer Service : 888-323-1461 Fax : 800-288-2264	Utilization Management and Case Management Company • Pre-Certification/Prior Authorization • Utilization Management • Case Management • Transplants

Participant Contact Guide	
Express Scripts Pharmacy <u>Customer Service</u> (855) 889-7708 www.Express-Scripts.com <u>Accredo Patient Customer Service:</u> (800) 803-2523 <u>Accredo Physician Service Line</u> (800) 987-4904 option 5 <u>Express Scripts / Accredo Prior Authorization</u> (800) 753-2851 Electronic option: express-scripts.com/PA <u>Specialty Medication SaveonSP copay assistance</u> (800) 683-1074 www.saveonsp.com/pebp	Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and EPO Plan • Prescription drug information • Retail network pharmacies • Prior authorization • Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies • Accredo Specialty Drug Services • Coverage and Clinical reviews • Appeals • External Review Requests • Copay/Deductible/Coinsurance assistance
HSA Bank HRA Claim Submission PO Box 2744 Fargo, ND 58108-2744 hsaforms@hsabank.com Fax: 855-764-5689 www.hsabank.com Customer Service: 833-228-9364 askus@hsabank.com myaccounts.hsabank.com	HSA and HRA Claims Administrator • HSA/HRA Claims and claim appeals
Diversified Dental Services 5470 Kietzke Lane, Ste 300 Reno, NV 89511 ProviderRelations@ddsppo.com 1-866-270-8326 diversifieddental.com	PPO Dental Network • Statewide PPO Dental Providers • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network

Participant Contact Guide	
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 www.myhpnstateofnevada.com/	Southern Nevada Health Maintenance Organization (HMO) • Medical claims/provider network
VIA Benefits 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888)598-7545 https://my.viabenefits.com/pebp Phone: (888) 598-7545; Fax: (402) 231-4310	Medicare Exchange and Medicare HRA administrator • Medigap (Supplemental) plans • Medicare Advantage Plans (HMO and PPO) • Voluntary Vision • Voluntary Dental • HRA claims administrator
United Healthcare Specialty Benefits Group Number: 370074 Customer Service: 1-888-763-8232 UnitedHealthcare Specialty Benefits P.O. Box 7149 Portland, ME 04112-7149	• Basic Life Insurance for eligible active and retirees • Member Assistance Program • Global Travel Assistance
Office for Consumer Health Assistance 3320 W. Sahara Ave, Suite 100 Las Vegas, NV 89102 Customer Service: (702) 486-3587 or (888) 333-1597 https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/	Consumer Health Assistance • Concerns and problems related to coverage • Provider billing issues • External review information
Corestream PEBP+ Customer Care: (775) 249-0716 E-mail: pebpcustomer@corestream.com www.corestream.com <u>Voluntary Life, Critical Illness, Accident, and Hospital Indemnity Insurance</u> The Standard Insurance Company (888) 288-1270 www.standard.com/mybenefits/nevada	PEBP+ Voluntary Benefits Administrator • Accident Insurance • Auto Insurance • Critical Illness • Disability Insurance (Long-term and Short-term) • Home Insurance • Hospital Indemnity • Identity Theft • Legal Services • Life Insurance (Supplemental) • Pet Insurance • Vision Care

DRAFT

Key Terms and Definitions

The following terms or phrases are used throughout this MPD. These terms or phrases have the following meanings. These terms and definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

Active Rehabilitation: refers to therapy in which a patient, who can learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Actively Engaged:

- Participation in regular office visits with your provider. The frequency of the office visits will be determined by your provider who will in turn report this information to the third-party administrator for monitoring.
- Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss provider including but not limited to routine exercise, proper nutrition and diet, and pharmacotherapy if prescribed. Commitment to your weight loss treatment will be measured by the third-party administrator who will review monthly progress reports submitted by the provider; and
- Losing weight at a rate determined by the weight loss provider.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding, or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

When benefits for the services of an acupuncturist are payable by this Plan, the acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, be certified by the National Certification Commission for Acupuncturists (NCCA).

Adverse Benefit Determination: [NRS 695G.012](#) - Means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Air Ambulance: A medical transport by a rotary wing air ambulance, as defined in [42 CFR 414.605](#), or fixed wing air ambulance, as defined in [42 CFR 414.605](#), for patients.

Allogenic: Refers to transplants of organs, tissues, or cells from one person to another person. Heart Transplants are always Allogenic.

Allowable Expenses: The Maximum Allowable Charge for any medically necessary, eligible item of expense, at least a portion of which is covered under the Plan. When some other non-Medicare plan pays first in accordance with the application to benefit determinations provision in the *Coordination of Benefits* section, this Plan's allowable expenses shall in no event exceed the other non-Medicare plan's allowable expenses.

When some other non-Medicare plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of each service rendered, by determining the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other non-Medicare plan include the benefits that would have been payable had claim been duly made; therefore, whether or not it is made.

Ambulance: A vehicle or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated, and staffed primarily for performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets the following requirements:
 - It is operated under the supervision of a licensed physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area.
 - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthesiologist who is administering the anesthetic, and that the anesthesiologist or anesthesiologist remain present throughout the surgical procedure.
 - It provides at least one operating room and at least one post-anesthesia recovery room.
 - It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
 - It has trained personnel and necessary equipment to handle emergency situations.
 - It has immediate access to a blood bank or blood supplies.

- It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
- It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or x-rays), an operative report and a discharge summary.

An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.

Ancillary Services/Charges: Charges for services provided by a hospital or other facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Ancillary services: for purposes of the No Surprises Act, are with respect to a PPO health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary of Department of Health and Human Services; and
- Items and services provided by a Non-PPO provider if there is no PPO provider who can furnish such item or service at such facility.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional, or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Annual/Annually: For the purposes of this Plan, annual and annually refers to the 12-month period starting July 1 through June 30.

Appliance (Dental): A device to provide or restore function or provide a therapeutic (healing) effect.

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Approved Clinical Trial: A phase I, II, III, or IV trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted.

An Approved Clinical Trial's study must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRO), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRO, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA), (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Assistant surgeon: A medically qualified doctor who assists the surgeon of record perform a procedure.

Autism Spectrum Disorders and related terms: Have the meanings ascribed to them under [NRS 695G.1645](#) and [NRS 427A.875](#).

Autologous: Refers to transplants of organs, tissues, or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.

Average Wholesale Price (AWP): The average price at which drugs are purchased at the wholesale level.

Bariatric Surgery Center of Excellence: This provider has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program ([ACS NSQIP](#)) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program ([MBSAQIP](#)). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These [MBSAQIP](#) accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

- Behavior modification program supervised by a qualified professional.
- Consultation with a dietician or nutritionist.
- Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen.
- Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise Therapist or other qualified professional.

- Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
- Reduced-calorie diet program supervised by dietician or nutritionist.

Base Plan: The self-funded Consumer Driven Health Plan (CDHP); the base plan is also defined as the “default plan” where applicable in this document and other materials produced by PEBP ([NRS 287.045](#)).

Behavioral Health Disorder: Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause.

Behavioral health disorders covered under this Plan may include, but are not limited to depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods and is provided by behavioral health practitioners as defined in this section. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the *Exclusions* section.

Behavioral Health Practitioner: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a master’s degree, or other provider who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Behavioral Health Treatment: Services, including room and board, given by a behavioral health treatment facility or area of a hospital that provides behavioral or mental health or substance abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the illness that is identified under the DSM code is considered a behavioral health treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated, and staffed primarily for providing a program for diagnosis, evaluation, and effective treatment of behavioral health disorders and which fully meets one of the following two tests:

- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets the following requirements:
 - has at least one physician on staff or on call and
 - provides skilled nursing care by licensed nurses under the direction of a full-time registered nurse (RN) and
 - prepares and maintains a written plan of treatment for each patient based on the medical, psychological, and social needs of the patient.

A behavioral health treatment facility that qualifies as a hospital is covered by this Plan as a hospital and not a behavioral health treatment facility. A transitional facility, group home, halfway house or temporary shelter is not a behavioral health treatment facility under this Plan unless it meets the requirements above in the definition of behavioral health treatment facility.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, subject to the Plan's Maximum Allowable Charge, or negotiated fee schedule, after calculation of Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets the following requirements:
- It is operated and equipped in accordance with any applicable state law for providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.
- It is equipped to perform routine diagnostic and laboratory examinations, including (but not limited) to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
- It has available to handle foreseeable emergencies, trained personnel, and necessary equipment, including (but not limited to) oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
- It provides at least two beds or two birthing rooms.
- It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.
- It has a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It has the capacity to administer local anesthetic and to perform minor surgery.
- It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
- It is expected to discharge or transfer patients within 48 hours following delivery.

A birth (or birthing) center that is part of a hospital, as defined in this section, will be a birth (or birthing) center for the purposes of this Plan.

Business Day: Refers to weekdays, except Saturday, Sunday, Nevada holiday, or federal holiday.

Case Management: A process administered by the UM company in which its medical professionals work with the patient, family, caregivers, providers, Claims Administrator, Pharmacy Benefit Manager and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential providers.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

Certified Surgical Assistant: A person who does not hold a valid health care license as an RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon, and who acts within the scope of their license or certification. Such individuals are payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

Chemical Dependency: This is another term for Substance Abuse. (See also the definitions of Behavioral Health Disorders and Substance Abuse).

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC) and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal column (vertebrae); and who acts within the scope of his or her license.

Chiropractic Services: PEBP considers chiropractic services to be medically necessary when the following criteria are met:

- participant has objective medical findings of a neuro-musculoskeletal disorder; and
- a clearly defined treatment plan has been established including treatment and discharge goals; and
- services are not for maintenance purposes.

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings.

Chronic Medication Synchronization: “Chronic medication” means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent, or lasting indefinitely. “Synchronization” means the alignment of the dispensing of multiple medications by a single contracted pharmacy for improving a patient’s adherence to a prescribed course of medication. This includes providing coverage for less than a 30-day supply to enable synchronization. See also [NRS 695G.1665](#))

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Clinical Trials: See *Experimental and Investigational* in the *Key Terms and Definitions* section.

Coinsurance: That portion of *Eligible Medical Expenses* for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses more than the Plan’s Deductible. The Coinsurance varies depending on whether In-Network or Out-of-Network providers are used.

Complications of Pregnancy: Any condition that requires hospital confinement for medical treatment, and if the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or, any condition that requires hospital confinement and if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.

Compound Drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Concierge Medicine: Is a relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of medical or dental care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care, and direct practice medicine. Most concierge medicine practices do not bill insurance.

Concurrent Review: A managed care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically

necessary by having the utilization management company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility.

Continuing Care Patient: Under the NSA, an individual who, with respect to a provider or facility-

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how Plan benefits are payable when a person is covered by two or more health care plans.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. This can be in addition to Coinsurance amounts due on the same incurred charges. Copayments are limited to certain benefits under this program.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or device) and Prosthetic Appliance (or device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator, UM company, or its designee.

Cost-Efficient: See the definition of medically necessary for the definition of cost-efficient as it applies to medical services that are medically necessary.

Cost-Share or Cost S-sharing: The amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts

paid towards premiums, balance billing by Non-PPO providers, or the cost of items or services that are not covered under the plan.

Cost Sharing Amount: for Emergency and Non-emergency Services at PPO Facilities performed by Non-PPO Providers, and air ambulance services from Non-PPO providers will be based on the Recognized Amount.

Covered Individual: Any employee or retiree (as those terms are defined in this Plan), and that person's eligible spouse or dependent child who has completed required formalities for enrollment for coverage under the Plan and is covered by the Plan.

Covered Medical Expenses: See the definition of *Eligible Medical Expenses*.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

Customary Charge: See the definition of *Usual and Customary Charge*.

Deductible: The amount of eligible medical, prescription drug and dental expenses you are responsible for paying before the Plan begins to pay benefits. The dental Deductibles are discussed in the separate PPO Dental Master Plan Document.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the Temporomandibular Joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies coverage is provided in the PPO Dental Plan (refer to the separate PPO Dental Plan MPD available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/)) and are not covered under the medical expense coverage of this Plan unless the medical Plan specifically indicates otherwise in the *Schedule of Medical Benefits*.

Dependent: Any of the following individuals: Dependent child(ren), spouse or domestic partner as those terms are defined in this document.

Dependent Child(ren): See also ([NAC 287.312](#))

For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the [Eligibility](#) section for details on QMCSO/NMSN),
- any other person who:
 - Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
 - Is unmarried.
 - Has not attained the age set forth in 45 C.F.R. § 147.120(a).
 - Either resides with the participant or is enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school or accredited trade or business school, on a full-time basis
 - Satisfies one of the following conditions:
 - a. Is currently under a permanent legal guardianship of the participant or his or her spouse or domestic partner pursuant to [chapter 159](#) of NRS; or
 - b. Was eligible to be claimed as a dependent on the federal income tax return of the participant or his or her spouse or domestic partner for the immediately preceding calendar year; and
 - Is in a relationship with the participant or his or her spouse or domestic partner that is like a child-parent relationship. The participant or his or her spouse or domestic partner must complete and submit to the Program an affidavit attesting to the facts of the relationship.

Disability: A determination by the Plan Administrator or its designee (after evaluation by a physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental

impairment such as intellectual disability, cerebral palsy, epilepsy, neurological disorder, or psychosis.

Domestic Partner: As defined by [NRS 122A.030](#).

Drug: See the definition for prescription drug.

Durable Medical Equipment: As defined by Centers for Medicare & Medicaid Services, the term DME is defined as equipment which, according to 42 CFR §414.202:

- Equipment that can withstand repeated use; and
- is primarily and customarily used for a medical purpose; and
- is not generally useful in the absence of an injury or illness; and
- is not disposable or non-durable; and
- is appropriate for the patient's home.

Durable medical equipment includes (but is not limited to) apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Elective Hospital Admission, Service or Procedure: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that they are medically necessary; and the charges for them are usual and customary and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule; and coverage for the services or supplies is not excluded (as provided in the *Exclusions* section); and the Plan Year maximum benefits for those services or supplies has not been reached.

Emergency: See the definition for Medical Emergency.

Emergency Medical Condition: A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Care: Medical and health services provided for an Emergency Medical Condition as defined above.

This Plan does not require precertification for medically necessary emergency services provided at any hospital in accordance with [NRS 695G.170](#). For information, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Emergency Services means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-PPO provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or

The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and

- The participant or beneficiary gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.

See also [NRS 695G.170](#).

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness, or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.

Employer: Unless specifically indicated otherwise when used in this document, employer refers to an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

Enteral Formulas: Enteral Formulas is subject to [NRS 689B.0353](#).

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Experimental and/or Investigational Services: See also [NRS 695G.173](#): Required provision concerning coverage for treatment received as part of clinical trial or study.

Unless mandated by law, the Plan Administrator, UM company, or its designee has the discretion and authority to determine if a service or supply is, or should be, classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator, UM company, or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply.
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
- In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
- With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered experimental and/or investigational if it is:
 - Approved by the FDA as an "Investigational new drug for treatment use"; or
 - Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease," as that term is defined in FDA regulations; or
 - Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

- The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

In determining if a service or supply is or should be classified as experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for precertification under the Plan's utilization management program:

- Medical records of the covered person.
- The consent document signed, or required to be signed, to receive the prescribed service or supply.
- Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply.
- Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including (but not limited to) "United States Pharmacopoeia Dispensing Information"; and "American Hospital Formulary Service".
- The published opinions of the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
- Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
- The latest edition of "The Medicare Coverage Issues Manual."

To determine how to obtain a precertification of any procedure that might be deemed to be experimental and/or investigational, see the *precertification* in the *Utilization Management* section.

Explanation of Benefits (EOB): When a claim is processed by the claims administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your Deductible, if your out-of-pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Expedited Appeal: If a participant appeals a decision regarding a denied request for precertification (pre-service claim) for an urgent care claim, the participant or participant's authorized representative can request an expedited appeal, either orally or in writing. Decisions

regarding an expedited appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

External Review: An independent review of an adverse benefit determination conducted by an external review organization.

External Review Organization: An organization that 1) conducts an external review of a final adverse benefit determination; and 2) is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.

Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Free-Standing Laboratory Facility: Free-standing laboratory facilities are stand-alone facilities that are not affiliated with a hospital system. Examples of preferred free-standing laboratory facilities include Labor Corp or Quest.

Formulary: A list of generic and brand name drug products available for use by participants. This is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

Gender Dysphoria: In accordance with [Senate Bill 163](#) from the 82nd Legislative Session in 2023: "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

- (1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.
- (2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.
- (3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.
- (4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.
- (5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.
- (6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

Generic; Generic Drug: A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the pharmacist as being generic. (See also the Prescription Drug section of the *Schedule of ~~Medical~~ Benefits* and the *Prescription Drug* subsection of the *Medical Exclusion* section).

Genetic Counseling: Counseling services provided before or in the absence of genetic testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of genetic testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from genetic testing, or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations. Tests that assist the health care practitioner in determining the appropriate course of action or treatment for a medical condition.

Gestational carrier: Gestational carrier means an adult woman who is not an intended parent and who enters into a gestational agreement to bear a child conceived using the gametes of other persons and not her own. [NRS 126.580.](#)

Government-Provided Services: Expenses for health care services provided to a covered participant that federal, state, or local law (e.g., Tricare/Champus, VA, except the Medicaid program), expenses for care required by a public entity and care for which there would not normally be a charge.

Health Care Facility: (for non-emergency services) is each of the following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act);
- and

- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, or other provider who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* section).

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency (as those terms are defined in this section).

Home Health Care Agency: An agency or organization that provides a program of Home Health Care and meets one of the following three tests:

- It is approved by Medicare; or
- It is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets the following requirements:
- It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or registered nurse to the home.
- It has a full-time administrator.
- It is run according to rules established by a group of professional health care providers including physicians and registered nurses.
- It maintains written clinical records of services provided to patients.
- Its staff includes at least one registered nurse, or it has nursing care by a registered nurse available.
- Its employees are bonded.
- It maintains malpractice insurance coverage.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." See also the *Exclusions* section of this document regarding homeopathic treatment and services. When the services of homeopaths are payable by this Plan (e.g., an office visit), the homeopath must be properly licensed to practice homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post-graduate courses or training in a program approved by the American Institute of Homeopathy.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a limited life expectancy. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family.

A hospice agency must meet one of the following tests:

- It is approved by Medicare; or is licensed as a hospice agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
 - It provides 24-hour-a-day, 7 day-a-week service.
 - It is under the direct supervision of a duly qualified physician.
 - It has a full-time administrator.
 - It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
 - The main purpose of the agency is to provide hospice services.
 - It maintains written records of services provided to the patient.
 - It maintains malpractice insurance coverage.
- A hospice agency that is part of a hospital will be considered a hospice agency for the purposes of this Plan.

Hospital: A public or private facility or institution, other than one owned by the U.S Government, licensed and operating according to law, that:

- Is legally operated in the jurisdiction where it is located.
- Is engaged mainly in providing inpatient medical care and treatment for injury and illness in return for compensation.
- Has organized facilities for diagnosis and major surgery on its premises.
- Is supervised by a staff of at least two physicians.

- Has 24-hour-a-day nursing service by registered nurses; and
- Is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or skilled nursing facility or similar institution; or a Long-Term Acute Care Facility (LTAC).

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, birth (or birthing) center, hospice, skilled nursing facility, sub-acute care facility, or other place for rest, custodial care, or the aged shall not be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician, and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be an illness only for coverage under this Plan. However, infertility is not an illness for coverage under this Plan.

Independent Freestanding Emergency Department: A health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Inherited Metabolic Disorder: See also NRS 689B.0353. A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates, or fats, as diagnosed by a physician using standard blood, urine, spinal fluid, tissue, or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an Inherited Metabolic Disorder under this Plan. See Special Food Products.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to teeth are payable under the medical Plan.

In-Network Provider: Means an In-Network provider that the network or one of its rental networks have contracted with or have arrangements with to provide health services to covered individuals. An In-Network provider has agreed to charge participants a discounted rate. To determine if a provider is an In-Network provider log on to www.pebp.state.nv.us <https://pebp.nv.gov/>. You may also call the number on the back of your ID card and a customer service representative can help you locate an In-Network provider.

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network services that are provided by a health care provider that is not a member of the PPO network.

In-Network Contracted Rate: The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the In-Network contracted amount may be applied to Out-of-Network provider charges.

Inpatient Services: Services provided in a hospital or other health care facility during the period when charges are made for room and board.

Intensive Care Unit: A section, ward, or wing within the hospital which:

- Is separated from other hospital facilities.
- Is operated exclusively for providing professional care and treatment for critically ill patients.
- Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use.
- Provides room and board; and
- Provides constant observation and care by registered nurses or other specially trained hospital personnel.

Intensive Outpatient Program: An intensive outpatient program (IOP) is a kind of treatment service and support program used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification. IOP operates on a small scale and does not require the intensive residential or partial day services typically offered by the larger, more comprehensive treatment facilities.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance Rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and or preserve the patient's functional level. Maintenance rehabilitation is not covered by the Plan.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are costlier than others that can achieve the same result.

Maximum Amount; Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Plan Administrator considering and after having analyzed:

- The reasonable and appropriate amount.
- The terms of the Plan.
- Plan negotiated and contractual rates with provider(s).
- The actual billed charges for the covered services; and

- Unusual circumstances or complications requiring additional time, skill, and experience in connection with a service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s).
- Medicare Allowable.

The Plan will reimburse the actual charge(s) if they are less than the Plan's Maximum Allowable Charge amount(s). The Plan has the discretionary authority to decide if a charge is reasonable and appropriate, as well as medically necessary. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary: Has the meaning ascribed to it in accordance with [NRS 695G.055](#): "Medically necessary" means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

1. Provided in accordance with generally accepted standards of medical practice;
2. Clinically appropriate with regard to type, frequency, extent, location and duration;
3. Not primarily provided for the convenience of the patient, physician or other provider of health care;
4. Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and
5. The most clinically appropriate level of health care that may be safely provided to the insured.

A medical or dental service or supply will be appropriate if:

- It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly

facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility:

- The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

Medically Necessary for External Review: Means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.

Medical management technique: Has the meaning ascribed to it within [NRS 695G](#) which means a practice which is used to control the cost or use/utilization of health care services, prescription drugs, or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Part A: Hospital insurance provided by the federal government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the federal government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the federal government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.

Medi-Span: A national drug pricing information database for drug pricing analysis and comparison.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a Midwife or certified as a Certified Nurse Midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe types of medications. See also the definition of Nurse.

Morbid Obesity: Characterized by body mass index $>40 \text{ kg/m}^2$ as defined by the National Library of Medicine.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage, or herbal tea. Note: Naturopathy providers, treatment, services, or substances are not a payable benefit under this Plan.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap, or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the *Schedule of ~~Medical~~ Benefits* are covered by this Plan. All others are not.

Non-Network: See *Out-of-Network*.

Non-PPO emergency facility: An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively

Non-PPO Provider or Non-Participating Provider: A health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA) and authorized to administer Anesthesia in collaboration with a physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners under the laws of the state or jurisdiction where the services are rendered.

Obesity: Body mass index of 30 kg/m² or higher is used to identify individuals with obesity as defined by the National Library of Medicine.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills to regain independence.

Office Visit: A direct personal contact between a physician or other health care practitioner and a patient in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is an office visit for the purposes of this Plan.

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism, Retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Orthotic (Appliance or Device): A type of corrective appliance or device, either customized or available "over the counter," designed to support a weakened body part, including (but not limited to) crutches, custom designed corsets, leg braces, extremity splints, and walkers. For the

purposes of the medical Plan, this definition does not include dental orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

Other Prescription Drugs: Drugs that require a prescription under state law but not under federal law.

Out-of-Network Rate: With respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system

Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network services that are provided by a health care provider that is a member of the PPO. Greater expense could be incurred by the participant when using Out-of-Network providers.

Out-of-Pocket Maximum (OOPM): The maximum amount of Coinsurance each covered person or family is responsible for paying during a Plan Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of eligible covered expenses for the remainder of the Plan Year. See the section on Out-of-Pocket Maximum in the *Medical Expense Coverage* section for details about what expenses do not count toward the Out-of-Pocket Maximum.

Outpatient Hospital Laboratory and Outpatient Hospital-Based Laboratory Draw Station: Outpatient hospital-based laboratory facilities include lab services performed in a hospital outpatient setting. Outpatient hospital-based laboratory draw stations are hospital affiliated whereby the draw station collects specimens and sends them to the central hospital lab for processing.

Outpatient Services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Partial Hospitalization Service: Also known as PHP, is a type of program used to treat mental illness and substance abuse in which the patient continues to reside at home but commutes to a treatment center up to seven days a week. This service model focuses on the overall treatment of the individual and is intended to avert or reduce in-patient hospitalization. Services are typically provided in either a hospital setting or by a free-standing community mental health center. Treatment during a typical day may include group therapy, psych-educational groups, skill building, individual therapy, and psychopharmacological assessments, and check-ins. Programs are available for the treatment of alcoholism and substance abuse, Alzheimer's disease, anorexia

and bulimia, depression, bipolar disorder, anxiety disorders, schizophrenia, and other mental illnesses.

Participant: The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse or dependent of a retiree. [NAC 287.095](#)

Participating Provider: A health care provider who participates in the Plan's Preferred Provider Organization (PPO).

Passive Rehabilitation: Refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until the patient can achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be medically necessary for the purposes of this Plan.

Pharmacy: A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery, or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform Activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician Assistant (PA): A person legally licensed as a physician assistant, who acts within the scope of his or her license and acts under the supervision of a physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising physician; under the laws of the state or jurisdiction where the services are rendered.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

Plan Year Deductible: The amount you must pay each Plan Year before the Plan pays benefits.

Plan Year Maximum Benefits: The maximum amount of benefits payable each Plan Year for certain medical expenses incurred by any covered Plan participant (or covered family member of the Plan participant).

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

Positive Annual Open Enrollment Period: This process requires that each eligible employee or eligible retiree affirmatively make his or her benefit elections during the PEBP annual enrollment period. Even if you do not want to make any coverage changes, you must affirmatively make your elections, or you will default to self-coverage only under the PEBP base Plan.

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis, 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury.

Precertification (preauthorization, prior authorization): Is a process used by the UM company and Pharmacy Benefit Manager to determine if a prescribed procedure, including, but not limited to inpatient admission, concurrent review, DME, outpatient services, or medication are medically necessary before the services and supplies are received. A precertification is not a guarantee of payment.

Preferred Provider Organization (PPO): A group or network of health care providers (e.g., hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted or reduced rates.

Prescribed for a Medically Necessary Indication: The term medically necessary indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

Prescription Drugs: For the purposes of this Plan, prescription drugs include:

- **Federal Legend Drugs:** Any medicinal substance that the Federal Food, Drug, and Cosmetic Act requires to be labeled, “Caution - Federal law prohibits dispensing without prescription”.
- **Other prescription drugs:** drugs that require a prescription under state law but not under federal law; or
- **Compound drugs:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prescription Prior Authorization (PA): Also known as “coverage review,” this is a process the Plan’s Pharmacy Benefit Manager might use to decide if your prescribed medicine will be covered. The Plan uses this to help control costs and to ensure the medicine being prescribed is an effective treatment for the condition.

Primary Care Doctor or Primary Care Physician (PCP): Per NRS 695G.060, “Primary care physician” means a physician or group of physicians who:

1. Provides initial and primary health care services to an insured;
2. Maintains the continuity of care for the insured; and
3. May refer the insured to a specialized provider of health care.

This may include a physician in family practice, internal medicine, pediatrics, obstetrics and gynecology.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: Means the Public Employees’ Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

Prophylactic Surgery: A surgical procedure performed for (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth are performed by a dentist or dental hygienist.

Prospective Payment System (PPS): This Plan follows CMS's Prospective Payment System (PPS) where the Plan's payment is based on a predetermined, fixed amount payable to a facility for inpatient or outpatient hospital services. The Plan will not allow separate reimbursement for specific HCPCS supplies, DME, orthotics, prosthetics, biological, and drugs billed on a HCFA claim form by any physician or other qualified healthcare professional in the following facility POS (place of service) 19, 21, 22, 23, and 24, see the following POS descriptions:

- **POS 19 Off Campus – Outpatient Hospital:** A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **POS 21 Inpatient Hospital:** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
- **POS 22 On Campus – Outpatient Hospital:** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision physicians to patients admitted for a variety of medical conditions.
- **POS 23 Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness and injury is provided.
- **POS 24 Ambulatory Surgery Center:** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Prosthetic Appliance (or Device): A type of corrective appliance or device designed to replace all or part of a missing body part, including (but not limited to) artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* Section).

Qualified Medical Child Support Orders (QMCSO): QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce, and also include a National Medical Support Notice. A QMCSO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- Specifies your last known name and address and the child's last known name and address.
- Describes the type of coverage to be provided, or how the type of coverage will be determined.
- States the period to which it applies; and
- Specifies each plan to which it applies.

The QMCSO cannot require the Plan to cover any type or form of benefit that they do not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions. You and the affected child will be notified if an order is received.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in [29 CFR 716-6\(c\)](#).

Quantity Limit: The maximum amount of a medication the Plan covers during a period of time. These limits are set for safety reasons and to help reduce costs.

Reasonable and/or Reasonableness: Means charges for services or supplies which are necessary for the care and treatment of an illness or injury. The determination that charges are reasonable will be made by the Plan Administrator taking into consideration the following:

- The facts and circumstances giving rise to the need for the service or supply.
- Industry standards and practices as they are related to similar scenarios; and
- The cause of the injury or illness necessitating the service or charge.

The Plan Administrator's determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and Organizations; (b) The Centers for Medicare and Medicaid Services (CMS); (c) Centers for Disease Control and Prevention; and (d) The Food and Drug Administration.

To be reasonable, charges must follow generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether a charge is reasonable. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charges that are not reasonable and therefore not eligible for payment by the Plan.

Recognized Amount: means (in order of priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

For air ambulance services furnished by Non-PPO providers,

Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease, or tumor, or for breast reconstruction following a total or partial mastectomy.

Reference Based Pricing/Reference Price: A methodology that determines the cost for a covered service based on a market or industry benchmark or reference price. The Plan Administrator may utilize this method in determining the Maximum Allowable Charge.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, or medically necessary treatment of a behavioral health condition, and that is performed by a licensed therapist acting within the scope of his or her license. See the *Schedule of ~~Medical~~ Benefits* and the *Exclusions* section of this document to determine the extent to which rehabilitation therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

Reimbursable Payments: Payments made by this Plan for benefits, including any payment for a covered pre-existing condition that are or become the responsibility of another party under the subrogation provisions as described in this MPD.

Rescission: A cancellation or discontinuance of coverage under the Plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the Plan if

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Retiree: Unless specifically indicated otherwise, when used in this document, Retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule.

Second Opinion: A consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

Serious and Complex Condition: With respect to a participant, beneficiary, or enrollee under the Plan one of the following:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a condition that is—
 - is life-threatening, degenerative, potentially disabling, or congenital; and
 - requires specialized medical care over a prolonged period of time.

Service Area: The geographic area serviced by the In-Network providers who have agreements with the Plan's network.

Sickle Cell Disease: An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable. See also [NRS 439.4927](#).

Significantly Inferior Coverage: The PEBP Board has defined Significantly Inferior Coverage as either:

- A mini-med or other limited benefit plan; or
- Catastrophic coverage plans with a Deductible equal to or greater than \$5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility or Extended Care/Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, sick people or people with disabilities, and that meets the following requirements:

- Is licensed pursuant to state and local laws.
- Is operated primarily for providing skilled nursing care and treatment for individuals convalescing from injury or illness.

- Is approved by and is a participating facility with Medicare.
- Has organized facilities for medical treatment.
- Provides 24-hour-a-day nursing service under the full-time supervision of a physician or registered nurse.
- Maintains daily clinical records on each patient.
- Has available the services of a physician under an established agreement.
- Provides appropriate methods for dispensing and administering drugs and medicines.
- Has transfer arrangements with one or more hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one physician; and
- Is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

A skilled nursing facility that is part of a hospital, as defined in this document, will be considered a skilled nursing facility for the purposes of this Plan.

Special Food Product: ([NRS 689B.0353](#)) A food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Specialist Physician: A doctor who has completed advanced education and training in a specific field of medicine. Per CMS, a specialist is a doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication.

Spinal Manipulation / Chiropractic Care: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by physicians.

Spouse: The employee's lawful spouse. The Plan will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

Standard Plan Benefits (Standard Benefits): Standard Plan Benefits or Standard Benefits under this Plan means the participant is covered under the Plan's Standard Benefits and is not eligible

for enhanced benefits due to non-participating and or engaging in programs such as the Obesity Care and Overweight Management Programs.

State: When capitalized in this document, the term State means the State of Nevada.

Step Therapy: see also “Medical Management technique.” A process designed to help control high medicine costs. If the Plan applies step therapy to your medication, it will require that you try a lower-cost medication that is proven effective to treat your condition, before it will cover a higher-cost medicine. If the lower cost medicine does not treat your condition effectively, the Plan’s coverage will “step” you to a higher-cost medicine to find a medicine that treats your condition effectively at the lowest possible cost.

The Plan also complies with step therapy for treatment of cancer or cancer symptom that is part of step therapy protocol per [NRS 695G.1675](#).

Sub-acute Care Facility: A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide sub-acute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, to the patient’s home or to a suitable skilled nursing facility, and that meets of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Sub-Acute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and
- It maintains on its premises facilities necessary for medical care and treatment; and
- It provides services under the supervision of physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse; and
- It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
- It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of behavioral health disorders and chemical dependency.

Surgery/Surgeries: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the claims administrator will determine which

multiple surgical procedures will be considered as primary, secondary, bilateral, add-on, or separate (incidental) procedures for determining benefits under this Plan.

Multiple Surgical Procedure Allowances:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: usual and customary, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Bilateral secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Add-on to secondary procedure in same operative area: limited to 100% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Separate (incidental) procedure in same operative area as any of the above: not covered.
- Separate operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.

Telehealth: Telehealth means the delivery of services from a provider of health care to a patient at a different location using information and audio-visual communication technology, not including facsimile, or electronic mail. See also [NRS 629.515](#)

Telehealth is a general term used to describe clinical services provided to patients through electronic communications not through a vendor. This can be patient-to-physician. Examples include patient consultation with a specialist that is out of the patient's geographical area or patient has a virtual visit with their primary care physician. Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health.

Telemedicine: Telemedicine (vendor/virtual visit) is the practice of medicine using technology to deliver care at a distance via electronic communications through a vendor.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome:

The Temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring, or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Termination: Under the No Surprises Act, includes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Therapist: A person trained in and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy. *See the Occupational, Physical and Speech Therapy* section.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. (See the *Schedule of ~~Medical~~ Benefits and Exclusions* section for additional information regarding transplants. See also the *Utilization Management* section of this document for information about precertification requirements for transplantation services).

Xerographic: Refers to transplants of organs, tissues, or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xerographic transplants are not covered by this Plan, except heart valves.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate, even though health and life are not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include (but are not limited to) fever, sprains, bone, or joint injuries, continuing diarrhea, vomiting, or bladder infections.

Urgent Care Claim: Means a claim for benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not urgent care claims could seriously jeopardize the participant's life, health, or the ability to regain maximum function by waiting for a routine appeal decision. An urgent care claim also means a claim for benefits that, in the opinion of a physician with knowledge of the participant's medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for precertification of an urgent care service was denied, the participant could request an expedited appeal for the urgent care claim.

Urgent Care Facility: A public or private hospital-based or free-standing facility, which includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance when the facility is open.

Usual and Customary: Covered expenses which are identified by PEBP, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) most patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or

“area” shall be defined as a metropolitan area, country, or such greater area as is necessary to obtain a representative cross- section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made.

To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, subject to the Plan’s Maximum Allowable Charge or negotiated fee schedule for any procedure, service, or supply, and whether a specific procedure, service or supply is usual and customary. Usual and customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, Average Wholesale Price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

Utilization Management (UM): A managed care process to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include (but is not limited to): precertification; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM, utilization review services, UR services, utilization management, concurrent review, or retro review services) are provided by licensed health care professionals employed by the utilization management company operating under a contract with the Plan.

Utilization Management Company (UM company): The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan’s utilization management services.

Visit: See the definition of office visit.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary, even though they are not provided because of illness, injury, or congenital defect. The Plan's coverage of well-baby care is described under *Preventive Care/Wellness Services* and in the *Schedule of ~~Medical~~ Benefits*.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.

DRAFT

Public Employees' Benefits Program



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Low-Deductible (LD) PPO Plan: PEBP Self-Funded Health Plan

Coverage Period: 07/01/2023 – 06/30/2024
Coverage for: Employee + Family | **Plan Type:** PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pebp.state.nv.us. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 775-684-7000 or 1-800-326-5496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-network</u> : Employee only: \$0 Family: \$0 Individual w/in Family: \$0. <u>Out-of-network</u> : Employee only: \$500 Family: \$1000; Individual w/in Family \$500	Generally, you pay all costs up to the <u>deductible</u> , except <u>preventive services</u> and certain <u>copayments</u> . Individuals within the family must meet their own individual <u>deductible</u> until the total expenses paid by all family members meets the overall family <u>deductible</u> . <u>In-network</u> and <u>Out-of-Network Deductibles</u> accumulate separately. Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>In-network Preventive care</u> services are covered before you meet your <u>deductible</u> .	Some items and services covered if the <u>deductible</u> has not been met; however, a <u>copayment</u> or <u>coinsurance</u> may apply. Example: <u>preventive services</u> and medications on the preventive drug list. For more additional limitations, refer to the LD Master <u>Plan</u> Document (MPD). For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	The <u>Plan</u> does not include separate <u>deductibles</u> for specific services. Separate <u>deductibles</u> apply to <u>network providers</u> and <u>out-of-network providers</u> . You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>Network providers</u> : Employee only: \$4,000; Family \$8,000, individual within Family: \$4,000. <u>Out-of-network</u> : Employee only: \$10,600; Family \$21,200	The <u>in-network Out-of-pocket limit</u> is the most an Individual or a Family must pay in a <u>Plan</u> Year for Eligible Medical Expenses. The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Penalties, <u>premiums</u> , balance-billing charges, <u>excluded services</u> , <u>prescription drug copay</u> assistance, non-covered services, and health care this <u>plan</u> doesn't cover.	Penalties you pay for failure to obtain required <u>preauthorization</u> , <u>premiums</u> , non-use of 30-day Express Advantage <u>Network</u> , non-compliance with 90-day retail/mail order, manufacturer-funded <u>copay</u> assistance, non-use of SaveonSP (for non-essential <u>specialty drugs</u>); penalties of balance-billing, and non-covered supplies and services. Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

For more information about limitations and exceptions, see the Low Deductible PPO Plan Master Plan Document at www.pebp.state.nv.us.

Will you pay less if you use a <u>network provider</u>?	Yes. See www.pebp.state.nv.us or call 1-888-763-8232 for a list of participating <u>providers</u> .	You will pay less if you use a <u>network provider</u>. You will pay more if you use an out-of-<u>network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need <u>specialist referral</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	<u>Primary care</u> visit to treat an injury or illness	\$30 <u>copay</u> /visit	50% <u>coinsurance</u>	<u>Balance billing</u> applies to <u>out-of-network claims</u> , except as provided by federal law.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	50% <u>coinsurance</u>	<u>Balance billing</u> applies to <u>out-of-network claims</u> , except as provided by federal law.
	<u>Preventive care/screening/immunization</u>	No charge	Not Covered	<u>Preventive care</u> must be provided in-network. Refer to the LD MPD for exceptions for explanations and limitations. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Routine labs must be performed at a free-standing lab. <u>Balance billing</u> applies to <u>out-of-network claims</u> , except as provided by federal and state law.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	May require <u>preauthorization</u> . <u>Balance billing</u> applies to <u>out-of-network claims</u> , except as provided by federal or state law.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.pebp.state.nv.us	Generic	30-day/\$10 <u>copay/prescription</u> 90-day/\$20 <u>copay/prescription</u>	Not Covered	30-day supply for short-term medications must be filled at Express Advantage <u>Network</u> (EAN) pharmacy to avoid a <u>copay</u> surcharge. Penalty applies if you do not use a Smart90 retail pharmacy or home delivery for long-term medications. Some drugs require <u>preauthorization</u> . Penalty applies for not participating in the SaveOnSp for drugs on the Non-Essential Benefit <u>Specialty drug</u> List. <u>Copay</u> assistance for <u>specialty drugs</u> do not apply to <u>deductible</u> or <u>out-of-pocket limit</u> . Must use the <u>Plan's</u> specialty pharmacy.
	Preferred brand	30-day/\$40 <u>copay/prescription</u> 90-day/\$80 <u>copay/prescription</u>	Not Covered	
	Non-preferred brand	30-day/\$75 <u>copay/prescription</u> 90-day/ \$150 <u>copay/prescription</u>	Not Covered	

For more information about limitations and exceptions, see the Low Deductible PPO Plan Master Plan Document at www.pebp.state.nv.us.

	<u>Specialty drugs</u>	30% <u>coinsurance</u>	Not Covered	
If you have outpatient surgery	Facility fee (ambulatory surgery center); physician /surgeon fees	\$500 <u>copay</u> /visit	50% <u>coinsurance</u>	Requires <u>preauthorization</u> . If you do not get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service. <u>Balance billing</u> applies to <u>out-of-network</u> , except as provided by federal law.
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$750 <u>copay</u> /visit	\$750 <u>copay</u> /visit	<u>Emergency room care</u> , <u>emergency medical transportation</u> , paid as <u>in-network</u> ; <u>Balance billing</u> applies to <u>out-of-network emergency medical transportation</u> , subject to the Plan's Maximum Allowable Charge, except as provided by federal or state law. See the LD PPO MPD.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	\$80 <u>copay</u> /visit	\$80 <u>copay</u> /visit	<u>Balance billing</u> applies to <u>out-of-network urgent care</u> , except as provided by federal or state law.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required or 50% penalty applies. <u>Balance billing</u> applies to <u>out-of-network</u> , except as provided by federal or state law
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient Visit	~~\$30~~ <u>copay</u> /office visit	50% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	\$0 <u>copay</u> /office visit	50% <u>coinsurance</u>	Routine prenatal care obtained from <u>Plan Provider</u> is covered at no charge. Maternity care, including non-routine maternity care, may include tests and services subject to <u>cost sharing</u> as described elsewhere in this SBC. (i.e., Ultrasound, Lab). <u>Cost sharing</u> does not apply for <u>preventive services</u> ." Depending on the type of services, a [<u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u>] may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. 60 visits/ <u>plan year</u> .
	<u>Outpatient rehabilitation services</u>	\$50 <u>copay</u> per visit	50% <u>coinsurance</u>	<u>Preauthorization</u> required. Limit visits to 90 combined (OT, PT, ST) per year.
	<u>Inpatient rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. Limited to 60 days per <u>Plan Year</u> related to the same cause.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for equipment over \$1,000.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required after 185 days.
If your child needs dental or eye care	Children's eye exam	\$10 <u>copayment</u>	\$10 <u>copayment</u>	Limited to 1 routine vision exam <u>plan year</u> . \$100 maximum benefit.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Coverage available under separate dental <u>plan</u> .

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)			
• Cosmetic surgery • Long-term care	• Non-emergency care when traveling outside the U.S. • approved drugs	• Orthodontia expenses • Private-duty nursing • Routine foot care	
Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your <u>plan</u> document.)			
• Acupuncture • Bariatric surgery	• Chiropractic care • Dental care (Adult) • Hearing aids	• Infertility treatment • Routine Eye Care (Adult) • Weight Loss Programs	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-326-5496 or 775-684-7000. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact HealthSCOPE Benefits Customer Service at 1-888-763-8232

Does this plan provide Minimum essential coverage? Yes.

For more information about limitations and exceptions, see the Low Deductible PPO Plan Master Plan Document at www.pebp.state.nv.us.

Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan does not meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: See Attachment A

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist [copay]</u>	\$50
■ Hospital (facility) <u>[coinsurance]</u>	20%
■ Other <u>[coinsurance]</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$2,540
What is not covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,638

Managing Joe's type 2 Diabetes*

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist [copay]</u>	\$50
■ Hospital (facility) <u>[coinsurance]</u>	20%
■ Other <u>[coinsurance]</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,120
What is not covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,136

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist [copay]</u>	\$50
■ Hospital (facility) <u>[coinsurance]</u>	20%
■ Other <u>[coinsurance]</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$750
<u>Coinsurance</u>	\$410
What is not covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,160

The plan would be responsible for the other costs of these EXAMPLE covered services.

Attachment A

Language Access Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-763- 8232 (TTY Users, Dial 7-1-1)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-763- 8232 (TTY Users, Dial 7-1-1)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-763- 8232 (TTY Users, Dial 7-1-1)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-763- 8232 (TTY Users, Dial 7-1-1) 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-763- 8232 (TTY Users, Dial 7-1-1)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በጎጃ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-763- 8232 (ማስማት ለተሳናቸው፡(TTY Users, Dial 7-1-1)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้ฟรี บริการช่วยเหลือ ทางภาษา ได้ฟรี โทร 1-888-763- 8232 (TTY Users, Dial 7-1-1)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-763- 8232 (TTY Users, Dial 7-1-1) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-7-1 (رقم هاتف الصم والبكم: 1-888-763-8232)

В Н И М А Н И Е : Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-763- 8232 (телетайп: 7-1-1).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-763- 8232 (ATS: 7-1-1).

تماس بگیریډ 1-888-763-8232 (TTY: 7-1-1) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. یا

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-888-763- 8232 (TTY Users, Dial 7-1-1)

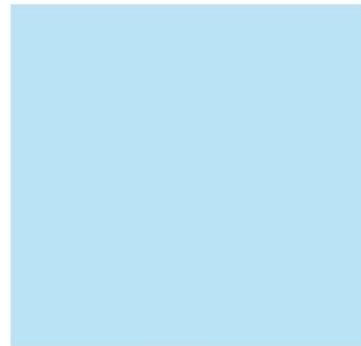
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-763- 8232 (TTY Users, Dial 7-1-1)

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-888-763- 8232 (TTY Users, Dial 7-1-1)

EXCLUSIVE PROVIDER ORGANIZATION MASTER PLAN DOCUMENT

Plan Year 2024~~3~~5

(Effective July 1, 202~~3~~4 – June 30, 202~~5~~4)





NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

~~775-684-7000~~

702-486-3100

or 1-800-326-5496

www.pebp.state.nv.us



Public Employees' Benefits Program

3427 Goni Road, Suite 109

Carson City, NV 89706

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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

~~“One Time HSA or HRA Funding for Active State Employees” — Add language that clarifies “Legislatively approved enhancements, such as HSA/HRA funding and enhanced basic life insurance amounts may be subject to change in subsequent plan years.”~~

Utilization Management

~~“Inpatient Admissions” — Remove “All” and “Same day surgeries.” Refer to the Outpatient and Physician Surgery category for outpatient and same day surgery prior authorization requirements.~~

Schedule of Medical Benefits

~~“Continuity of Coverage” which is within the “No Surprises Act” — Add the clarifying statement “Per NRS 695G.164, the Plan provides coverage for continued medical treatment for a medical condition from a provider of health care whose contract with the insurer is terminated during active medically necessary treatment. Unless excepted, this is until the later of:~~

- ~~• The 120th day after the date the contract is terminated; or~~
- ~~• If the medical condition is pregnancy, the 45th day after:~~
 - ~~○ The date of delivery; or~~
 - ~~○ If the pregnancy does not end in delivery, the date of the end of the pregnancy.”~~

“Preventative Services”

- ~~• Update mammogram by removing specification to 2-D or 3-D for mammograms.~~
- ~~• While already covered, specify Prostate Cancer Screening to coincide with NRS 695G.177: Add “Limited to 1 preventative per plan year and offered in accordance with NRS 695G.177 which includes reference to the American Cancer Society guidelines.”~~

Schedule of Prescription Drug Benefits

~~The Pharmacy Benefit Manager, Express Scripts, has offered a benefit for our members not expressly noted in the plan documents. Add “Diabetes Care Value: Express Scripts offers a program that supports members with diabetes (type 1 and 2) pre-diabetes, and even common comorbidities like obesity. ESI’s digital diabetes prevention and obesity solution offers a personalized coaching and weight loss program, including an app-connected scale, to help patients avoid type 2 diabetes. The Diabetes Care Value is administered by Express Scripts and qualifying participants will receive a personal invitation, with instructions, to join the program.”~~

Benefit Limitations and Exclusions

~~“Abortion” — Add “This plan provides abortion benefits in accordance with NRS 422.250.”~~

~~“Corrective Appliance” — Update limitation language for motorized modes of transportation to include “determined to be not medically necessary.”~~

~~“Maternity/Family Planning” — Clarified “Expenses related to delivery associated with a newborn of a pregnant dependent child.”~~

~~Appeals~~

~~Updated contact information for Office of Consumer Health Assistance: Removed fax number and updated website address.~~

~~Coordination of Benefits~~

~~Added information from the Health and Welfare Wrap Document for member benefit.~~

~~Key Terms and Definitions~~

~~“Medically Necessary” — Update the definition for Medically Necessary to include “Has the meaning ascribed to it in accordance with NRS 695G.055.”~~

~~“Step Therapy” — Add to the definition to include “see also “Medical Management technique” and “The Plan also complies with step therapy per NRS 695G.1675.”~~

~~Add “Medical management technique: Has the meaning ascribed to it within NRS 695G which means a practice which is used to control the cost or use/utilization of health care services, prescription drugs, or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.”~~

Outcomes from the 82nd Legislative Session 2023

Utilization Management

~~“Outpatient and Physician Diagnostic Services” Update to clarify that Genetic Testing includes Biomarker Testing as this is generally used interchangeably. This is related to Assembly Bill 155. “Gender Dysphoria” Update to remove “Coverage for procedures is based on the UM company’s clinical policy for medical necessity.” Added “In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.”~~

Schedule of Medical Benefits

~~“Genetic Testing” Add “Biomarker testing: In accordance with Assembly Bill 155 from the 82nd Legislative Session in 2023, the Plan provides benefits for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.”~~

~~“Women’s Contraceptives” under “Preventative Services” Add plan language “In accordance with Senate Bill 280 from the 82nd Legislative Session in 2023, the Plan provides benefits for contraceptive injection or the insertion of a device at a hospital immediately after an insured gives birth.”~~

~~“Gender Dysphoria” Remove limitations and add to plan language:~~

~~“In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.~~

~~This plan does not discriminate on the basis of gender identity or expression. Claim or coverage appeal shall include a consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment. The plan does not provide coverage cosmetic benefits as defined by Senate Bill 163.~~

~~Cosmetic Surgery means:~~

- ~~• Means a surgical procedure that:

 - ~~○ Does not meaningfully promote the proper function of the body~~
 - ~~○ Does not prevent or treat illness or disease; and~~~~

- ~~○ Is primarily directed at improving the appearance of a person.~~
- ~~● This includes, without limitation, cosmetic surgery directed at preserving beauty."~~

~~Prescription Drug Benefits~~

Add to plan language:

~~"In accordance with Assembly Bill 156 from the 82nd Legislative Session in 2023, the Plan provides benefits for substance use disorder including coverage for all drugs approved by the United States Food and Drug Administration to provide medication assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone."~~

~~"In accordance with Senate Bill 167 from the 82nd Legislative Session in 2023, the Plan provides prescription benefits for psychiatric conditions for drugs that are approved by the Food and Drug Administration or the use of a drug to treat a psychiatric condition that is supported by medical or scientific evidence when prescribed by a Provider acting within the scope of their license. These prescription drugs are not subject to medical management techniques, such as step therapy."~~

~~Benefit Limitations and Exclusions~~

~~"Cosmetic Services and Surgery" — Add language and clarified: "Breast augmentation/augmentation mammoplasty excluded, except as otherwise covered and described above." This is related to Senate Bill 163 from the 82nd Legislative Session in 2023.~~

~~"Gender Dysphoria and/or Gender Services" — Related to Senate Bill 163 from the 82nd Legislative Session in 2023:~~

~~Remove "No more than one genital surgery in the individual's lifetime when covered under any current or previous PEBP health plan." And "A surgery to reverse a surgery to treat gender dysphoria will not be covered."~~

~~Add "The Plan provides benefits to individuals seeking services for the treatment of gender dysphoria and gender incongruence in accordance with Senate Bill 163 from the 82nd Legislative Session in 2023."~~

~~Key Terms and Definitions~~

~~"Gender Dysphoria" — Change definition: "In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023: "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:~~

- ~~(1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.~~

- ~~(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.~~
- ~~(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.~~
- ~~(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.~~
- ~~(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.~~
- ~~(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth."~~

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP offers medical, vision, dental, and life insurance, in addition to flexible spending accounts, and other voluntary benefits for eligible state and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may access whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and plan requirements. These plans include the Consumer Driven Health Plan (CDHP), Exclusive Provider Organization (EPO) Plan, ~~Low Deductible~~ PPO (Low Deductible) Plan, and the Health Plan of Nevada HMO Plan. You are also encouraged to research plan provider access and quality of care in your service area.

PEBP participants choosing this Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the Active Employee Health and Welfare Wrap Plan, Retiree Health and Welfare Wrap Plan, Section 125 Document, and the PEBP Enrollment and Eligibility Master Plan Document. These documents are available at ~~www.pebp.state.nv.us~~<https://pebp.nv.gov/> or by calling 775-684-7000, 702-486-3100, or 1-800-326-5496.

Master Plan Documents are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted in the Active Employee Health and Welfare Plan Document and Retiree Health and Welfare Wrap Plan Document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the *Participant Contact Guide*.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,
Public Employees' Benefits Program

Introduction

This Master Plan Document describes the Exclusive Provider Organization (EPO) Plan. This Plan is available to eligible employees, retirees and their dependents participating in the Public Employees' Benefits Program, hereafter referred to as PEBP.

The Exclusive Provider Organization Plan is a self-funded plan administered by PEBP and governed by the State of Nevada. The benefits offered with the Exclusive Provider Organization Plan includes medically necessary behavioral health, medical, prescription drug, vision, and dental coverage. Additional benefits include basic life insurance for active employees and eligible retirees. The medical and prescription drug benefits are described in this document. The dental benefits are described in the [PEBP Dental Plan and Summary of Benefits for Life Insurance](#) Master Plan Document. An independent third-party Claims Administrator pays the claims for medical, dental and vision benefits. An independent Pharmacy Benefit Manager pays the claims for prescription drug benefits.

~~The Plan and this document is~~are intended to comply with [Chapter 287 of the Nevada Revised Statutes \(NRS\)](#)~~Chapter 287~~, [Chapter 287 of the Nevada Administrative Code \(NAC\)](#)~~287 as amended~~, and [all other applicable certain](#) provisions of [NRS 695G and NRS 689B](#)~~Nevada law~~. ~~The Plan Sponsor certifies that this article incorporates the provisions set forth in 45 CFR Section 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii)~~Additionally, PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA).

The Plan described in this document is effective **July 1, 2023**~~34~~, and unless stated differently, replaces other Exclusive Provider Organization Plan medical and prescription drug benefit plan documents/summary plan descriptions provided to you. This document will help you understand and use the benefits provided by PEBP. You should review it and show it to members of your family who are or will be covered by the Plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims and your responsibilities to provide necessary information to the Plan. Be sure to read the *Benefit Limitations and Exclusions* and *Key Terms and Definitions* sections. Remember, not every expense you incur for health care is covered by this Plan. Provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, please contact PEBP at the number listed in the *Participant Contact Guide* section.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Per [NRS 287.0485](#) no officer, employee or retiree of the State has any inherent right to benefits provided under thePEBP.

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Suggestions for Using this Document:

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The Table of Contents provides you with an outline of the sections.
- The *Participant Contact Guide* helps you become familiar with PEBP vendors and services they provide.
- The *Participant Rights* section describes your rights and responsibilities as a participant of this Plan.
- The *Key Terms and Definitions* [section](#) explains many technical, medical, and legal terms that appear in the text.
- The *Eligible Medical Expenses* and *Non-Eligible Medical Expenses, Summary of ~~Medical~~ Benefits* and *Schedule of ~~Medical~~ Benefits*, and *Benefit Limitations and Exclusions* sections describe your benefits in more detail.
- The *Preventive ~~Care/Wellness~~ Services* [section provides](#) wellness information that can help you proactively manage your health.
- The *Utilization Management* section provides information on what health care services require precertification and the process to request precertification.
- The *Claims Administration* section describes how benefits are paid and how to file a claim.
- The *Appeals ~~Procedure~~* section describes how to request a review (appeal) if you are dissatisfied with a claims decision.
- The *Coordination of Benefits* section describes situations where you have coverage under more than one health care plan, including Medicare

Accessing Other Benefit Information:

You will also want to access the following documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, Consolidated Omnibus Budget Reconciliation Act (COBRA), third-party liability and subrogation, Health Insurance Portability and Accountability Act (HIPAA) and Privacy and Security and mandatory notices. These documents are available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

- ~~State of Nevada PEBP Active Employee Health and Welfare Wrap Plan~~[State of Nevada PEBP Active Employee Health and Welfare Wrap Plan](#)
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan
- ~~Consumer Driven Health Plan (CDHP) Master Plan Document~~[Consumer Driven Health Plan \(CDHP\) Master Plan Document](#)
- ~~CDHP Summary of Benefits and Coverage for Individual and Family~~[CDHP Summary of Benefits and Coverage for Individual and Family](#)
- Low Deductible PPO Plan Master Plan Document
- ~~PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan~~

~~Document~~ PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document

- ~~Exclusive Provider Organization Plan Master Plan Document~~ Exclusive Provider Organization Plan Master Plan Document
- ~~Exclusive Provider Organization Plan Summary of Benefits and Coverage for Individual and Family~~ Exclusive Provider Organization Plan Summary of Benefits and Coverage for Individual and Family
- ~~Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage~~ Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- ~~PEBP Enrollment and Eligibility Master Plan Document~~ PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- ~~Section 125 Health and Welfare Benefits Plan Document~~ Section 125 Health and Welfare Benefits Plan Document
- ~~Medicare Retiree Health Reimbursement Arrangement Summary Plan Description~~ Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

Participant Rights

You have the right to:

- Participate with your health care professionals in your health care decisions and have your health care professionals give you information about your condition and your treatment options.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with State and Federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and providers and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's participants' rights and responsibilities policies.
- Express, respectfully and professionally, any concerns you may have about PEBP or any benefit or coverage decisions the Plan, or the Plan's designated administrator, makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing future treatment and be informed by your physician(s) of the medical consequences.

Summary of the EPO Plan Components

The Exclusive Provider Organization (EPO) Plan is a PEBP administered plan which provides In-Network benefits. As a member, you receive coverage for many medically necessary services and supplies, subject to any limits or exclusions in the Plan. However, apart from exceptional circumstances, such as emergent care and urgent care, this Plan only covers services when accessing Exclusive Provider Organization Plan providers within the network.

Highlights of the Plan

- This Plan is available to participants residing in the following northern Nevada counties: Carson City, Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Pershing, Storey, Washoe, and White Pine.
- This Plan provides open access to most specialists within the northern Nevada area. With open access, participants can see In-Network specialist care physicians without an Out of Area gap exception.
- **This Plan is a northern Nevada regional plan and does not provide coverage outside of 14 counties** listed in on the first point without an Out of Area gap exception unless the health care services are rendered as part of an emergency room visit, urgent care visit, or when the requested treatment is prior authorized by the utilization management company.
- Covers eligible preventive care services at 100% when using In-Network providers (refer to the *Preventive Services* section for more information); and
- Provides access to In-Network medical and prescription drug coverage.
- Provides a Plan Year Individual and Family Deductible and Out-of-Pocket Maximum for Eligible Medical Expenses.
- Health care resources and tools to assist you in making informed decisions about your and your family's health care services. For more information log onto your E-PEBP portal account at www.pebp.state.nv.us <https://pebp.nv.gov/>.

Plan Year Deductibles and Out-of-Pocket Maximums		
	In-Network Deductible	In-Network Out-of-Pocket Maximum
Individual (self-only coverage)	\$100	\$5,000
Family	Family: \$200 Individual family member: \$100	Family: \$10,000 Individual family Member: \$5,000
In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums are not interchangeable.		

Note: Deductible and Out-of-Pocket Maximums are for In-Network only; this plan does not provide Out-of-Network benefits except urgent and emergent care.

Deductibles

The Plan Year Deductibles (combined medical and specialty drugs) include two tiers:

- **Individual Deductible:** Applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible:** Applies when two or more individuals are covered on the same Plan (e.g., Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductible may be met through a combination of Eligible Medical Expenses from covered family members. The In-Network Family Deductible includes an embedded “Individual Family Member” Deductible. This means one single family member is only required to meet the Individual Family Member Deductible before the Plan starts to pay Coinsurance for that member.

The Individual and Family Deductibles start July 1st (the first day of the Plan Year) and reset the following Plan Year on July 1st. This Plan does not include a Deductible carryover or rollover provision.

During the Plan Year, you are responsible for paying for your eligible medical and prescription drug expenses (except eligible Preventive Services provided In-Network), including amounts exceeding the Plan’s reference-based pricing for hip and knee replacement, preauthorization penalties, [and other](#) out of pocket [costs](#).

In-Network Individual Deductible

The In-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible is **\$100**. Participants are responsible for paying Out-of-Pocket for eligible medical and prescription drug expenses that are subject to the Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

In-Network Family Deductible

The In-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **\$200** and includes a **\$100** embedded “Individual Family Member” Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible In-Network medical and prescription drug expenses for the entire family after the **\$200** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **\$100** “Individual Family Member” Deductible (under no circumstances will one single family member be required to pay more than **\$100** toward the **\$200** Family Deductible). The **\$200** In-Network Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Coinsurance

Coinsurance is the percentage of costs that generally you and the Plan pay for Eligible Medical Expenses after your Deductible is met. If you receive covered health care services using a health care provider who is a participating provider of this Plan's EPO network, you will be paying less money out of your pocket. This Plan generally pays **80%** of the In-Network provider's contract rate and you are responsible for paying the remaining **20%**. For Specialty Pharmacy expenses, the Plan generally pays **80%** and the participant pays **20%** for specialty drugs.

Copayments

Copayments apply as specifically stated in this document and are payable by the covered participant. Copayments do not apply to the Deductible but do apply to the Out-of-Pocket Maximum

Out-of-Pocket Maximum

The Plan Year In-Network Out-of-Pocket Maximum (OOPM) is the maximum amount a participant will pay for In-Network Eligible Medical and Prescription Drug Expenses during the Plan Year. Member cost share (Deductible, Copayments, and or Coinsurance) for Eligible Medical Expenses apply to the OOPM. The Out-of-Pocket Maximum for:

- An Individual (covered as self-only) is **\$5,000**
- Family coverage (participant plus one or more covered dependents) is **\$10,000**
 - The Family OOP Maximum includes a **\$5,000** embedded "Individual Family Member" OOP Maximum. An Individual Family Member OOP Maximum means one single family member will not pay more than **\$5,000** in the Plan Year for Eligible Medical Expenses.

Once an Individual or Family satisfies the OOPM, the Plan will pay 100% of eligible medical and prescription drug expenses for the remainder of the Plan Year. The OOPM accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year. The accumulation of Eligible Medical Expenses toward the OOPM is based on the date the medical or prescription drug expense is received by the Plan and not on the date of services.

Only Eligible Medical Expenses that are subject to cost-sharing (Deductible, Copayments, and Coinsurance) will apply to the OOPM. The OOPM does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges, and penalties, and Out-of-Network charges, including emergent and urgent services that exceed the Plan's Maximum Allowable Charge. This list is not all-inclusive and does not include all services and supplies that do not apply to the OOPM.

For this section only, references to the OOPM, Eligible Medical Expenses, Copayments, Deductibles and Coinsurance are specific to In-Network benefits, including benefits for Out-of-Network urgent and emergent services which are generally applied as an In-Network benefit, subject to the Plan's Maximum Allowable Charge, except where prohibited by law.

Out-of-Network urgent and emergent care providers are paid at the Maximum Allowable Charge, except where prohibited by law.

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Description of In-Network and Out-of-Network

This section includes information about how in-network and out-of-network benefits work and how emergency health services are covered.

The Plan only provides in-network benefits (refer to the *Summary of ~~Medical~~ Benefits and Schedule of ~~Medical~~ Benefits* and the *Benefit Limitations and Exclusions* sections for more information). In-network benefits are payable for covered expenses which are:

- Provided by an in-network physician or other in-network provider; or
- Considered to be an out-of-network benefit exception.

~~The Plan Administrator or its designee~~PEBP leases its Provider network through a contract with a vendor who arranges for providers to participate in maintains such a network. In-network providers are independent practitioners.

Payment for in-network benefits is based on the in-network provider's negotiated rate as established by the network.

The credentialing process confirms public information about the provider's licenses and other credentials but does not assure the quality of the services provided. Before obtaining services, you should always verify the network status of a provider. A provider's status may change. You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another in-network provider.

It is possible that you might not be able to obtain services from an in-network provider. You also might find that an in-network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available to you, you must choose another in-network provider to get in-network benefits.

Do not assume that an in-network provider's agreement includes all covered expenses. Some in-network providers agree to provide only certain covered expenses, but not all covered expenses. Some in-network providers choose to be an in-network provider for only some products. You may contact the Claims Administrator for assistance in choosing a provider or with questions about a provider's network participation.

Provider Network

~~The Plan or its designee arranges for providers to participate in a network. For more information, see the Participant Contact Guide section of this document.~~ In-Network providers are hospitals, physicians, medical laboratories, and other health care providers located within a service area who have agreed to provide health care services and supplies at negotiated discount fees. Network providers are not the Plan's employees or employees of any Plan designee.

The contracted Network is responsible for credentialing providers by confirming public information about the providers' licenses and other credentials but does not assure the quality

of the services provided.

Before obtaining services, you should always verify the network status of a provider. A provider's status may change. ~~You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another In-Network provider.~~ You can verify the provider's status by calling the third-party administrator or on the PEBP website in the Find a Provider section. The provider listing is maintained and updated by the contracted network.

The provider network is subject to change. It is possible that you might not be able to obtain specific services from an In-Network provider. ~~The provider network is subject to change.~~ Or you might find that an In-Network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available, you must choose another In-Network provider to get In-Network benefits.

Do not assume that an In-Network provider's agreement includes all Eligible Medical Expenses. Some In-Network providers agree to provide only certain covered expenses, but not all covered expenses. Some In-Network providers choose to be an In-Network provider for only some products and services. You may contact the third-party administrator for assistance in choosing a provider or with questions about a provider's network participation.

~~This plan also adheres to NRS 695G.164 for required provision in certain plans concerning coverage for continued medical treatment.~~ Pursuant to NRS 695G.164, if a member is receiving medical treatment from a provider whose In-Network status changes during the course of treatment, the member may continue to receive treatment with that provider at In-Network rates under certain circumstances. See more detailed explanation in PPO Network Health Care Provider Services section.

In-Network Provider Benefits

The Plan provides In-Network benefits when the services are provided by an In-Network provider. In-Network benefits are payable for Eligible Medical Expenses.

When a participant uses the services of an In-Network health care provider, the participant is responsible for paying the applicable cost-share (-Copay, Deductible, and/or Coinsurance) on the discounted fees for medically necessary services or supplies, subject to the Plan's coverage, limitations, and exclusions.

If you receive medically necessary services or supplies from an In-Network provider, you will pay a lower Coinsurance-cost than if you received those services or supplies from a health care provider who is not in the EPO network (Out-of-Network). In-Network providers have agreed to accept the Plan's payment (plus any applicable cost-share ~~Coinsurance~~ you are responsible for paying) as payment in full. The In-Network health care provider generally deals with the Plan or its designee directly for any additional amount due.

Out-of-Network Benefits

Out-of-Network (non-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.

Out-of-network benefits are not provided under this Plan except as specified in the *Summary of ~~Medical~~ Benefits, Schedule of ~~Medical~~ Benefits, Utilization Management and Benefit Limitations and Exclusions* sections and when prohibited by law, such as the No Surprises Act.

Out-of-Network Benefit Exceptions

There is an exception for emergent or urgent care or without services being approved in advance by the Plan's utilization management company.

Emergency Care

The Plan provides benefits for emergency care when required for stabilization and initiation of treatment as provided by or under the direction of a physician. Eligible Medical Expenses that are provided as a result of Urgent or Emergent care provided by In-Network providers are paid at the In-Network benefit level. Out-of-Network Urgent and Emergent care for Eligible Medical Expenses are paid at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge and the No Surprises Act.

Confinement in an Out-of-Network Hospital Following an Emergency

If you are confined in an Out-of-Network hospital after you receive emergency services, the utilization management company must be notified within two business days or on the same day of admission if reasonably possible. The UM company may elect to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the utilization management company decides a transfer is medically appropriate, and the provider obtains informed consent, and you receive the required notice as required under the No Surprises Act. Providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing).

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the *Eligible Medical Expenses* at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge. Services subject to the No Surprises Act are subject to the Recognized Amount.

Other Providers

If you have a medical condition that the Claims Administrator or the UM company believes needs special services, they may direct you to a provider chosen by them. If you require certain complex covered services for which expertise is limited, the Claims Administrator or the UM company may direct you to an out-of-network provider.

In both cases, benefits will only be paid if your covered expenses for that condition are provided

by the provider chosen by the Claim's Administrator or the UM company.

Directories of Network Providers

Participants are encouraged to confirm the In-Network participation status of a provider prior to receiving services.

A list of PPO providers is available to you without charge by visiting your member website from the Third-Party Administrator's website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

The online provider directory updates are made seven (7) days a week for Sierra HealthCare Options (SHO), United Healthcare Choice Plus, and Behavioral Healthcare Options (BHO) networks. Providers are available in the Find Care and Cost tool available 24/7. The list of PPO providers is maintained and updated by the contracted network based on information supplied by Providers.

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services, and supplies. The expenses for which you are covered are called eligible medical expenses. Eligible medical expenses are limited to the covered benefits specified in the *Summary and Schedule of ~~Medical~~ Benefits* and are:

- Determined by the Plan Administrator or its designee to be medically necessary (unless otherwise stated in this Plan), but only to the extent that the charges are Usual and Customary (U&C), provided in-network, do not exceed the Plan's Maximum Allowable Charge, costs that do not exceed the Plan's reference-based pricing for services performed at exclusive facilities; (as those terms are defined in the *Key Terms and Definitions* section of this document);
- Are not excluded from coverage under this Plan; and
- The health care benefits, services and supplies are not in excess of the limited overall, lifetime and/or Plan year maximum benefits.

Generally, the Plan will not reimburse you for all eligible medical expenses. Usually, you will have to pay some portion of costs, known as cost-sharing such as copayments or coinsurance toward the amounts you incur that are eligible medical expenses. However, you are only required to pay copayments and coinsurance for eligible medical expenses up to the Plan year individual or family out-of-pocket maximum.

The above is not all-inclusive. For more information regarding eligible medical expenses, see the *Summary of ~~Medical~~ Benefits and Schedule of ~~Medical~~ Benefits, Key Terms and Definitions, Benefit Limitations and Exclusions* sections.

A Person Whose Status Changes from Employee/Retiree to Dependent or from Dependent to Employee

A person who is continuously covered on this Plan before, during, and after a change in status, will be given credit for portions of the medical, prescription drug and dental Deductibles previously met in the same Plan Year, including the benefit maximum accumulators (e.g., medical Out-of-Pocket Maximums, dental frequency maximums and annual benefit maximum) will continue without interruption.

Non-Eligible Medical Expenses

You are responsible for paying the full cost of expenses that are not Eligible Medical Expenses, including expenses that are:

- Not determined to be medically necessary (unless otherwise stated in this Plan).
- Determined to be in excess of the usual and customary charges.
- Determined to be in excess of the Plan's Maximum Allowable Charge.
- Expenses for medical services or supplies that are not covered by the Plan, including, but not limited to, expenses that exceed the EPO provider contract rate, services listed in the *Exclusions* section of this document and dental expenses.
- Benefits exceeding those services or supplies subject to limited overall maximums for each covered individual for certain *Eligible Medical Expenses*.
- Additional amounts you are required to pay because of a penalty for failure to comply with the Plan's utilization management requirements described in the *Utilization Management* section of this document. If you fail to follow certain requirements of the Plan's utilization management program, the Plan may pay a smaller percentage of the cost of those services, and you may have to pay a greater percentage of those costs. The additional amount you may have to pay is in addition to your Deductibles or Out-of-Pocket Maximums described in the tables.
- *Preventive Care/Wellness Services* that are paid by the Plan at 100% do not accumulate towards the Out-of-Pocket Maximum.
- Received Out-of-Network services except emergent and urgent care, or without services being approved in advance by the Plan's utilization management company.

With exception of services subject to the No Surprises Act, Out-of-network providers may bill you their standard charges and any balance that may be due after the Plan payment. It is the participant's responsibility to verify the In-Network status of a chosen provider.

For more information regarding non-eligible medical expenses, see the *Benefit Limitations and Exclusions* section.

Health Reimbursement Arrangement (HRA)

PEBP and its HRA vendor require direct deposit for HRA reimbursements. [PEBP's HRA benefits are subject to the provisions explained in IRS Publication 969. Also see PEBP HRA Summary Plan Document on PEBP's website.](#)

Active Employees

This section provides summary information only. For more detailed information regarding this important benefit, see Internal Revenue Service (IRS) Publication 502 or contact the HRA third-party claims administrator listed in the *Participant Contact Guide*.

PEBP will be funding an HRA for active employees enrolled in a qualifying PEBP plan for **Plan Year 2024~~5~~**. **This is a one-time event.**

Funds in the HRA account may be used to pay for qualified medical expenses as defined by the IRS (see [IRS Publication 502](#)), other than premiums, including payment of [Copay](#), Deductibles, Coinsurance, and other Out-of-Pocket qualifying healthcare expenses not covered by this Plan.

The HRA may only be used to pay or reimburse qualified Out-of-Pocket health care expenses incurred by the following individuals enrolled in this Plan (or other non-HRA group health coverage providing minimum value):

- the participant; or
- the participant's spouse; or
- participant's dependent(s) who could be claimed on the participant's annual tax return.

HRA funds may not be used for a person who does not meet the IRS definition of a qualified tax dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether PEBP provides coverage for the dependent.

The entire annual PEBP one-time contribution for **Plan Year 2024~~5~~** will be available for use at the beginning of the Plan Year on or about **July 1, 2023~~4~~** (subject to certain limitations). Participants who initially elect PEBP coverage after **July 1, 2023~~4~~**, will receive a pro-rated base contribution for the participant based upon the coverage effective date and the months remaining in the Plan Year. Participants cannot contribute to an HRA. If the annual funds in the HRA are exhausted, neither PEBP nor the participant will contribute any additional funds.

Any funds remaining in the HRA at the end of the Plan Year will carryover (i.e., will not be forfeited) and will be available for use in the following Plan Year as long as the member maintains the same Plan.

Participants are allowed the option annually, and at termination in the plan, to permanently opt-out of the HRA, and thereby forfeit any unused balance.

Unlike a Flexible Spending Account (FSA), participants cannot be reimbursed from funds that are not yet available in the HRA. Any reimbursement from the HRA will be the lesser of the available HRA balance or the claim amount paid to the provider.

HRA funds are not portable between different plan types; participants cannot use HRA funds if they are no longer covered by the initial Plan with an HRA. If a participant terminates their coverage, the remaining balance in the HRA account will revert to PEBP, unless the qualified beneficiary elects COBRA. Participants enrolled with an HRA who change plans during the Open Enrollment period or during a Qualifying Life Event to a plan with an HSA and retirees who transition coverage to the Medicare Exchange will forfeit any remaining funds in the HRA account.

Active employees who retire and who are not Medicare age (typically at age 65 years) can maintain the balance of their HRA account at retirement if:

- They are eligible to enroll in and continue coverage under a PEBP plan; or
- Continue coverage under COBRA.
 - If a participant elects COBRA coverage, the HRA account will remain in place until COBRA coverage is terminated.

In the case of a retroactive coverage termination, any funds used from the HRA for expenses that are incurred after the date of coverage termination will be recovered by PEBP through the collection process.

Retirees who have a HRA balance and who transition to the Medicare Exchange will forfeit any remaining funds in the HRA on the last day of coverage under this Plan.

The death of an active employee or retiree will cause any remaining funds in the HRA to be forfeited on the first day following the date of death.

Timely Filing of HRA Claims

In accordance with [NAC 287.610](#), claim requests must be submitted to the third-party claims administrator within one year (12 months) from the date of service that the claim is incurred. No plan benefits will be paid for any claim requests submitted after this period.

When your HRA-eligible coverage ends, you will have one year (12 months) from the date your coverage ends to file a claim for reimbursement from your HRA for eligible claims incurred during your coverage period in accordance with [NAC 287.610](#). HRA funds may not be used to pay premiums.

HRA Contributions for Eligible State Active Employees	
Tier	One-Time Contribution
~~PEBP Funded Contribution~~	
~~State Active Employee Only~~	~~\$300~~
~~State Active Employee + Spouse/Domestic Partner~~	~~\$300~~
~~State Active Employee + Child(ren)~~	~~\$300~~
~~State Active Employee + Family~~	~~\$300~~
Legislature Appropriated One-Time Contribution	
State Active Employee Only	\$300
State Active Employee + Spouse/Domestic Partner	\$400
State Active Employee + Child(ren)	\$400
State Active Employee + Family	\$500

*One-time contribution provided to eligible active, State employees enrolled in a Plan on **July 1, 2024~~3~~**. State employees who initially elect PEBP coverage after **July 1, 2024~~3~~**, will receive a pro-rated base contribution based on the tier and the coverage effective date and the months remaining in the Plan Year.

Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing plans.

Legislatively approved enhancements, such as HSA/HRA funding and enhanced basic life insurance amounts may be subject to change in subsequent plan years.

Utilization Management

The Plan is designed to provide you and your eligible dependents with financial protection from significant health care expenses. To enable the Plan to provide coverage in a cost-effective way, it has a Utilization Management (UM) program designed to help control increasing health care costs by avoiding unnecessary services, directing participants to more cost-effective treatments capable of achieving the same or better results and managing new medical technology and procedures. If you follow the procedures of the Plan's UM program, you may avoid some Out-of-Pocket costs. However, if you do not follow these procedures, Plan benefits are reduced, and you will be responsible for paying more out of pocket.

The Plan's UM program is administered by an independent professional UM company operating under a contract with the Plan. The name, address and telephone number of UM company appears in the *Participant Contact Guide* section. The health care professionals at the UM company focus their review on the medical necessity of hospital stays and the medical necessity, appropriateness, and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM company has been given discretionary authority by the Plan administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of the Plan.

The UM program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document, PEBP's *Employee Health and Welfare Wrap Plan*, and *Retiree Health and Welfare Wrap Plan* documents. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered, either in whole or in part, by an exclusion in the Plan.

~~Regardless of whether~~ Even if your physician recommends surgery, hospitalization, confinement in a skilled nursing or sub-acute facility, or your physician or other provider proposes or provides any medical service or supply, ~~does not mean~~ the recommended services or supplies are not automatically considered medically necessary for purpose of ~~will be considered medically necessary for~~ determining coverage under the Plan.

Benefits payable by the Plan may be affected by the determination of the UM company. If:

- The UM company does not authorize a proposed surgery or other proposed medical treatment as medically necessary; or
- The Plan will not pay regular benefits for a hospitalization or confinement in a skilled nursing or sub-acute facility because the UM company does not authorize a proposed confinement.

PEBP, the third-party claim administrator, and the UM company are not engaged in the practice of medicine and are not responsible for the outcomes of health care services rendered (even if the health care services have been authorized by the UM company as medically necessary), or

for the outcomes if the patient chooses not to receive health care services that have not been authorized by the UM company as medically necessary.

When reviewing services for appropriateness of care and medical necessity, the UM company uses guidelines and criteria published by nationally recognized organizations, along with medical judgement of licensed health care professionals.

Delivery of Services

You are entitled to receive medically necessary medical care and services as specified in this Plan's *Schedule of ~~Medical~~ Benefits*. These include medical, mental health, behavioral health, surgical, diagnostic, therapeutic, and preventive services. If a precertification is required and you do not obtain the required precertification, the service may not be covered, even if the service is medically necessary. These services, although not all-inclusive are those that generally:

- Are provided In-Network,
- Are performed or ordered by a participating provider,
- Require a precertification according to the utilization management and quality assurance protocols, if applicable.

Concurrent Review

Concurrent Review (continued stay) is the ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or skilled nursing or sub-acute facility. When you are receiving medical services in a hospital or other inpatient facility, the UM company monitors your stay by contacting your physician or other providers to assure that continuation of medical services in the facility are medically necessary. The UM company will also help coordinate your medical care with other healthcare benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services, and or advising your physician or other providers of various options and alternatives for your medical care available under this Plan.

If at any point, your stay is found not to be medically necessary and care could be safely and effectively delivered in another environment (such as through home health care or in another type of health care facility), you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, expenses incurred after the notification will be your responsibility. If your hospital stay is determined not to be medically necessary, no benefits will be paid on any related hospital, medical or surgical expense. You may also appeal the determination (refer to the *Appealing a Utilization Management ~~d~~Determination* section).

Retrospective Review

The review of health care services after they have been provided to determine if those services were medically necessary. The Plan will pay benefits only for those days or treatment that would

have been authorized under the utilization management program; and case management: The process whereby the patient, the patient's family, physician, or other providers work together with the Plan Administrator or its designee under the guidance of the UM company to coordinate a quality, timely and cost-effective treatment plan.

Case Management

Case management is a voluntary process administered by the UM company. Its ~~medical~~ professionals work with the patient, the patient's family, caregivers, providers, the third-party claims administrator, and the Plan Administrator or its designee to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly and/or high-technology services, or when assistance is needed to guide the patient through a maze of potential providers. Case management is available for individuals diagnosed with sickle cell or its variants, ~~among other conditions (see NRS 695G.174),~~ among other conditions. Case management is also available for a disability resulting from a mental health or substance use disorder diagnosis.

The case manager will work directly with your physician, hospital, and/or other provider to review proposed treatment plans and to assist in coordinating services and obtaining discounts from providers as needed. From time to time, the case manager may confer with your physician or other providers and may contact you or your family to assist in making plans for continued health care services or obtaining information to facilitate those services.

You, your family, or your physician may call the case manager at any time to ask questions, make suggestions or offer information. The case manager can be reached by calling the UM company at the telephone number shown in the *Participant Contact Guide* section or on the PEBP website at <https://pebp.nv.gov>.

Precertification (Prior Authorization) Process

Precertification prior authorization review is a procedure administered by the UM company to assure health care services meet or exceed accepted standards of care. In certain cases, as set forth below, for a benefit to be covered, the UM company must approve and/or pre-certify the service. **If a precertification is required and you do not obtain the required precertification, benefits may be reduced, even if the service is medically necessary.** The UM company uses nationally recognized guidelines and criteria as standard measurement tools to determine whether benefits are approved and/or pre-certified.

Precertification also includes the determination of whether the admission and length of stay in a hospital or skilled nursing or sub-acute facility, surgery or other health care services are medically necessary and if the location of service is high quality and lowest cost.

A precertification is required for referrals to physicians and providers for certain services. Benefits listed in this Plan may be subject to precertification requirements and concurrent or retrospective review depending upon the circumstances associated with the services. Refer to the Services Requiring Precertification section below for more information.

Failure to obtain precertification may result in your benefits being reduced or denied (see the *Failure to Follow Required Utilization Management Procedures* in this section).

Services Requiring Precertification (Prior Authorization)

Inpatient Admissions

- Acute inpatient or observation
- Long-Term Acute Care
- Rehabilitation
- Behavioral health
- Transplant including ~~all~~ pre-transplant related expenses
- Skilled Nursing facility and sub-acute facility
- Residential Treatment Facility, ~~including outpatient partial hospitalization programs,~~ and partial residential treatment programs
- Hospice (inpatient/outpatient) exceeding six (6) months.
- Obstetric – (precertification only required if days exceed 48 hours for vaginal delivery or 96 hours for a C-section)
- Intraoperative Neuro Monitoring
- Surgeries to treat Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery

Outpatient and Physician – Surgery

When outpatient and physician surgery is performed at an In-Network, contracted ambulatory surgical center (ASC) by an In-Network, contracted physician, prior authorizations is not required.

However, when services are not performed at an In-Network, contracted ASC, procedures will require prior authorization. This is commonly referred to as Site of Service. Examples of services that require prior authorization include, but are not limited to:

- Outpatient partial hospitalization programs
- Back Surgeries and hardware related to surgery
- Total and remaining Hip and Knee Surgeries
- Biopsies (excluding skin, colonoscopy and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Frenectomy
- Oophorectomy, unilateral and bilateral
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Surgeries to treat Gender Dysphoria

- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery
- Sleep apnea related surgeries, limited to:
 - Radiofrequency ablation (Coblation, Somnoplasty)
 - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic) and reconstruction surgery
- Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Varicose vein surgery/sclerotherapy
- Prophylactic surgery
- Any procedure deemed to be Experimental and/or Investigational (provider must indicate on the pre-certification request that the service/procedure is Experimental and/or Investigational and/or part of a clinical trial)
- Intraoperative Neuro Monitoring
- Prophylactic surgery

Outpatient and Physician – Diagnostic Services

- CT, PET, SPEC, and MRI
- Capsule endoscopy
- Genetic Testing including:
 - BRCA
 - Biomarker Testing (Assembly Bill 155 from the 82nd Legislative Session in 2023)

Outpatient and Physician – Continuing Care Services

- Applied Behavior Analysis (ABA) Therapy for Medical, Mental Health, and Substance Use Disorder
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- ~~Dialysis~~
- Chemotherapy (including oral)
 - Oral Chemotherapy to be reviewed by Pharmacy Benefit Manager
- Radiation Therapy
- Oncology and transplant related injections, infusions, and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric Oxygen
- Home Health Care
- Durable Medical Equipment exceeding \$1,000
 - prior authorization is based on overall cost to the plan and/or purchase price, not the amount billed for monthly rental. DME rental to purchase in accordance with Medicare guidelines.

- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables and infusions excluding services reviewed by the PBM
- ~~Behavioral Health~~ Intensive Outpatient Program, including partial hospitalization programs
- Sickle Cell Disease
- Vein Therapy
- ~~Electroconvulsive Therapy (ECT)~~
- ~~Transcranial Magnetic Stimulation (TMS)~~
- Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a combined visit limit of 90 visits per Plan Year
 - Visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder.

Services Not Requiring Precertification (Prior Authorization)

Prior authorization is not required for medically necessary emergency services when a medical condition that manifests itself by symptoms of such severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the participant.
- Serious jeopardy to the health of an unborn child.
- Serious impairment of a bodily function; or
- Serious dysfunction of any bodily organ or part.

The UM company must be notified of an emergency hospital admission within one business day so the UM company can conduct a *concurrent review*. Your physician or the hospital should call the UM company to initiate the concurrent review. Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding UM, such as concurrent review.

How to Request Precertification (Prior Authorization)

It is your responsibility to ensure that precertification occurs when it is required by the Plan. Any penalty or denial of benefits for failure to obtain precertification is your responsibility, not the provider's. Your ~~or your~~ physician must call the UM company at the telephone number shown in the *Participant Contact Guide* to request precertification. Calls for elective services should be made at least 15 calendar days before the expected date of service or may be subject to the benefit reduction listed in the *Utilization Management* section. The UM company will require the following information:

- The employer's name.
- Employee's name.
- Patient's name, address, phone number and Social Security Number or PEBP unique ID.
- Physician's name, phone number or address.

- The name of any hospital or outpatient facility or any other provider that will be providing services.
- The reason for the health care services or supplies; and
- The proposed date for performing the services or providing the supplies.

The UM company will review the information and provide a determination to you, your physician, the hospital or other provider, and the third-party claims administrator as to whether the proposed health care services have been determined to be medically necessary. Additionally, the UM company may approve medical necessity but not site of care. In these circumstances, the UM company will provide approved alternate locations to the caller. While industry and accreditation standards require a preauthorization determination within 15 calendar days for a non-urgent case, the UM company will usually respond to your physician or other provider by telephone within (5) five business days of receipt of the request. The determination will then be confirmed in writing.

If your hospital admission or medical service is determined not to be medically necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal (refer to the *Appealing a UM Determination* section).

Second Opinion

The utilization management company may authorize a second opinion upon your request in accordance with this Plan. Examples of instances where a second opinion may be appropriate include:

- Your physician has recommended a procedure and you are unsure whether the procedure is necessary or reasonable.
- You have questions about a diagnosis or plan or care for a condition that threatens substantial impairment or loss of life, or bodily functions.
- You are unclear about the clinical indications about your condition.
- A diagnosis is in doubt due to conflicting test results.
- Your physician is unable to diagnose your condition; and a treatment plan in progress is not improving your medical condition within a reasonable period.

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in Services Requiring Precertification (Prior Authorization).

[2ndnd-MD](#)

[2ndnd-MD is PEBP's preferred second opinion Service. See benefits in the Schedule of Medical Benefits, below, for additional information](#)

Hospital Admission

You are responsible for ensuring the UM company is notified at least 5 (five) business days before an inpatient admission to obtain pre-certification.

Your physician or other provider may notify the UM company, but it is ultimately your responsibility to make sure they are notified. The UM company will review the physician/provider's recommendation and treatment plan to determine the level of care and place of service. If the UM company denies the precertification for hospital admission as not covered or they determine that the services do not meet the UM company's medical necessity criteria, the Plan's third-party administrator will only pay benefits for inpatient that has been pre-certified.

You are required to obtain a precertification before you obtain services for inpatient elective surgeries. If you do not follow the required UM process, benefits for the elective surgeries may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network surgery expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum, if applicable.

Emergency and Urgent Hospital Admission

This Emergency and Urgent Hospital Admissions includes complications of pregnancy

You are not required to obtain a precertification before you obtain services for a medical emergency. However, the UM company must still be notified within 24 hours, the next business day, or as soon as reasonable after admission so the UM company can conduct a concurrent review. If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times, they must receive notification as soon as reasonably possible after the admission or you may be subject to reduction or denial of benefits as provided by the Plan.

- Emergency Hospital Admission: Admission for hospital confinement that results from a sudden and unexpected onset of a condition that requires medical or surgical care. In the absence of such care, you could reasonably be expected to suffer serious bodily injury or death. Examples of emergency hospital admission include, but are not limited to, admissions, for heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal injuries, and other acute conditions.
- An urgent hospital admission means an admission for a medical condition resulting from injury or serious illness that is less severe than an emergency hospital admission but requires care within a short time, including complications of pregnancy.

Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding utilization management, such as concurrent review.

If you do not follow the required UM process, benefits payable for the services may be reduced by 50% of this Plan's Maximum Allowable Charge. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum.

Confinement in an Out-of-Network Hospital Following an Emergency Admission

Please refer to the No Surprises Act section of this document for claims subject to that Act. For other confinements, if you are confined in an Out-of-Network hospital after you receive emergency services, the UM company must be notified within 24 hours, the next business day, or as soon as reasonable after admission. The UM company may determine it is appropriate to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the UM company decides a transfer is medically appropriate, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service. Benefits for the continued stay will not be covered under this Plan.

Other Exceptions

If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the Eligible Medical Expenses at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge.

Elective Knee and Hip Joint Replacement – Nevada Exclusive Hospitals and Outpatient Surgery Centers

Precertification is required; the UM company will review the request based on surgery type, medical necessity, covered benefits, provider quality, cost, and provider location.

Due to cost variations for elective knee and hip joint replacement performed in Nevada, the third-party claims administrator has identified exclusive providers who meet the Plan's cost threshold for routine knee and hip replacement procedures. The exclusive provider list can be found on the PEBP website.

If you choose a provider on the exclusive list, you will potentially reduce your out-of-pocket costs in accordance with the standard plan benefits.

However, if you choose to use a non-exclusive provider, the Plan will pay benefits in accordance with its cost threshold or Maximum Allowable Charge. You may be subject to balance billing for any amount exceeding this Plan's cost threshold. Amounts exceeding the Plan's established threshold will not apply to your Deductible (if applicable) or Out-of-Pocket Maximum.

Inpatient or Outpatient Surgery

You are responsible for ensuring that the UM company is notified at least 5 (five) business days before elective inpatient or outpatient surgery is performed to ensure that it is covered.

Your physician or other provider may notify the UM company, but it is your responsibility to make sure they are notified. The UM company will review the physician's recommended course of treatment to ensure the requested treatment meets established medical necessity criteria and protocols.

The claims administrator will only pay benefits for inpatient or outpatient surgery that is pre-certified, and the services/supplies are a covered benefit.

Outpatient Infusion Services

Precertification is required for outpatient infusion services. The UM company will review the request based on covered benefits, medical necessity, provider quality, cost, and location. If you choose to receive your infusion at a non-exclusive hospital or infusion center, you will be responsible for any amount that exceeds this Plan's Maximum Allowable Charge. Amounts exceeding this Plan's established cost threshold will not apply to your annual Deductible or Out-of-Pocket Maximum.

Air Ambulance Services

This Plan provides coverage for emergency air ambulance and inter-facility patient air transport if there is a life-threatening situation, or the service is deemed medically necessary by the UM company. The air ambulance services are subject to the Plan cost-share (Deductible, copay, and/or coinsurance), if applicable, then the Plan will pay the lower of the EPO allowable for In-Network air ambulance providers, or for Out-of-Network providers, the Plan will pay up to the Recognized Amount.

See the Utilization Management section for air ambulance precertification requirements.

Air/Flight Schedule Inter-Facility Transfer

Inter-facility transport services require precertification. The UM company may discuss with the physician and/or hospital/facility the diagnosis and the need for inter-facility patient transport versus alternatives. Failure to obtain a precertification may result in a reduction or denial of benefits for charges arising from or related to flight-based inter-facility transfers. Non-compliance penalties imposed for failure to obtain a precertification will not be included as part of the annual out-of-pocket maximum.

Inter-facility transport may occur if there is a life-threatening situation, ~~or~~ if the transport is deemed medically necessary. The following conditions apply:

- Services via any form of air/flight for inter-facility transfers must be pre-certified before transport of the participant to another hospital or facility, and the participant is in a hospital or other health care facility under the care or supervision of a licensed health care provider; and
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

Emergency Air Ambulance

This Plan provides coverage for emergency air ambulance transportation for participants whose medical condition at the time of pick-up requires immediate and rapid transport due to the

nature and/or severity of the illness/injury. Air ambulance transportation must meet the following criteria:

- Services via any form of air/flight for emergency air ambulance; and
- The patient's destination is an acute care hospital; and
- The patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health; or
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

See *Air Ambulance Services* [and the No Surprises Act](#) for details on plan benefits and coverage.

Gender Dysphoria

The participant or their physician must contact the UM company to begin the process toward surgical intervention [often to treat](#) gender dysphoria. The initial contact will include:

- Notification to the participant that the precertification process begins with the initial contact to the UM company.
- In accordance with [Senate Bill 163](#) from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.
- Advising participants of providers who specialize in this type of treatment.

This service is provided by the UM company and will be initiated upon the first call for a precertification. Case management services are particularly helpful for a participant or their covered dependent who is receiving complex medical services for medical conditions such as gender dysphoria. Your assigned case manager nurse will provide you with assistance addressing any concerns you may have about issues such as continuity of care or finding providers or a provider who specializes in gender dysphoria.

[In accordance with Senate Bill 163 from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include consideration of the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.](#)

Health Care Services and Supplies Review

A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in *Services Requiring Precertification (Prior Authorization)*.

Non-participating providers may not know to notify the UM company to obtain precertification for services. In such a case, you must confirm that the UM company pre-certified the service to assure that it is covered.

The Plan will pay for covered health care services and supplies only if authorized as outlined above. The Plan will not pay for any health care services or supplies that are not covered services or do not meet medically necessary criteria and protocols.

Failure to Follow Required Utilization Management Procedures

If you do not follow the required precertification review process described in this section, benefits payable for the services you failed to receive a precertification may be reduced by 50% of the Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network *Eligible Medical Expenses*. Expenses related to the penalty will not apply to your Plan Year Deductible or Out-of-Pocket Maximum. If you wish to appeal a decision made by the UM company, refer to the *Appealing a UM Determination* section.

Summary of ~~Medical~~ Benefits

To determine the benefit limitations for any health care service or supply, review the Summary and Schedule of ~~Medical~~ Benefits listed below.

To determine precertification requirements, refer to the *Utilization Management* section.

Copay applies to primary Care Physician (PCP) and Specialist office visits for evaluation and management services only; imaging, surgery, and other services provided during a PCP or Specialist office visit are subject to the Plan Year Deductible and Coinsurance.

Benefit Description	In-Network	Out-of-Network
Primary Care Physician Office Visit	\$20 Copay	Not Covered
Specialist Services (including Allergy Services)	\$40 Copay	Not Covered
<i>No referral is required for these visits. Imaging, surgery, and other services provided in an office setting subject to Deductible and Coinsurance.</i>		

Benefit Description	In-Network	Out-of-Network
Wellness/Preventive Office Visits and Preventive Screenings		
Primary Care ACA Wellness Visit	\$0 Copay	Not Covered
Obstetrics and Gynecology ACA Services	\$0 Copay	Not Covered
Prenatal and Postnatal Office Visit	\$0 Copay	Not Covered
<i>No referral is required for these visits. Imaging, surgery, and other services provided in an office setting subject to Deductible and Coinsurance.</i>		

Benefit Description	In-Network	Out-of-Network
Wellness/Preventive Office Visits and Preventive Screenings		
Mammography screening	\$0 Copay	Not Covered
<i>Limit: One preventative 2D or 3D mammogram screening per Plan Year for women aged 40 years and older or beginning at age 35 for members with a high-risk of breast cancer.</i>		
Papanicolaou (Pap) test	\$0 Copay	Not Covered
Prostate Specific Antigen (PSA) screening	\$0 Copay	Not Covered
Colorectal screening	\$0 Copay	Not Covered
<i>Colorectal Screening: Starting at age 45 in accordance with the American Cancer Society's screening guidelines.</i>		
Counseling for sexually transmitted infections (STI), HIV counseling and testing	\$0 Copay	Not Covered
Breastfeeding support, supplies, and counseling	\$0 Copay	Not Covered
<i>Contact the third-party claims administrator for the purchase of covered breast pumps. Rental for heavy duty electrical (hospital grade) covered only when medically necessary and only during the newborn's inpatient hospital stay.</i>		
Screening for interpersonal and domestic violence	\$0 Copay	Not Covered
Contraceptives/In-office counseling	\$0 Copay	Not Covered
<i>FDA approved injections, implants, and contraceptive devices not covered under the pharmacy benefits.</i>		
Screening for Gestational Diabetes	\$0 Copay	Not Covered
High-risk Human Papillomavirus (HPV) testing	\$0 copay	Not Covered

Real Appeal	\$0 copay	Not Covered
<i>For more information, refer to the Preventive Services in the Schedule of ~~Medical~~ Benefits section. An office visit copay may apply if services provided during the visit include additional services that are not preventive services.</i>		

Benefit Description	In-Network	Out-of-Network
Hospital Facility Services		
Elective Inpatient Hospital Admission	\$600 Copay per Admission	Not Covered
Emergency Inpatient Hospital Admission	\$600 Copay per Admission	\$600 Copay per Admission
Inpatient Delivery Postpartum/Newborn Care Services	\$600 Copay per Admission	Not Covered
Outpatient Observation	\$600 Copay	Not Covered
<i>Outpatient Observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement.</i>		
Outpatient Surgery	\$350 Copay	Not Covered
<i>Other services related to, and during, the outpatient surgery on that date is not subject to the deductible and coinsurance.</i>		
Skilled Nursing Facility (Limited to 100 days per Plan Year)	\$600 Copay per Admission	Not Covered
Rehabilitation, Habilitation Facility ** (~~Limited to 60 days per Plan Year~~)	\$600 Copay per Admission	Not Covered
<i>Hospital facility services require precertification. In emergencies in which a member is admitted to hospital for an inpatient stay, the UM company must be notified within 24 hours, the next business day following the admission. See the Utilization Management section for precertification requirements, including emergency hospital admissions.</i> <i><u>**Rehabilitation, Habilitation Facility services are limited to 60 days per Plan Year; however, visit</u></i>		

limits will not apply to Medically Necessary treatment of mental health or substance use disorder.

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Benefit Description	In-Network	Out-of-Network
Urgent and Emergency Services		
Urgent Care Services*	\$50 Copay	\$50 Copay, subject to the Plan's Maximum Allowable Charge and applicable law*
Emergency Room Services*	\$600 Copay	\$600 Copay, subject to the Plan's Maximum Allowable Charge and applicable law*
Ambulance (ground/water)	Plan pays 80% after Deductible	Plan Pays 80% after Deductible, subject to the Plan's Maximum Allowable Charge and applicable law
Ambulance (air)	Plan pays 80% after Deductible	Plan Pays 80% after Deductible, subject to the Plan's Maximum Allowable Charge and applicable law
<i>*When using Out-of-Network ambulance providers you are responsible for paying your Copayment amount, Deductible, and Coinsurance, in addition to amounts exceeding the Plan's applicable Maximum Allowable Charge for air ambulances, including ground and water ambulance services. See the Utilization Management and Schedule of ~~Medical~~ Benefits for precertification requirements (inter-facility patient air transfer/transport), including the Maximum Allowable Charge for air ambulance. See Key Terms and Definitions for more information. Emergency Room services: If admitted to the hospital, the ER Copay is waived and the Inpatient Hospital Copay applies.</i> <i>*see also NRS 695G.170 for medically necessary emergency services at any hospital in Nevada.</i>		

Benefit Description	In-Network	Out-of-Network
Outpatient Specialty Imaging and Diagnostic Testing		
Computer Tomography (CT) Scan	Plan pays 80% after Deductible	Not Covered
Positron Emission Tomography (PET) Scan	Plan pays 80% after Deductible	Not Covered
Magnetic Resonance Imaging (MRI/MRA)	Plan pays 80% after Deductible	Not Covered
Nuclear Medicine	Plan pays 80% after Deductible	Not Covered
Angiograms and Myelograms	Plan pays 80% after Deductible	Not Covered
<i>See the Utilization Management section for precertification requirements.</i>		

Benefit Description	In-Network	Out-of-Network
Non-Specialty Imaging and Diagnostic Testing (Including X-rays and Ultrasounds; except Specialty Imaging and Diagnostic Testing)		
Services provided in a Primary Care Physician Office	Plan pays 80% after Deductible	Not Covered
Services provided in a Specialty Care Physician's Office	Plan pays 80% after Deductible	Not Covered
Services provided in a hospital outpatient setting	Plan pays 80% after Deductible	Not Covered
Diagnostic Mammography	\$40 Copay	Not Covered

Benefit Description	In-Network	Out-of-Network
Laboratory Services		
General laboratory Services	Plan pays 80% after Deductible	Not Covered
Routine/Preventive Lab Testing*	Plan pays 80% after Deductible	Not Covered
Routine and Preventive Lab Services *Routine/Preventive lab services must be performed at a freestanding non-hospital-based lab facility. Medically necessary routine labs when ordered by a physician as part of comprehensive medical care. Preventive laboratory services such as basic metabolic panel, lipid <u>panel</u>, ~~etc or general health panel~~. Routine/preventive lab tests performed at an outpatient hospital or hospital-based free-standing facility/draw station are not covered.		
Pre-admission Lab Testing Services**	Plan pays 80% after Deductible	Not Covered
Pre-Admission Lab Testing Services **Pre-admission lab testing performed on an outpatient basis at a hospital-based lab or free-standing hospital-based lab draw station within 7 days prior to a scheduled hospital admission or outpatient surgery. Testing must be related to the sickness or injury for which admission or surgery is planned.		

Benefit Description	In-Network	Out-of-Network
Outpatient ~~Short-Term~~ Rehabilitation <u>and Habilitative Therapy</u> Services Outpatient Speech, Occupational, and Physical Therapy		
Speech Therapy	\$40 Copay per Visit	Not Covered
Occupational Therapy	\$40 Copay per Visit	Not Covered
Physical Therapy	\$40 Copay per Visit	Not Covered

Outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) is subject to copay for each therapy type.

Precertification required; speech, occupational, and physical therapy visits are limited to a combined 90 visits based on distinct visit-types per Plan Year. Visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder.

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Benefit Description	In-Network	Out-of-Network
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and Pulmonary rehabilitation	Plan pays 80% after Deductible	Not Covered
<i>Limited to medically necessary services; 60 visits per Plan Year for all modalities combined.</i>		
Dialysis	Plan pays 80% after Deductible	Not Covered
Wound Therapy	Plan pays 80% after Deductible	Not Covered
Chemotherapy Treatment	Plan pays 80% after Deductible	Not Covered
Radiation Therapy (Outpatient hospital, facility, or physician's office)	Plan pays 80% after Deductible	Not Covered
Infusion Therapy (home/outpatient, including specialty drugs)	Plan pays 70% after Deductible	Not Covered
<i>See the Utilization Management section for precertification requirements.</i>		

Benefit Description	In-Network	Out-of-Network
Hinge Health		
<i>Digital Musculoskeletal (MSK) Care</i>	\$0 Copay	Not Covered

Benefit Description	In-Network	Out-of-Network
Surgical Services		
Performed in a Primary Care Physician's office	Plan pays 80% after Deductible	Not Covered

Performed in a SpecialtyCare Physician's office	Plan pays 80% after Deductible	Not Covered
Performed in same-day surgery facility or Ambulatory Surgery Center (ASC)	\$350 Copay	Not Covered
<i>See the Utilization Management section for surgical services requiring precertification.</i>		

Benefit Description	In-Network	Out-of-Network
Medical Supplies, Equipment, and Prosthetics		
Durable Medical Equipment (DME)	Plan pays 80% after Deductible	Not Covered
<i>Durable Medical Equipment (DME): Limited to one purchase, repair, or replacement of a specific item of DME every 3 years. DME rental to purchase in accordance with Medicare guidelines. The purchase or rental of DME, including oxygen related equipment in excess of \$1,000 requires precertification.</i>		
Orthopedic and prosthetic devices	Plan pays 80% after Deductible	Not Covered
<i>Orthopedic and prosthetic devices: Limited to a single purchase of a type of prosthetic device, including repair and replacement, every 3 years. Orthopedic and prosthetic devices in excess of \$1,000 require precertification.</i>		
Hearing Aids	\$25 Copay per Device	Not Covered
<i>Coverage for medically necessary, FDA approved air conduction hearing aids. Subject to a \$25 Copay per device, Maximum benefit \$1,500 per device, per each ear, every 3 years.</i>		
Special Food Product	Plan pays 80% after Deductible	Not Covered
<i>~~Special Food Product: \$2,500 maximum benefit per Plan Year for the Special Food Products for the treatment of inherited metabolic diseases.~~ See Enteral Formulas and Special Food Products in the Schedule of Medical Benefits.</i>		
Enteral Formula	Plan pays 80% after Deductible	Not Covered
<i>Enteral Formula for the treatment of inherited metabolic disease. See Enteral Formulas and Special Food Products in the Schedule of Medical Benefits.</i>		

Benefit Description	In-Network	Out-of-Network
Mental/Behavioral Health Treatment		
Inpatient/Residential Rehabilitation	\$600 Copay per Admission	Not Covered
Intensive Outpatient Treatment Program	<u>Plan pays 100% after Deductible</u> ~~\$20 Copay per Visit~~	Not Covered
Partial Hospitalization Program	\$600 Copay per Admission	Not Covered
Outpatient treatment	<u>Plan pays 100% after Deductible</u> ~~\$20 Copay per Visit~~	Not Covered
Applied Behavioral Therapy	<u>Plan pays 100% after Deductible</u> ~~\$20 Copay per Visit~~	Not Covered
Psychological testing	Plan pays 80% after Deductible	Not Covered
<i>Refer to the Utilization Management section for precertification requirements.</i>		

Benefit Description	In-Network	Out-of-Network
Mental Health		
Inpatient medically necessary services for mental health disorders	\$600 Copay per Admission	Not Covered
Mental health Outpatient Visit	\$20 Copay per Visit	Not Covered
<i>Inpatient admission requires precertification. Refer to the Utilization Management section for more information.</i>		

Benefit Description	In-Network	Out-of-Network
Other Medical Services Doctor on Demand, Telehealth, 2nd MD		

Doctor on Demand Telemedicine Visit		
Medical Visit	\$10 Copay per Visit	Not Covered
Psychology Visit (25-minute visit)	\$20 Copay per Visit	Not Covered
Psychologist Visit (50-minute visit)	\$20 Copay per Visit	Not Covered
Psychiatrist Visit (45 minute/initial visit)	\$20 Copay per Visit	Not Covered
Psychiatry Visit (15-minute follow-up visit)	\$20 Copay per Visit	Not Covered

Benefit Description	In-Network	Out-of-Network
Other Medical Services Doctor on Demand, Telehealth, 2nd MD		
Telehealth Visit		
Primary Care Visit	\$20 Copay per Visit	Not Covered
Specialist Care Visit	\$40 Copay per Visit	Not Covered
2nd.MD (Second Opinion Services)		
2nd.MD (Second Opinion Services)	\$0 Copay per Visit	Not Covered

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Chiropractic (Spinal manipulation services)	\$40 Copay per Visit	Not Covered

Chiropractic and spinal manipulation services: Limited to 20 office visits per Plan Year.		
Acupuncture, acupressure services	\$40 Copay per Visit	Not Covered
Acupuncture and acupressure services: Limited to 20 visits (combined) per Plan Year, 100 visits (combined) per lifetime.		
Home Health Care	Plan pays 80% after Deductible	Not Covered
60 visits per Plan year; may provide for private duty nursing in the home; requires precertification.		

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Office-based infertility services	\$40 Copay per Visit	Not Covered
~~Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility for a covered individual (limited to one diagnostic evaluation for infertility every Plan Year, and up to three (3) per lifetime, and up to six (6) artificial inseminations per lifetime. See exclusions in the Benefit Limitations and Exclusions. These limits and exclusions apply to both office-based and non-office-based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in the Summary of Medical Benefits~~		
Temporomandibular Joint (TMJ) Disorder Services		
Office-based services (Excluding surgical services)	- Specialist Visit: \$40 Copay - Other office-based services: Plan pays 80% after Plan Year Deductible.	Not Covered
TMJ Surgical Services	Inpatient: \$600 Copay Outpatient: \$350 Copay	Not Covered
TMJ disorder and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Limited to two (2) surgeries in a lifetime.		
Hospice	\$600 Copay per Admission	Not Covered

The hospice care program administers palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill patients with a life expectancy of 6 months or less as certified by patient's medical physician. For outpatient bereavement services, see Hospice Services in the Schedule of ~~Medical~~ Benefits. Precertification is required for both inpatient and outpatient hospice services exceeding six (6) months. For a description of the hospice care benefits, see Hospice Services in the Schedule of ~~Medical~~ Benefits.

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Benefit Description		In-Network	Out-of-Network
Obesity Care Management (OCM) Program (Disease Management Program)			
Weight Loss Medication	*Preferred Retail Network 30-Day Supply	Home Delivery 90-Day Supply	
Preferred/Formulary Generic	\$0 Copay	\$0 Copay	Not Covered
Preferred/Formulary Brand	\$20 Copay	\$40 Copay	Not Covered
Non-Preferred/Non-Formulary Brand	\$75 Copay	\$150 Copay	Not Covered
*Preferred Retail Network Pharmacies: Copayments apply if you fill your prescription at a Preferred Retail Network pharmacy. If you fill your prescription at a non-Preferred Retail Network retail pharmacy, you will pay an additional \$10 per prescription. If you currently use a non-Preferred Retail Network pharmacy and you want to avoid the \$10 upcharge, call a Preferred Retail Network pharmacy to transfer your prescription. See the Schedule of Pharmacy Benefits for instructions on how to find a Preferred Retail Network pharmacy. Certain weight loss medications may not be available in 90-day supply. Contact Express Scripts for information about your prescribed medication. * Retail 90-day Supply is three (3) times the copay for the 30-day supply			
Office Visit (OCM weight loss provider)	\$0 Copay		Not Covered
Laboratory test	\$0 Copay		Not Covered
Outpatient laboratory test services as determined by your weight loss provider (and as covered under this Plan). Outpatient laboratory tests must be performed at an in-network, free-standing, non-hospital based, lab facility such as Lab Corp or Quest.			

Benefit Description	In-Network	Out-of-Network
Obesity Care Management (OCM) Program (Disease Management Program)		
Nutritional Counseling Services	\$0 Copay	Not Covered
<i>Nutritional Counseling Services are covered for enrolled OCM participants who are actively engaged in the program. Nutritional counseling services must be provided by a registered dietician or nutritionist. The frequency of the nutritional counseling services will be determined by the third-party claims administrator and will be based on medical necessity and engagement in the OCM program.</i>		
<i>OCM benefits subject to requirements/compliance with the OCM program as indicated in the Schedule of Medical Benefits Section.</i>		

Benefit Description	In-Network	Out-of-Network
Vision Care Services		
Vision ~~Screening~~ Exam (~~Preventative~~)	\$10 Copay	\$10 Copay
<i>Limited to one, ~~preventative~~ exam per Plan Year, per covered individual. The maximum benefit this Plan will pay per Plan Year, per covered individual is \$100.</i>		
Prescription eye ~~wear~~ glasses	\$10 Copay	\$10 Copay
<i>Single vision, bifocal and trifocal lenses, and prescription contact lenses. Eyeglasses, or contact lenses in lieu of eyeglasses, limited to \$100 every 24 months.</i>		

Prescription Drug Benefits

In-Network Pharmacy Benefits

	Preferred Retail Network Pharmacies* (30-Day Supply)	Smart90 Retail Pharmacies (90-Day Supply)	Home Delivery from Express Scripts Pharmacy (90-Day Supply)
Preferred Formulary Generic	\$10 Copay	\$20 Copay	\$20 Copay
Preferred Formulary Brand	\$40 Copay	\$80 Copay	\$80 Copay
Non-Preferred/Non-Formulary Brand	\$75 Copay	\$150 Copay	\$150 Copay

Specialty Drugs

Specialty Drugs Accredo Specialty Mail Order Pharmacy	N/A	N/A	You pay 20% after PlanYear Deductible for drugs on the SaveOnSP program. OR Copay limit of \$100 min and \$250 max applies (30-Day supply)

** Pharmacies: Copayments apply if you fill your prescription at a pharmacy. If you fill your prescription at a non- retail pharmacy, you will pay an additional \$10 per prescription. If you currently use a non-EAN pharmacy and you want to avoid the \$10 upcharge, call a Preferred Retail Network pharmacy to transfer your prescription.*

Prescription drugs are not covered when purchased from Out-of-Network pharmacies.

See the Schedule of ~~Medical~~ Benefits in this document for important information related to pharmacy benefits, including how to find a Smart90 pharmacy.

Schedule of ~~Medical~~ Benefits

The Schedule of ~~Medical~~ Benefits provides a description of benefits, including certain limitations under this Plan. Covered services must be medically necessary and are subject to exclusions and limitations as described herein. Precertification is required for many services, plan benefit limitations apply to certain benefit categories, and out-of-network are not covered unless otherwise specified in this document.

When the Plan Administrator determines that two or more courses of treatment are substantially equivalent, the Plan Administrator reserves the right to substitute less costly services or benefits for those that this Plan would otherwise cover.

Example: If both inpatient care in a skilled nursing facility and intermittent, part-time nursing care in the home would be medically appropriate, and if inpatient nursing care would be less costly, this Plan could limit coverage to the inpatient care. This Plan could limit coverage to inpatient care even if this means extending the inpatient benefit beyond the quantity provided in the Summary of ~~Medical~~ Benefits or Schedule of ~~Medical~~ Benefits.

The fact that a participating provider prescribed, ordered, recommended, or approved a service, treatment, or supply does not necessarily make it a covered service or medically necessary.

The *Summary of ~~Medical~~ Benefits and Schedule of ~~Medical~~ Benefits* should be read in conjunction with the *Benefit Limitations and Exclusions* and Key ~~Definitions~~ *Terms and Definitions* sections. The Explanations and Limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any precertification requirements), *Benefit Limitations and Exclusions*, *Key Terms and Definitions* and other sections that may apply to a specific benefit.

Claims must be submitted within twelve (12) months of the date of service to be considered for payment.

Acupuncture and Acupressure Services

Acupuncture and acupressure are covered under this Plan if performed by a licensed health care provider acting within the scope of their license. Acupuncture and acupressure services must be provided by In-Network and are limited to 20 visits per Plan Year, maximum 100 visits per lifetime.

Maintenance services are not a covered benefit.

Alcohol and Substance Abuse Services (inpatient and outpatient)

Medically necessary inpatient and outpatient alcohol and substance abuse services will be provided under the same terms as medical and surgical benefits, with no additional financial or treatment limitations. Substance abuse care benefits are for acute medical detoxification and for

substance abuse rehabilitation and counseling. The main purpose of medical detoxification is to rid the body of toxins, monitor heart rate, blood pressure and other vital signs, manage withdrawal symptoms and administer medications as needed. Inpatient and outpatient programs for alcohol and substance abuse treatment require precertification. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require precertification.

Allergy Testing and Treatment

Coverage is provided for medically necessary allergy testing, preparation of serum, serum, and administration of injections. For allergy treatment only, the participant will be responsible for the lesser of the primary care or specialist office visit copay or the cost of the serum/injection.

Ambulance Services

Ambulance services are covered if the services are medically necessary, and they are:

- Provided in an emergency; or
- Provided in a non-emergency setting when prior authorized by the UM company.

Autism Spectrum Disorders

This Plan provides coverage for autism spectrum disorder per [NRS 695G.1645](#), including coverage of screening for and diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders for covered dependents individuals.

~~Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription drug care, psychiatric care, psychological care, behavioral therapy, or therapeutic care that is:~~

- ~~• Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and~~
- ~~• Provided for a person diagnosed with an autism spectrum disorder by a licensed psychologist, licensed behavior analyst or other provider that is acting within the scope of his/her license.~~

Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

Note: Capitalized terms in this Autism Spectrum Disorders section have the definitions assigned to them in [NRS 689B.0335](#) and not necessarily the definitions in this MPD.

Bariatric/Weight Loss Surgery

Covered services include medically necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese *with* associated illnesses. These services may have a reduced benefit unless you receive precertification.

Bariatric weight loss surgery benefits, pre-and post-surgery, are available only when performed

at an in-network Bariatric Surgery Center of Excellence facility, by an in-network surgeon and ancillary providers. The third-party Claims Administrator will determine the in-network Bariatric Surgery Center of Excellence facility. It is the participant's responsibility to ensure that bariatric surgery services providers are in-network and facility chosen to provide services are in-network.

There is no payment if services are provided at an out-of-network facility or out-of-network surgeon, or other ancillary providers are used.

Participants are limited to one obesity related surgical procedure of any type in an individual's lifetime while covered under this Plan or any PEBP self-funded Plan. For example, a participant cannot have lap band surgery and subsequently seek benefits for gastric bypass. The first service related to surgical weight loss will be considered payable under this Plan, any others will not. If a participant had coverage under a different plan (any other plan other than a PEBP self-funded Plan) previously and subsequently had a bariatric surgery, they are still eligible to have one bariatric procedure paid for under the Plan, provided that precertification criteria are met.

For lap band adjustments, the Plan will consider any adjustments made in the 12 months following surgery if the participant remains compliant with their post-surgical agreement as verified by the UM company. Any adjustments to the lap band after the first 12 months post-surgery will be subject to precertification.

It is the responsibility of the participant to ensure that their providers and facilities chosen to provide these services are in-network for benefits to be paid. Participants can verify the network status of any provider (including a facility) by calling the Claims Administrator located in the *Participant Contact Guide*.

Participants must receive treatment in a Bariatric Surgery Center of Excellence which has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

- Behavior modification program supervised by a qualified professional.
- Consultation with a dietician or nutritionist.
- Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen.
- Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to

- surgery, supervised by an exercise therapist or other qualified professional.
- Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
- Reduced-calorie diet program supervised by dietician or nutritionist.

If a participant has started any type of program to meet the pre-surgery criteria outlined below with an out-of-network provider (including a facility), those services will NOT be considered part of the Plan's mandatory precertification requirements. For the Plan to consider your bariatric surgery a covered benefit under this Plan; you will have to begin the precertification process again with the appropriate providers.

Services, pre- and post-surgery must be at an in-network facility, with in-network providers AND be at a certified Center of Excellence for bariatric weight loss.

Precertification/Pre-Surgery Criteria for Weight Loss Surgery

The participant or their physician must contact the UM company to begin the process toward surgical intervention for obesity. The initial contact will include:

- Notifying the participant that the precertification process begins with the initial contact to UM company.
- Notifying the participant that precertification requests presented to the UM company before the clinical criteria listed below has been completed will be denied. A precertification request may be reconsidered upon completion of the clinical criteria.
- Informing the participant of the requirement to access and participate in a weight management and nutrition program.
- Documenting participant completion of the associated assessments required to be considered for the procedure.
- Educating the participant on how to access wellness/preventive services and how to proceed with meeting the clinical indications listed below; and
- Advising participants of Centers of Excellence in bariatric surgery provider in their geographic area.

Clinical Criteria for Weight Loss Surgeries is managed by the UM Company.

Surgical or invasive treatments for obesity or morbid obesity including but not limited to bariatric weight/loss services, reversals, and treatments to resolve complications are generally excluded, unless medically necessary and are covered as described above.

Travel Expenses:

This Plan provides reimbursement of certain costs associated with travel and hotel accommodations for the member and one additional person (spouse/domestic partner, family member or friend) when associated with bariatric/weight loss surgery and performed at a Center of Excellence that is located 50 or more miles from the member's residence. For travel expense benefits, refer to the Travel Expenses benefit section.

Expenses incurred for travel and hotel accommodations for bariatric/weight loss surgery not performed at a Center of Excellence are not covered.

Blood Services for Surgery

Medically necessary blood and related supplies provided during a surgical or other procedure that requires blood replacement are covered services.

Chemotherapy

Chemotherapy and other drug therapies that are medically necessary to treat cancers and other diseases and conditions are covered services, covered when ordered by a physician; chemotherapy must be pre-certified by the UM company.

See prescription benefits for orally administered chemotherapy drugs:

Patients undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year (excluding sales tax).

Chiropractic Services

Spinal Manipulation (non-surgical)

Coverage is provided for up to 20 visits per Plan Year for medically necessary spinal manipulations and adjustments.

Maintenance services are not a covered benefit.

Clinical Trials

Coverage for certain treatment received as part of a clinical trial or study for treatment of cancer or chronic fatigue syndrome will be provided subject to the requirements and limitations set forth in ~~The routine medical treatment costs, including items and services that are otherwise generally available to Plan participants, received as part of a clinical trial or study, may be covered under NRS 695G.173.~~ A clinical trial is the process for testing new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases.

Diabetic Services for Type 1, Type 2, and Gestational Diabetes

Coverage is provided for the medically necessary management and treatment of diabetes, including infusion pumps and related supplies, medication, equipment, supplies, and appliances for the treatment of diabetes.

Coverage is provided for the medically necessary self-management of diabetes for training and education provided after you are diagnosed with diabetes for the care and management of diabetes, including, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.

Durable Medical Equipment (DME)

Coverage is provided for the purchase, rental, repair, or maintenance of durable medical equipment prescribed by a provider for a medically necessary condition other than kidney dialysis. **DME is limited to one purchase, repair, or replacement of a specific item of DME every 3 years.** Rental of DME ~~to cover~~will be subject to Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME more than \$1,000 requires precertification from the UM company.

To help determine what ~~D~~urable medical equipment is covered, see the definition of “Durable Medical Equipment” in the Key Terms and Definitions section, below. ~~equipment that:~~

- ~~• Can withstand repeated use.~~
- ~~• Is not disposable.~~
- ~~• Is appropriate for use in the home.~~
- ~~• Is not useful in the absence of an illness or injury.~~
- ~~• Is prescribed by a physician.~~
- ~~• Meets CMS guidelines for coverage; and~~
- ~~• Is not primarily for convenience or comfort but serves a medical purpose.~~

~~Durable medical equipment includes, but is not limited to the following:~~

- ~~• Oxygen equipment (oxygen and oxygen related equipment, except for oxygen while traveling on an airline).~~
- ~~• Wheelchairs.~~
- ~~• Hospital beds.~~
- ~~• insulin pumps and supplies,~~
- ~~• Glucose monitors; and~~
- ~~• Warning or monitoring devices for infants (defined as a child 24 months old or less) suffering from recurrent apnea.~~

Coverage will be based on an amount equal to the generally accepted cost of durable medical equipment that provides the medically necessary level of care at the lowest cost.

Items not covered under this benefit include, but are not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, and any other primarily non-medical equipment, except as otherwise covered and described within this *Schedule of ~~Medical~~ Benefits* and the *Benefit Limitations and Exclusions* sections.

Also excluded are exercising equipment, vibratory or negative gravity equipment, swimming or therapy pools, spas, and whirlpools (even if recommended by your medical provider to treat a medical condition).

Enteral Formulas and Special Food Products

Enteral Formulas and Special Food Products are covered in accordance with [NRS 689B.0353](#).

There is a \$2,500 maximum benefit per Plan Year for Special Food Products for the treatment of a person with inherited metabolic diseases or for Medically Necessary treatment of a mental health diagnosis. The maximum will not apply to Medically Necessary treatment of a mental health disorder.

Inherited metabolic diseases is characterized under NRS 689B.0353 as the following:

- deficient metabolism, or
- malabsorption originating from congenital defects, or
- defects arising shortly after birth,

for amino acid, organic acid, carbohydrate or fat.

Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception

Medical or surgical treatment for sexual dysfunction: There are some limits on sexual dysfunction drugs such as Viagra or Muse and are subject to the Plan Year Deductible. For more information, contact the pharmacy benefit manager

Coverage is provided for vasectomies and tubal ligations. Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals, are excluded.

~~Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility are covered for one workup per Plan Year up to three (3) evaluations per lifetime. For infertility services that are not covered under this Plan, see the *Benefit Limitations and Exclusions* section. Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility for a covered individual (limited to one diagnostic evaluation for infertility every Plan Year, and up to three (3) per lifetime, and up to six (6) artificial inseminations per lifetime. See exclusions in the *Benefit Limitations and Exclusions*. These limits and exclusions apply to both office-based and non-office-based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in~~

the Summary of ~~Medical~~ Benefits.

Contact the Utilization Management company for prior authorization for procedures related to sexual dysfunction.

Gender Dysphoria

This Plan provides certain benefits to individuals seeking medical services for the treatment of gender dysphoria.

Procedures, services, and supplies related to surgery and sex hormones associated with gender affirmation/confirmation should be reviewed by the UM Company for medical necessity.

In accordance with [Senate Bill 163](#) from the 82nd Legislative Session in 2023, the Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license. Determinations of medical necessity shall include [consideration of the most](#) recent ~~Standards of Care~~ published by the World Professional Association for Transgender Health, or its successor organization.

This plan does not discriminate on the basis of gender identity or expression. Claim or coverage appeal shall include a consult with ~~a provider of health care who has experience in~~ prescribing or delivering gender-affirming treatment. The plan does not provide coverage cosmetic benefits as defined by Senate Bill 163.

Cosmetic Surgery under the bill means:

- Means a surgical procedure that:
 - Does not meaningfully promote the proper function of the body
 - Does not prevent or treat illness or disease; and
 - Is primarily directed at improving the appearance of a person.
- This Includes, without limitation, cosmetic surgery directed at preserving beauty.

Genetic Counseling/Testing

Covered services include medically necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests solely for research, or for the benefit of individuals not covered under the Plan.

Covered services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical

records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk, and review testing options, where available.

Genetic testing may only be done after consultation with an appropriately certified genetic counselor and/or, in our discretion, as approved by a physician that we may designate to review the utilization, medical necessity, clinical appropriateness, and quality of such genetic testing. Medically necessary genetic counseling will be covered in connection with pregnancy management with respect to the following individuals:

- Expenses for genetic tests, except where otherwise noted in this document, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities, or genetically transmitted characteristics including:
- Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents; and
- Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder, except that payment is made for fluid or tissue samples obtained through amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), fetoscopy and alpha fetoprotein (AFP) analysis in pregnant women.
- Participants should contact the Plan's Claims Administrator to determine if proposed genetic testing is covered or excluded and the UM company for precertification requirements. See also the exclusions related to prophylactic surgery or treatment later in this section.

Genetic Counseling except as related to covered genetic testing as listed in the Genetic Testing and Counseling and the Preventive Covered services include genetic testing of heritable disorders as medically necessary when the following conditions are met:

- The results will directly impact clinical decision-making and/or clinical outcome for the individual.
- The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and
- One of the following conditions is met:
 - The participant demonstrates signs/symptoms of a genetically linked heritable disease, or
 - The participant or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

Additional genetic testing/counseling will be covered in accordance with federal or state mandates.

Biomarker testing: In accordance with [Assembly Bill 155](#) from the 82nd Legislative Session in

2023, the Plan provides benefits for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.

In the absence of specific information regarding advances in the knowledge of mutation characteristics for a disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the member.

Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology or mandated by federal or state law.

Hearing Aids

Air conduction hearing aids are considered medically necessary when one or more of the following hearing loss criteria are met *in either or both ears*:

- Hearing thresholds 40 dB HL or greater at two or more of these frequencies: 500, 1000, 2000, 3000, 4000 Hz; or
- Hearing thresholds 26 dB HL or greater at three of these frequencies; or
- For high frequency hearing loss, defined as loss occurring only above 2000 Hz:
 - a. Hearing thresholds of 26 dB HL or greater at three or more of these frequencies: 2000, 3000, 4000, 6000 or 8000 Hz
- Speech recognition less than 80 percent in either or both ears regardless of hearing threshold level.

Participants who meet the above hearing loss criteria: Each air conduction hearing aid is subject to a \$50 copay (per device, per each ear), with maximum plan benefit of \$1,500 per device every three (3) years.

Participants may submit a copy of their hearing aid payment receipt from the hearing aid provider to the third-party claims administrator to request reimbursement for the hearing aid benefit, less applicable copayment(s), and deductibles to receive credit towards the Out-of-Pocket Maximum.

Over the Counter hearing aids are excluded from the Plan.

Hinge Health Digital Musculoskeletal (MSK) Care

Hinge Health's Digital MSK Program is offered through the Pharmacy Benefit Manager and is designed to help members with Musculoskeletal Care using digital technology. The program offers qualifying participants virtual physical therapy focusing on prevention, acute injury, chronic and surgical care programs via digital physical therapy plus additional physical and behavioral support through a full clinical-care team. Members will also have access to other services, such as pelvic floor therapy, advanced wearable technology for electrical nerve stimulation and pain relief, expert medical opinion consultation, health education, etc.

Members will complete a screener to assess which Digital MSK Clinic™ programs is right for them. The questionnaire screener leverages data analytics combined with a dedicated clinical care team review to match each member's personal needs with the right program tools and resources. This program is managed by Express Scripts and is provided at no cost to members.

Home Health Care

Medically necessary home health care is covered if such care is provided by an organization or professional licensed by the state to render home health services. Such care will not be available if it is substantially or primarily for the participant's convenience or the convenience of a caregiver. Home care is covered in the home only on a part-time and temporary basis and to the extent that such care is performed by a licensed or registered nurse or other appropriate therapist or provider acting within the scope of their license.

Home health care covered includes skilled nursing care, therapies, and other health related services provided in the home environment for other than convenience for patient or patient's family, personal assistance, or maintenance of activities of daily living or housekeeping. Covered home health care services under this part include home health care provided by a professional as the nature of the illness dictates.

Excluded from coverage as home health care are:

- Personal care, custodial care, domiciliary care, or homemaker services.
- In-home services provided by a licensed provider acting within the scope of their license.
- Over-the-counter medical equipment, over-the-counter supplies, or any prescription drugs, except to the extent that they are covered elsewhere in this *Schedule of ~~Medical~~ Benefits*.

Hospice Services

The following hospice care services are covered for members with a life expectancy of six months or less as certified by his or her provider (Additional time after six (6) months will require preauthorization):

- Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week
- Outpatient bereavement counseling of the participant and his or her immediate family (limited to 6 visits for all family members combined if they are not otherwise eligible for mental health benefits under their specific plan). Counseling must be provided by:
 - A psychiatrist.
 - A psychologist; or
 - A licensed, ~~masters~~master's level clinician.

- Respite care providing nursing care for a maximum of 8 inpatient respite care days per Plan Year and 37 hours per Plan Year for outpatient respite care services. Inpatient respite care will be provided only when the UM company determines that home respite care is not appropriate or practical.

Hospital, Skilled Nursing Care, and Services in an Outpatient Surgical Center

Inpatient Care

Medically necessary inpatient hospital care is covered. Services include, but are not limited to:

- Services for medical conditions treated in an acute care hospital inpatient environment.
- Semi-private room and board (private room when medically necessary).
- General nursing care facilities, services, and supplies on an inpatient basis.
- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility. For related covered services refer to Other Services and Supplies in the *Schedule of ~~Medical~~ Benefits* section.
- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Maternity and newborn care for up to 48 hours of inpatient care for a mother and her newborn child following a vaginal delivery and up to 96 hours of inpatient care for a mother and her newborn child following a cesarean delivery. The time-periods will commence at the time of the delivery. Any decision to shorten the length of inpatient stay to less than those time-periods will be made by the attending physician after conferring with the mother.
 - Inpatient, short-term rehabilitative services, limited to treatment of conditions that are subject to significant clinical improvement over a continuous 30-day period from the date inpatient therapy commences in a distinct rehabilitation unit of a hospital, skilled nursing facility, or other facility approved by us (limited to 100 days per Plan Year).
- Inpatient alcohol and substance abuse rehabilitation services in a hospital, residential treatment facility, or day treatment program; and
- Inpatient mental health services.

Inpatient services to treat mental illness conditions are subject to medical necessity. Provider visits received during a covered admission are also covered. Benefits are provided for medically necessary inpatient care, outpatient care, partial hospitalization, and provider office services for the diagnosis, crisis intervention and treatment of severe mental illness conditions and substance abuse conditions as noted in the *Schedule of ~~Medical~~ Benefits*.

Inpatient services must be provided by a licensed hospital, psychiatric hospital, alcoholism treatment center, or residential treatment center.

The member should contact the UM company to determine medical necessity, appropriate treatment levels and appropriate settings. Inpatient services are subject to precertification notification guidelines to avoid potential penalties related to non-notification of services.

If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times in the UM section, above, the UM Company must receive notification as soon as reasonably possible after the admission or you may be subject to reduced benefits as provided in this Plan.

Medically necessary care at a skilled nursing facility (limited to 100 days per Plan Year) for non-custodial care is covered. A skilled nursing facility is a facility that is duly licensed by the state and/or federal government and that provides inpatient skilled nursing care, rehabilitation services, or other related health services that are not custodial or convenience in nature. Skilled nursing care includes medically necessary services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse. This Plan does not cover skilled nursing care that is not covered by CMS. Prior care in a hospital is not required before being eligible for coverage for care in a skilled nursing facility.

For drugs administered in an inpatient setting, there may be cost-share assistance. See "UMR Copay Maximizer Benefit" under Prescription Drug Benefits.

Outpatient Care

Medically necessary outpatient hospital or outpatient surgical center care is covered. Services furnished in a hospital's or outpatient surgical center premises are covered, including use of a bed and periodic monitoring by a hospital's nursing or other staff that are medically necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital. If a hospital intends to keep a patient in observation status for more than 48 hours, observation status will become an inpatient admission for administration of benefits.

Coverage for the following benefits is dependent upon the benefits described in the *Schedule of ~~Medical~~ Benefits* for this Plan. Mental health and substance abuse outpatient services include, but are not limited to:

- Services for medical conditions treated in an acute care hospital outpatient environment.
- Semi-private room and board (private room when medically necessary) if patient is in observation status.
- General nursing care facilities, services, and supplies on an outpatient basis.
- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility.

- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Outpatient, short-term rehabilitative services.
- Outpatient alcohol and substance abuse rehabilitation services in a hospital, hospital residential treatment facility, or day treatment program; and
- Outpatient mental health services.

Medically necessary short-term outpatient habilitative and rehabilitative services are covered for:

- Short-term speech, physical, and occupational habilitative and rehabilitative therapy for acute conditions that are subject to significant clinical improvement over a 90-day period, as determined by the UM company from the date outpatient therapy commences or to maintain function in an individual. Precertification required for habilitative and rehabilitative therapy exceeding a combined visit limit of 90 visits per Plan Year: and
- Services for cardiac rehabilitation and pulmonary rehabilitation (limited to 60 visits/sessions per Plan Year for each type of therapy).

Medically necessary services such as radiation therapy and chemotherapy (including chemotherapy drugs), are covered to the extent that such services are delivered in the most appropriate clinical manner and setting as part of a treatment plan.

Services that are not covered under this benefit include:

- Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution.
- Private duty nursing and private rooms in an inpatient setting.
- Personal, beautification, or comfort items for use while in a hospital or skilled nursing facility; and
- Services related to psychosocial rehabilitation or care received as a custodial inpatient.

Lab and Diagnostic Services

Coverage is provided for medically necessary laboratory and diagnostic procedures, services, and materials, including:

- Diagnostic x-rays.
- Fluoroscopy.
- Electrocardiograms; and
- Laboratory tests.

Coverage is also provided for other laboratory and diagnostic screenings as well as physician services related to interpreting such tests.

Outpatient laboratory services are covered for pre-admission testing, urgent care, or emergency room. Pre-admission testing must be performed within 7 days of a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Outpatient laboratory services for routine/preventive lab testing must be performed at a non-hospital-based, freestanding laboratory such as Lab Corp or Quest.

If a freestanding, non-hospital-based laboratory facility is not available within 50 miles of your residence, you may use an in-network outpatient hospital facility or hospital-based lab draw station.

Routine lab services from independent labs may not be paid as wellness unless the TPA system finds a corresponding wellness office visit within a reasonable number of days prior or after lab date to validate wellness diagnosis.

Mastectomy and Reconstructive Surgery

Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member.

Subject to the terms and conditions of this *Schedule of ~~Medical~~ Benefits*, if a covered mastectomy or other breast cancer treatment is performed, we will also provide coverage for:

All stages of reconstruction of the breast on which the mastectomy has been performed.

- Surgery and reconstruction of the other breast to produce a symmetrical structure.
- Prostheses; and
- Physical complications for all stages of mastectomy, including lymphedemas.

If reconstructive surgery occurs within three years after a mastectomy, the amount of the benefits for that surgery will equal the amounts provided for in the Plan at the time of the mastectomy. If the surgery occurs more than three years after the mastectomy, the benefits provided are subject to the terms, conditions, and exclusions contained in the Plan at the time of reconstructive surgery.

This Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA) Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. For any covered individual who is receiving mastectomy-related benefits, coverage will be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.

- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- External prostheses (breast forms that fit into your bra) that are need before or during reconstruction; and Treatment of physical complications of all stages of the mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery).

Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy as mandated by the Women's Health and Cancer Rights Act.

Participants should use the Plan's precertification procedure to determine if a proposed surgery or service will be considered cosmetic surgery or medically necessary reconstructive services.

Medical Care

Medically necessary medical care and services, performed by a physician or other professional on an inpatient and outpatient basis, are covered, including:

- Office visits and consultations.
- Hospital and skilled nursing facility services.
- Ambulatory surgical center services.
- Home health care services.
- Surgery; and
- Other professional services.

Note: The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the Surgery/Surgeries definition in the *Key Terms and Definitions* section.

Assistant surgeon fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. See Certified Surgical Assistant in the *Key Terms and Definitions* section.

Mental Health Services

Medically necessary mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other qualified mental health care professional are covered according to the limits provided in the *Schedule of ~~Medical~~ Benefits* sections.

Outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require precertification. This Plan provides mental health and substance abuse benefits in accordance with the *Mental Health Parity and Addition Equity Act of 2008*.

Maternity and Newborn Services

Medically necessary maternity services for pregnant participants are covered, including prenatal and postpartum care, related delivery room and ancillary services and newborn care. Newborn care includes care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of newborn to and from the nearest facility staffed and equipped to treat the newborn's condition. Newborn care is subject to the eligibility requirements as defined in the Schedule of ~~Medical~~ Benefits.

Notwithstanding anything in this Schedule of ~~Medical~~ Benefits to the contrary, participant does not need precertification from the UM company to obtain access to obstetrical or gynecological care from a professional in this Plan's network who specializes in obstetrics or gynecology. The provider, however, may be required to comply with certain procedures, including obtaining precertification for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating providers who specialize in obstetrics or gynecology, refer to the EPO Plan network at ~~www.pebp.state.nv.us~~<https://pebp.nv.gov/>.

Notwithstanding anything in this *Schedule of ~~Medical~~ Benefits* to the contrary, in the case of a person who has a child enrolled in coverage, this Plan will permit such person to designate any pediatrician as a primary care physician if such pediatrician is a participating provider.

When the member has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days ([NRS 689B.033](#)). Individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.

Services that are not covered include:

- Amniocentesis to the extent that it is performed to determine the sex of the child.
- Non-newborn circumcisions after eight weeks of age unless medically necessary and provided a precertification.

No Surprises Act

The federal No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from a Non-PPO provider at an in-network facility. Beneficiaries receiving these services will only be responsible for paying their in-network cost sharing and cannot be balance billed by the provider or facility for emergency services.

Emergency Services

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility, as applicable, with respect to the services;

- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities;
- Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO provider or a PPO emergency facility;
- By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by a PPO provider or a PPO emergency facility.

Your cost sharing amount for Emergency Services from Non-PPO Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount (QPA).

[*In addition to the No Surprises Act, the Plan complies with the requirements of see also NRS 695G.170 with respect to coverage](#) for medically necessary emergency services at any hospital ~~in Nevada.~~

Post Stabilization Services

Emergency Services furnished by a Non-PPO Provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; and
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the nonparticipating provider, acknowledging that the participant or beneficiary understands that continued treatment by the nonparticipating provider may result in greater cost to the participant or beneficiary.

Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-PPO provider at a PPO facility, the items or services are covered by the plan:

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such Non-PPO provider were equal to the Recognized Amount for the items and services.
- By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a PPO provider,
- Non-emergency items or services performed by a Non-PPO provider at a PPO facility will be covered based your out-of-network coverage if:
 - At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
 - The participant or dependent gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.
- The notice and consent exception does not apply to Ancillary services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-PPO provider satisfied the notice and consent criteria, and therefore these services will be covered:
 - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider,
 - With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and
 - With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a PPO provider.

Your cost sharing amount for Non-emergency Services at PPO Facilities by Non-PPO Providers will be based on the lesser of billed charges from the provider or the Qualifying Payment Amount.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from a non-PPO provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from a Non-PPO provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a PPO provider.
- In general, you cannot be balanced billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a PPO provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your Network (PPO) deductible and Network (PPO) out-of-pocket maximum in the same manner as those received from a PPO provider.

Payments to non-PPO Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-PPO provider. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

The Plan will pay a total plan payment directly to the non-PPO provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a non-PPO provider at a PPO facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review. Please see the External Review procedures in the SPD for further information.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

- You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
- You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

Per [NRS 695G.164](#), the Plan provides coverage for continued medical treatment for a medical condition from a provider of health care whose contract with the insurer is terminated during active medically necessary treatment. Unless excepted, this is until the later of:

- The 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 45th day after:
 - The date of delivery; or
 - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Incorrect PPO Provider Information

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

Obesity Care Management Program

The Obesity Care Management (OCM) Program is open to participants who have been diagnosed as obese by their physician and who meet the criteria set out in this section.

Participants who opt-in to the OCM Program may be eligible for enhanced benefits. These benefits include:

- Services provided by an in-network provider certified by the American Board of Bariatric Medicine (ABBM) and specializes in weight loss services or if there is no certified provider within 50 miles of a participant's residence, services may be provided by any in-network provider.
- Laboratory tests provided by an in-network free-standing, non-hospital-based outpatient laboratory facility such as Lab Corp or Quest.
- Nutritional counseling services, when provided in-network, frequency is determined by the Claims Administrator and is based on medical necessity.

Weight Loss Medications:

- The Plan covers certain only short-term use obesity/weight loss generic medications as identified by the Plan's Pharmacy Benefits Manager. Contact the Pharmacy Benefit Manager or refer to the Plan's prescription drug formulary to determine what weight loss medications are covered by the enhanced benefit. Long-term weight loss medications are excluded.
- Copayments for Tier 1 (Generic) drugs apply to the Out-of-Pocket Maximum. Copayment for a 31-90-day supply is subject to three times the listed 30-day retail copayment.
- This Plan does not coordinate prescription drug plan benefits.

Medications purchased at non-participating pharmacies are not covered under this Plan.

Gym memberships, exercise equipment and bariatric restrictive weight loss surgery is not included in the OCM benefits. Refer to the *Summary of ~~Medical~~ Benefits* section for more information.

For enrollment information, please contact the Claims Administrator as listed in this document under the *Participant Contact Guide*. When you enroll in the program, your effective date will typically be the 1st of the month following your enrollment in the program. The effective date will be determined by PEBP.

The information described in this section provides a summary of the Program's functions. For more detailed information, please contact the Claims Administrator.

The Obesity Care Management Program is optional and considered an "opt-in" Program. To be eligible for the enhanced wellness benefits, participants must meet certain criteria and adhere to certain participation requirements.

Once you have met your final weight loss goal as determined by your weight loss provider at the onset of your participation in a medically supervised weight loss program, benefits under the Obesity Care Management Program will end. This Plan does not provide benefits for ongoing maintenance care. If you choose to receive ongoing maintenance care, you will be responsible for the cost of receiving the services.

The Claims Administrator provides an Obesity Care Management Participant Program navigation guide available through the PEBP Member Portal, see the *Participant Contact Guide* for more information.

The Obesity Care Management Program is administrated by the Claims Administrator.

Engagement in the Program

You must remain actively engaged in a medically supervised weight loss program.

Monitoring Engagement

The Claims Administrator will assist your weight loss provider with completing monthly progress reports. The initial report should include your weight and BMI or waist circumferences, and a description of your treatment plan to include weekly weight loss goals, final weight loss goal, exercise regimen, diet, and nutrition instructions. Subsequent monthly reports should provide information regarding your weight loss progress and adherence to the treatment plan. Submission of these reports will be a requirement for payment under the enhanced wellness benefits. If your monthly weight loss reports are not received by the Claims Administrator, your benefits under this program will end, and your coverage will return to the standard EPO Plan benefits where other Plan limitations will apply. The effective date of the return to the standard EPO Plan benefits will be the first day of the month following the non-compliance notification received from the Claims Administrator.

How to Enroll in the Obesity Care Management Program

- Contact the Claims Administrator for a list of in-network weight loss providers. This information is located on the Claims Administrator's website by logging into the E-PEBP Portal.
- Make an appointment with an in-network weight loss provider. The Claims Administrator can also help you identify which in-network provider may best meet your needs, based on geography or other specialized needs you may have.
- When you make an appointment with your in-network weight loss provider, before you go, be sure to take an Obesity Care Management Program Enrollment form with you. This form is located on the Claims Administrator's website under forms.
- Have your in-network weight loss provider complete the enrollment form and submit (by mail or fax) the completed form to the Claims Administrator. Their name, address and fax number are provided on the enrollment form.
- The Claims Administrator will review the information submitted by your provider and if the information indicates that you meet the criteria for the weight loss program benefits, the Claims Administrator will enroll you in the program. The Claims Administrator will notify PEBP and the Pharmacy Benefit Manager of your enrollment. If you do not meet the criteria for weight loss benefits, the Claims Administrator will notify you of the denial of benefits.
- Engagement in the Program.

Benefits under the Obesity Care Management Program

The following benefits are included, many at no cost to you, when provided under this program subject to the limits in the *Summary of ~~Medical~~ Benefits* section:

- Office Visits.
- Laboratory tests.
- Nutritional counseling, and

- Certain medications under the prescription drug component of the Plan.

Oral Surgery, Dental Services, and Temporomandibular Joint Disorder

Medically necessary oral surgery procedures are covered (inpatient or outpatient) related to the following:

- Accidental injury to the jaw bones or surrounding tissues when the injury occurs, and the repair. Services must commence within 90 days after the accidental injury, regardless of date enrolled in the Plan. *Services that commence after 90 days are not covered, unless determined to be medically appropriate.*
- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
- Non-dental surgical procedures and hospitalization required for newly born and children placed for adoption or newly adopted to treat congenital defects, such as cleft lip and cleft palate.
- Repair and restoration of teeth from injuries that arise from non-gustatory trauma.
- Extraction of teeth when related to radiation therapy or in advance of an organ transplant (other than a corneal transplant).
- Medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including treatment of fractures.
- Under certain circumstances (listed below) the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services:
 - o Dental general anesthesia for a beneficiary when services are rendered in a hospital or outpatient surgical facility, when enrolled individual is being referred because, in the opinion of the dentist, the individual:
 - Is under age 18 and has a physical, mental, or medically compromising condition; or
 - Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy; or
 - Patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient.
 - Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.
 - No payment is extended toward the dentist or the assistant dental provider under this Plan. Refer to the dental benefits described in the PEBP Self-funded PPO Dental Plan Master Plan Document available at ~~www.pebp.state.nv.us~~<https://pebp.nv.gov/>.

Temporomandibular Joint Disorder (TMJ) and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. TMJ

surgeries are covered under the medical benefits based on medical necessity and are limited to an annual maximum of one surgery and a lifetime maximum of two (2) surgeries.

Precertification is required for dental general anesthesia in a hospital or outpatient surgical facility. Dental anesthesiology services are covered only for procedures performed by a qualified specialist in pediatric dentistry, a dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

Only the services and supplies described above are covered, even if the condition is due to a genetic, congenital, or acquired characteristic. Exclusions include:

- Except as described above as an inclusion, services involving treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; and repairs and restorations except for appliances that are medically necessary to stabilize or repair teeth after an injury as set forth above;
- Dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth above.
- Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and near the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and
- Other supplies and services including but not limited to cosmetic restorations, veneers, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthopedic Devices and Prosthetic Devices

Coverage for orthopedic devices is limited to medically necessary braces for problems requiring complete immobilization or for support, or if the braces are custom fitted or have rigid bar or flat steel supports and stays, splints, devices for congenital disorders, post, and pre-operative devices.

One medically necessary prosthetic device, approved by the Centers for Medicare & Medicaid Services (CMS), is covered for each missing or non-functioning body part or organ every three years. Coverage is limited to:

- Devices that are required to substitute for the missing or non-functioning body part or organ.
- Adjustment of initial prosthetic device; and
- The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.
- Repair and replacement of prosthetic devices is not covered except in limited situations involving mastectomy reconstructive surgery.

Orthopedic shoes, foot orthotics or other supportive devices of the feet are excluded, except when such devices are:

- An integral part of a covered leg brace and its expense is included as part of the cost of the brace:
- For diabetes mellitus and for foot deformity, history of pre-ulcerative calluses, history of previous ulceration, peripheral neuropathy with evidence of callus formation, poor circulation or previous amputation of the foot or part of the foot:
- For rehabilitation prescribed as part of post-surgical or post-traumatic casting care; or
- Prosthetic shoes for members with a partial foot.

Ostomy Care Supplies

Coverage is provided for medically necessary care and supplies after colon, ileum, or bladder surgery to assist in carrying on normal activities with a minimum of inconvenience.

Outpatient Rehabilitative and Habilitative Therapy Services

Coverage is provided for medically necessary physical, speech, occupational, cardiac, and pulmonary therapy habilitative and rehabilitation services that are performed by a physician or by a therapy provider licensed in accordance with state regulations for that therapy discipline.

Coverage for these services is available for acute conditions arising from illness or injury, as well as chronic or developmental conditions up to the benefit limits as defined in the benefit Plan.

- Outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) is subject to cost-share for each therapy type per visit.
- Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year (limit not applied to therapy treating a behavioral health condition).
- There is no limit for Cardiac Rehabilitation services.

PEBP also offers participants access to Hinge Health Digital Musculoskeletal (MSK) Care program for virtual therapy focusing on prevention, acute injury, chronic and surgical care programs. See Hinge Health, above, for more information.

Partial Hospitalization Services

Partial hospitalization services are covered for mental illness and substance abuse according to the benefits listed in the *Schedule of ~~Medical~~ Benefits*. The same services covered for inpatient

services are also covered for partial hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One partial treatment day is defined as no less than three and no more than 12 hours of therapy per day. Partial day treatment is covered only when the member receives care through a day treatment program.

Podiatry Services

Podiatry services are covered for the medically necessary treatment of acute conditions of the foot such as infections, inflammation, or injury and other foot care that is disease related.

The following services are not covered:

- Non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and routine foot care.

Preventive Services

Notwithstanding anything to the contrary in this *Summary of ~~Medical~~ Benefits*, the following preventive services will be covered without any participant cost-sharing if such services are provided by a participating provider:

- Periodic physical examinations and routine immunizations.
- Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination.
- ~~Screening mammograms every 1-2 years for women 40 years of age or older regardless of diagnosis or beginning at age 35 for members with a high-risk of breast cancer.~~
- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics.
- Colorectal cancer screening starting at age 45 years in accordance with:
 - The guidelines published by the American Cancer Society; or
 - Other guidelines or reports concerning such screening that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data.
- Immunizations, including COVID-19, influenza, pneumococcal, Haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, measles, diphtheria, human papillomavirus (HPV), pertussis (whooping cough), poliovirus, rotavirus, varicella (chickenpox), shingles (herpes zoster) and tetanus, if such immunizations have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (Note: Immunizations related to foreign travel or employment are excluded.);
- Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.

- Evidence-based items or services that have an “A” or “B” Recommendation by the [United States Preventive Services Task Force \(USPSTF\)](#) and [Section 2713\(a\)\(5\) of the Public Health Service Act](#) and Section 9(h)(v) (229) of the 2015 Consolidated Appropriations Act.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services guidelines including the American Academy of Pediatrics Bright Futures guidelines; and
- With respect to women, such additional preventive care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- Human Papillomavirus testing and vaccination under [NRS 695G.171](#).

Women's ~~Contraceptives~~ Preventive Services

This Plan covers FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity. The FDA requires the services to be “prescribed” by a physician even for over-the-counter methods. [This Plan complies with the coverage requirements for contraception and related health services set forth in NRS 695G.1715](#)~~This Plan also adheres to [NRS 695G.1715](#).~~

In accordance with [Senate Bill 280](#) from the 82nd Legislative Session in 2023, the Plan provides benefits for contraceptive injection or the insertion of a device at a hospital immediately after an insured gives birth.

Colorectal Cancer Screening

Colorectal screening tests are covered at 100% when provided in-network for adults aged 45 years and older who are at average risk of colorectal cancer in accordance with the American Cancer Society’s qualified recommendations; or beginning at age 40 for members with a high-risk of colorectal cancer. For more information regarding colorectal screening guidelines, contact the Claim’s Administrator.

Screening Mammograms

Preventative mammograms are covered at 100% for women aged 40 years and older, under the [Affordable Care Act](#) and [USPSTF](#), or beginning at age 35 for members with a high-risk of breast cancer, when performed in-network.

Prostate Cancer Screening

Limited to 1 preventative per plan year and offered in accordance with [NRS 695G.177](#), which includes reference to the [American Cancer Society](#) guidelines.

Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions

Healthy Diet/Physical Activity Counseling and Obesity Screening/Counseling for adults aged 18 years and older are covered under the Wellness/Preventive Care Benefit when the Participant or covered dependent is referred by a primary care practitioner; for those who have a basal metabolic index (BMI) of 30 or greater; and have additional cardiovascular disease (CVD) risk factors. This wellness/preventive benefit is limited to twelve (12) Healthy Diet/Physical Activity Counseling or Obesity Screening/Counseling sessions per Plan year according to recommendations from the USPSTF. Additional visits are subject to a specialist visit copay, deductible, or coinsurance where applicable.

Smoking/Tobacco Cessation

- Prescription and over-the-counter smoking/tobacco cessation products are covered under the prescription drug program. Over-the-counter smoking cessation products must be accompanied by a prescription written by a physician.
 - Some examples of cessation products eligible to be paid at 100% include Chantix (by prescription only), nicotine gum, nicotine patches, and nicotine lozenges.
 - Some limitations on quantity may apply and are at the discretion of the Pharmacy Benefit Manager and your physician.
- Benefits for over-the-counter products are limited to those that are FDA approved and recommendations by the Surgeon General.
- Over-the-counter smoking/tobacco cessation products may be obtained by presenting your physician's written prescription to an In-Network pharmacy, or you can submit your purchase receipt for the product with your physician's written prescription attached to the Prescription Drug Reimbursement Claim Form (this form is located at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.state.nv.ushttps://pebp.nv.gov/)).
- Second-line therapies such as clonidine hydrochloride and nortriptyline hydrochloride are sometimes used in the management of smoking/tobacco-cessation; however, due to the lack of an FDA-approved indication for smoking cessation, as well as undesirable side effect profiles, currently prohibit these agents from achieving first-line classification and therefore, not covered under the *Preventive Care/Wellness Services* Benefit.
- The Plan does not cover electronic cigarettes.

For more information, please visit:

Preventive Services for Adults and Families: Visit the U.S. Preventive Task Force at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>

Preventive Services for Women, Including Pregnant Women: Visit Human Resources & Services Administration (HRSA) at <https://www.hrsa.gov/womens-guidelines/index.html>

Vaccines for infants, children, and teens: Visit the U.S. Department of Health & Human Services at <https://www.hhs.gov/vaccines/index.html>

Vaccines & Immunizations: Visit the Centers for Disease Control and Prevention at <https://www.cdc.gov/vaccines/index.html>

Preventive Health Services: Visit HealthCare.gov at <https://www.healthcare.gov/coverage/preventive-care-benefits/>

Preventive care services identified through the above links is recommended services. It is up to the participant and their physician or provider of care to determine which services to provide. The Plan Administrator has the authority to determine which services and quantity limits will be covered at the 100% wellness benefit; unless otherwise mandated by the Affordable Care Act or mandated in accordance with applicable Nevada Revised Statutes.

Note: This Plan complies with [NRS 695G](https://www.leg.state.nv.us/nrs/nrs-695g.html) as related to contraceptive methods, utilization management, step therapy, prior authorization, categorization of prescription drugs (meaning Preferred Generic, Preferred Brand and Non-Preferred Brands), and cost-sharing. For more information, refer to <https://www.leg.state.nv.us/nrs/nrs-695g.html>.

Radiation Therapy

The Plan covers medically necessary specialty radiology when ordered by a physician or health care practitioner acting within the scope of their license, including, but not limited to, MRI, MRA, MRS, MRT, PET, SPEC, and CT scan. See the *Utilization Management* (Prior Authorization) section for precertification requirements.

The Plan covers technical and professional fees associated with:

- diagnostic and curative services, including radiation therapy, and
- pre-admission testing: Outpatient radiology tests performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Real Appeal

Nevada Public Employees' Benefits Program has partnered with UMR's Real Appeal program. Real Appeal provides eligible members a benefit for virtual weight loss and weight management coaching sessions. Sessions are covered under the preventive care benefit resulting in no cost-sharing to members. Real Appeal supports members eighteen (18) years of age and older.

This support includes, but not limited to, one-on-one coaching and online group sessions with supporting video content delivered by a virtual coach.

A qualified enrolled member will receive:

- Access to a coaches who will guide you through the program and develop a custom plan that fits your needs, preferences, and goals.
- 24/7 access to digital tools and dashboards.
- A Real Appeal kit containing health weight management tools that may include fitness

guides, recipes, digital food and weight scales

- Support from online group classes with a coach and other members who share what's helped them achieve success.

For more information, contact the Plan's third-party claims administrator listed in the Participant Contact Guide.

Skin Lesions

Coverage is provided for medically necessary removal of skin lesions and related pathological analysis of such lesions. Coverage is provided for the removal of port wine lesions.

Transplant Services

Medically necessary organ transplants at an approved Center of Excellence are covered when you are the organ recipient in the following cases:

- Bone marrow.
- Cornea.
- Heart.
- Heart and lung.
- Intestinal and liver.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Pancreas and kidney; and
- Stem cell.

Centers of Excellence are facilities that meet vigorous credentialing requirements for the specific type of organ transplant. A facility that is designated as a Center of Excellence for one type of organ transplant may not be designated as a Center of Excellence for another type of organ transplant. Designation as a Center of Excellence is at the UM company's sole discretion.

Organ transplants are only covered where the organ donor's suitability meets the OPTN/UNOS (Organ Procurement and Transplantation Network/United Network for Organ Sharing) donor evaluation and guideline criteria, when applicable.

Coverage for related transplant services is limited to:

- Tests necessary to identify an organ donor.
- The reasonable expense of acquiring the donor organ.
- Transportation of the donor organ (but not the donor), and life support where such support is for the sole purpose of removing the donor organ.
- Storage costs of an organ, but only as part of an authorized treatment protocol; and
- Follow-up care.

The following services are excluded from coverage:

- Services provided at a facility that has not been designated as an approved Center of Excellence.
- Services provided to an organ donor unless otherwise specified elsewhere in this document.
- Services provided in connection with purchasing or selling organs.
- Transplants utilizing any animal organs.
- Any transportation of the donor (as opposed to transportation of the donor organ only) is excluded, except as otherwise covered under the *Travel Expense* section for transplant services.
- Any expenses associated with an organ transplant where an alternative remedy is available are excluded.
- Artificial heart implantation is excluded.
- Services for which government funding or other insurance coverage is available are excluded.
- Tissue transplants (whether natural or artificial replacement materials or devices are used) or oral implants, including the treatment for complications arising from tissue or organ transplants or replacement are excluded, except as described above.

2nd.MD Opinion

2nd.MD provides eligible members with direct access to elite specialists across the county for expert second opinions. Specialists answer questions about disease, cancer, chronic conditions, surgery or procedure, medications, and treatment plans. Specialists are board certified, leaders in research, and pioneers in medicine. To learn more visit www.2nd.MD/PEBP or call 1-866-841-2575.

Telemedicine or Telehealth (Doctor on Demand)

Telemedicine (virtual medicine) is available through Doctor on Demand, PEBPs contracted telehealth provider and is considered In-Network. Participants can register with Doctor on Demand and connect face-to-face with a board-certified doctor or licensed psychologist on a smartphone, tablet, or computer through live video. Some of the medical and behavioral health conditions that may be treated include cold and flu, bronchitis, sinus issues, urinary tract infection, anxiety, depression, etc. Doctor on Demand providers can also prescribe medications (except controlled substances). For more information, visit www.pebp.state.nv.us <https://pebp.nv.gov/> or the *Summary of ~~Medical~~ Benefits*.

Services available include:

- Medical visit
- Psychologist visit
- Psychiatry visit

You may receive services from a provider who is in a different location using information and audio-visual communication technology. Telemedicine does not include communication through telephone, facsimile, or email.

Doctor on Demand physicians do not prescribe DEA controlled substances and may elect not to treat or prescribe other medications based on what is clinically appropriate. In a true medical emergency, such as chest pains, shortness of breath or broken bones, dial 911 or seek immediate medical attention as appropriate.

Alternatively, telemedicine may be available from in-network providers and is covered on the same basis as in-person services. It is your responsibility to ensure the providers you use are in-network providers. Failure to use in-network providers will result in a denial of benefits and higher cost to you.

This Plan ~~also~~ adheres to the provisions of [NRS 695G.162](#) regarding [coverage for services provided through](#) telehealth.

Continued Coverage Following Termination of a Provider Contract

For serious health conditions not covered by the No Surprises Act, if a participant is receiving a medically necessary course of treatment from an in-network provider and that provider leaves the network (except for termination due to medical incompetence or professional misconduct), and the participant and the provider agree that a disruption to the participant's current care may not be in the best interest or if continuity of care is not possible immediately with another in-network provider, this Plan will pay that provider at the same level they were being paid while contracted with this Plan's network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- Such treatment is no longer medically necessary or no later than the 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 90th day after:
 - The date of delivery; or
 - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Transplant Services (Organ and Tissue)

Organ, bone marrow and tissue transplant coverage are provided only for eligible services related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.

This Plan will provide coverage for the donor when the recipient is a participant under this Plan. Coverage is provided for organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his/her Plan will pay first and benefits under this Plan will be reduced by the amount payable under the

donor's Plan.

Transplantation-related services require precertification (see the *Utilization Management* section of this document for details).

See the specific exclusions related to experimental and investigational services and transplants in the *Benefit Limitations and Exclusions* section.

This Plan provides for reimbursement of certain costs associated with travel and hotel accommodations for the patient and one additional person when the travels are associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to *Transplant Services* section for additional information. Expenses incurred for travel and hotel accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.

This Plan does not provide advance payment for travel expenses related to organ or tissue transplants.

See the specific exclusions related to experimental and investigational services and transplants in the *Benefit Limitations and Exclusions* section.

This Plan provides for reimbursement of certain costs associated with travel and hotel accommodations for the patient and one additional person when the travels are associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to *Schedule of ~~Medical~~ Benefits* section for additional information. Expenses incurred for travel and hotel accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.

This Plan does not provide advance payment for travel expenses related to organ or tissue transplants.

Use of Centers of Excellence for Transplant and Gastric (Bariatric) Procedures

This Plan requires participants to use an in-network Center of Excellence for transplant and bariatric weight/loss surgery. An appropriate Center of Excellence facility will be identified by the Plan's UM company and third-party Claims Administrator.

~~Travel~~ Expenses

This Plan allows for the reimbursement of travel and hotel accommodation expenses permitted under [IRS Regulation 213\(d\)](#) and [IRS Publication 502](#) for qualified medical expenses when the expenses are associated with the following services and have been pre-certified by the UM company:

- Organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence; or
- Elective surgeries performed at exclusive hospitals/ambulatory facilities; and
- Outpatient infusion services if the UM company requires you to travel more than 50 miles one way for a service subject to precertification.
- Travel for a participant located in a State with restricted access to abortion to the nearest care center for abortion services covered under this Plan.

Travel expenses are covered when incurred in conjunction with the member's:

- Transplant or bariatric surgery (does not include pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon. Travel expenses incurred on or after one year are not eligible for reimbursement.
- Hip and knee total joint replacement surgery performed at an approved exclusive Nevada hospital/ ambulatory surgery facility when prior authorized by the utilization management company (including pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon; and
- Travel expenses related to an organ or tissue transplant, or bariatric surgery scheduled or performed at a facility or other provider type that is not a Center of Excellence as determined by the Plan Administrator or its designee will not be covered. Travel expenses related to an inpatient or outpatient surgery that is not determined to be a preferred hospital/ambulatory surgical facility by the UM company will not be covered. There are no exceptions.
- If the travel companion has their own separate PEBP Plan, travel expense reimbursement will not apply to the companion.
- PEBP does not provide advance payment for travel expenses.
- This Plan incorporates the travel expense reimbursement guidelines established in IRS Regulation 213(d) and IRS Publication 502.
- The least expensive method of transportation must be used.
- Standard mileage reimbursement for the use of a personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center is based on the mileage from the member's residence to and from the facility (based on an objective source such as Google Maps).
- The Plan Administrator or its designee has full authority to approve or deny all or part of the travel expenses. The reduction and/or denial of travel expenses cannot be appealed.
- Travel expenses are subject to Deductible and Out-of-Pocket Maximum.

Participants are required to use the least expensive method of transportation. Participants who use their personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center will be compensated for mileage from the participant's residence to and from the Center of Excellence or exclusive hospital/ambulatory surgical facility or outpatient infusion facility (based on an objective source such as Google Maps) at the standard mileage reimbursement rate for medical travel.

This Plan incorporates the travel expense reimbursement guidelines established in [IRS Regulation 213\(d\)](#) and [IRS Publication 502](#).

NOTE: The Plan Administrator or its designee has full authority to approve or deny all or part of your travel expenses. The denial of travel expenses cannot be appealed.

Excluded Travel Expenses:

The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved):

- Alcoholic beverages.
- Car maintenance.
- Vehicle insurance.
- Flight insurance.
- Cards, stationery, stamps.
- Clothing.
- Dry cleaning.
- Entertainment (cable televisions, books, magazines, movie rentals).
- Flowers.
- Household products.
- Household utilities, including cell phone charges, house cleaner, baby-sitter, or day care services.
- Kennel fees.
- Laundry services.
- Meals (insomuch as it is excluded under the IRS Publication 502 and Regulations under 213(d).
- Security deposits.
- Toiletries.
- Travel expenses related to a facility or provider that is not a certified Center of Excellence, exclusive hospital/ambulatory surgical facility, or outpatient infusion facility; and
- Travel expenses incurred on or after one year following surgery are not eligible for reimbursement.
- Travel expenses are subject to the annual cost sharing requirements.

Note: PEBP will not reimburse travel or any other expense to any participant covered under PEBP's Exclusive Provider Organization ([EPO](#)) Plan, the self-funded Consumer Driven Health Plan (CDHP), or the Low Deductible PPO Plan twice for any service or event.

PEBP does not provide advance payment for travel expenses.

Pre-Approval of your Travel Expenses

Unless there are extenuating circumstances, travel expenses must be pre-approved by PEBP or its designee. Travel expenses not pre-approved by PEBP or its designee will not be eligible for reimbursement.

If the participant is unable to obtain pre-approval by PEBP or its designee because the organ or tissue transplant required immediate travel, the participant may submit associated travel costs to PEBP or its designee after the transplant surgery for consideration. The participant should designate someone to notify PEBP or its designee regarding the emergency travel and the circumstances surrounding such travel. Travel claims must be submitted within 12 months of the date of surgery to be considered eligible. Other requests for travel expenses require pre-approval.

Pre-approval will provide an approximation of your travel reimbursement. Final reimbursement will be based on actual expenses using the actual number of days and travel times and may differ from the pre-approved approximation. The Pre-approval Travel Expense Request form is available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Submitting your Travel Expense Receipts

A claim for travel expense reimbursement must be submitted to PEBP on a Travel Expense Reimbursement claim form. Relevant sections of the form must be completed including the start and end times, destination, and purpose of trip.

Travel expense reimbursement claims should be accompanied by original itemized receipts which include the name(s) of the person(s) incurring the expense.

Reimbursement of eligible travel expenses, including any eligible travel expenses relating to a travel companion, will be payable to the primary participant (employee or retiree) and not to the service vendor (credit card company, hotel, hospital, restaurant, etc.).

Vision Care Services

Vision Screening Exam (preventative)

One annual preventive vision screening exam including refractive error testing per Plan Year. PEBP does not maintain a network specific to vision care; however, the PPO network does have a list of some vision providers.

Prescription eyewear

Single vision, bifocal and trifocal lenses, and prescription contact lenses. Eyeglasses, or contact lenses in lieu of eyeglasses, limited to \$100 every 24 months.

Schedule of Prescription Drug Benefits

Benefits for prescription drugs are provided through the prescription drug plan administered by the Pharmacy Benefit Manager, Express Scripts. Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the U.S. Food and Drug Administration (FDA) as requiring a prescription and FDA approval for the condition, dose, route, duration, and frequency, if prescribed by a physician or other practitioner.

The following includes explanations and limitations that apply to each benefit; however, the explanations and limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any precertification requirements), [Benefit Limitations and Exclusions](#), *Key Terms and Definitions* and other sections that may apply to a specific benefit.

For helpful tools such as “Price a Medication” see the *Participant Contact Guide* section or go to the PEBP website at ~~www.pebp.state.nv.us~~<https://pebp.nv.gov/>.

Some over the counter (OTC) drugs and prescription drugs are eligible to be covered under the Plan’s Preventive Care Services benefit in accordance with the Affordable Care Act; whereby, the Plan will waive the Copay and Deductible and products are paid at 100%. Examples include aspirin, folic acid, smoking cessation products and female oral contraceptives. Please contact Express Scripts for more information.

Certain OTC female contraception products are covered when presented with a prescription from your physician to your pharmacy. These types of products include the female condom, sponges, and spermicides. Refer to the ~~Women’s Preventive Services~~[Care](#) section for more information or call Express Scripts whose contact information is in the *Participant Contact Guide*.

Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. Contact the pharmacy benefit manager listed in the *Participant Contact Guide* or visit www.express-scripts.com to check vaccine coverage and locate your nearest in-network pharmacy.

Coverage is also provided for, but not limited to:

- COVID-19 vaccinations and medications
- Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (tetanus, diphtheria, and pertussis -whoopingcough)
- Prenatal & pediatric prescription vitamins
- Prescription female oral contraceptives
- Insulin, diabetic supplies (such as lancets, syringes, test strips), insulin pumps, and insulin pump supplies.
 - Insulin pumps and supplies are covered under the pharmacy benefit’s base day and quantity limits, subject to copayments, deductibles, or coinsurance.

- Orally Administered Chemotherapy: The Copayment or Coinsurance amount for orally administered chemotherapy drugs will be consistent with the drug's formulary tier for retail, home delivery and Specialty pharmacy; and in accordance with [NRS 695G.167](#), the cost will not exceed \$100 per prescription. For more information, see *Key Terms and Definitions* section.
- [Prescription drugs irregularly dispensed for purposes of synchronization of chronic medication synchronization per pursuant to the provisions of NRS 695G.1665.](#)
- Topical Ophthalmic Products [NRS 695G.172](#). Refills of topical ophthalmic products will be covered when medically necessary, including when requested: (a) After 21 days or more but before 30 days after receiving any 30-day supply of the product; (b) After 42 days or more but before 60 days after receiving any 60-day supply of the product; or (c) After 63 days or more but before 90 days after receiving any 90-day supply of the product.
- Medically necessary prescription drugs to treat sickle cell disease and its variants ([NRS 695G.174](#)).
- Human Papillomavirus testing and vaccination under [NRS 695G.171](#).
- In accordance with [Assembly Bill 156](#) from the 82nd Legislative Session in 2023, the Plan provides benefits for substance use disorder including coverage for all drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.
- In accordance with [Senate Bill 167](#) from the 82nd Legislative Session in 2023, the Plan provides prescription benefits for psychiatric conditions for drugs that are approved by the Food and Drug Administration or the use of a drug to treat a psychiatric condition that is supported by medical or scientific evidence when prescribed by a Provider acting within the scope of their license. These prescription drugs are not subject to medical management techniques, such as step therapy.

Preventive Drug Benefit Program

The Preventive Drug Benefit Program 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 logging on to [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) or by contacting Express Scripts located in the Participant Contact Guide section.

The plan adheres to [NRS 695G.1715](#) regarding contraception and related health services.

Specialty Drugs

Certain drugs fall into a category called specialty drugs. Specialty drugs are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, etc. Specialty drugs and prescriptions are limited to a 30-day supply. Specialty drugs must be filled through Accredo, an Express Scripts Specialty Pharmacy (see the *Participant Contact Guide*). Plan participants are encouraged to register with the Accredo Specialty Pharmacy before filling their first prescription for a specialty drug. Check with Express Scripts to determine if your prescription is considered specialty.

~~Certain drugs fall into a category called specialty drugs. Specialty drugs are available only through the Specialty Pharmacy listed in the Participant Contact Guide section, and prescriptions are limited to a 30-day supply. Plan participants are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. Contact Express Scripts to determine if your prescription is considered specialty.~~

Special pharmaceuticals, which include injectables, oral medications, and medications given by other routes of delivery, may be delivered in any setting. Special pharmaceuticals are pharmaceuticals that typically have:

- Limited access.
- Treat complex medical conditions.
- Complicated treatment regimens.
- Compliance issues.
- Special storage requirements; or
- Manufacturer reporting requirements.

This Plan's Pharmacy Benefit Manager maintains a list of special drugs classified as special pharmaceuticals. For information regarding special pharmaceuticals, contact ~~the Pharmacy Benefit Manager listed in the Participant Contact Guide~~[Express Scripts](#).

For Specialty Drugs part of the SaveOnSP program, the coinsurance applies. For Specialty Drugs not part of the SaveOnSP program, the respective coinsurance applies with a copay limitation maximum of \$250.



Copayment assistance (manufacturer-funded patient assistance) for specialty drugs will not apply toward your Deductible and Out-of-Pocket Maximum.

Preferred Retail Pharmacy Network

For short-term prescriptions, such as antibiotics, use a Preferred Retail Pharmacy (for lower copays) or a Non-Preferred Retail Pharmacy (where you will pay \$10 extra for each short-term prescription). Your Preferred Retail Pharmacy Network has more than 34,000 pharmacies consisting of approximately 50% independent pharmacies in addition to grocers and other stores.

To find a preferred pharmacy near you, register or log in to express-scripts.com/findapharmacy or call Express Scripts' Member Services at 855-889-7708.

90-Day Retail and Home Delivery Program

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 both a 90-day supply and to either a participating retail pharmacy or Express Scripts Home Delivery Pharmacy. 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.

Smart90 Retail Pharmacy

To locate a participating Smart90 Retail Pharmacy or a Preferred Retail Network Pharmacy, log in to the E-PEBP Portal located at www.pebp.state.nv.ushttps://pebp.nv.gov/ and select *Express Scripts*. You can also get pharmacy information by calling Express Scripts' Member Services at 855-889-7708. You can transfer your medications easily in-store, by phone or online.

Express Scripts Home Delivery:

You may use home delivery through the Express Scripts Home Delivery Pharmacy to receive a 90-day supply of your maintenance medications and have them mailed to you with free standard shipping. Not all drugs are available via mail order. Check with Express Scripts for further information on the availability of your prescription medication. Enrolling in home delivery is easy! First, log in to express-scripts.com.

If you are enrolling a new prescription in home delivery:

- **Contact your doctor** and ask them to e-prescribe a 90-day prescription directly to ExpressScripts
- **OR send a request** by selecting "Forms" or "Forms & Cards" from the "Benefits" menu, print and mail-order form and follow the mailing instructions
- **OR call** Express Scripts' Member Services at 855-889-77058 and they will contact your doctor for you if you are enrolling a current prescription:

Transfer retail prescriptions to home delivery by clicking **"Add to Cart"** for eligible prescriptions and check out. You can also refill and renew prescriptions. Express Scripts will contact your doctor and take care of the rest.

Check **Order Status** to track the shipping of your prescriptions. After we receive your prescription from your doctor, you will receive your medication within 7 days. Please keep in mind, longer

delivery times may be due to additional correspondence need with prescribers, medication availability and/or delivery times from the shipping vendor.



Generics Preferred Program

When your doctor prescribes a brand-name drug and a generic substitute is available, you will automatically receive the generic drug unless:

- Your doctor writes “dispense as written” (DAW) on the prescription; or
- You request the brand-name drug at the time you fill your prescription.

If you choose generic medicines, you get safe medicines at the lowest cost. Your copayment for the generic drug will be less than the copayment for the brand-name drug.

If a generic is available, but you or your doctor request the brand-name drug, you will pay the applicable brand copayment, plus the full difference in cost between the brand-name drug and the generic equivalent. This difference in cost is referred to as the ancillary fee. The ancillary fee is in addition to the copayment, so the cost could exceed the copayment maximum.

SaveonSP Program

As part of your prescription drug plan, ~~Nevada Public Employees’ Benefits Program~~ PEBP has partnered with an Express Scripts’ copay assistance program, SaveOnSP, to help save money on certain specialty medications. Through the SaveonSP Program, manufacturer-funded assistance is available to help assisting members with the cost of the Program drug(s) is reimbursed by the manufacturer at no cost to the participant.

The medications included in the SaveonSP Program are classified as Non-Essential Health Benefits under the Affordable Care Act. The cost of these drugs will not be applied towards satisfying your deductible or out-of-pocket maximum.

Members currently taking a medication, or those who will be taking a medication, captured under this Program are eligible to participate.

- Select medications on the *Non-Essential Benefit Specialty Drug List* will be free of charge(\$0) to members who participate.
- Prescriptions must be filled through Accredo Specialty Pharmacy.
- The medications and associated copays included in this program are subject to the Pharmacy Benefit Manager’s clinical rules.
- If the medication you are taking is on the *SaveOnSP Non-Essential Benefit Specialty DrugList* and you wish to participate, call SaveOnSP at 1-800-683-1074.
- The SaveonSP Program drug list can be found at www.saveonsp.com/pebp



Participation in the SaveOnSP Program is voluntary; however, if you are taking or will be taking a medication that is on the Non-Essential Benefit Specialty Drug List, and you choose not

to participate in the SaveOnSP Program, you will be responsible for the copay outlined in the SaveonSP Program Drug List and that cost will not apply toward your Deductible or Out-of-Pocket Maximum.

Diabetes Care Value

Express Scripts offers a program that supports members with diabetes (type 1 and 2) pre-diabetes, and even common comorbidities like obesity. ESI's digital diabetes prevention and obesity solution offers a personalized coaching and weight loss program, including an app-connected scale, to help patients avoid type 2 diabetes. The Diabetes Care Value is administered by Express Scripts and qualifying participants will receive a personal invitation, with instructions, to join the program.

Extended Absence Benefit

If you are going to be away from your home for an extended period, either in the country or outside of the country, you may obtain an additional fill (30 or 90-day supply) of your prescription drugs from your local retail or mail order pharmacy. This limited benefit must be requested in advance by the participant to ~~the pharmacy benefit manager listed in the Participant Contact Guide~~[Express Scripts](#). A maximum of two (2) early refills are allowed every 180 days. You may be required to obtain a new written prescription from your physician and any necessary prior authorizations.

Out-of-Network Pharmacy Benefit

Prescriptions filled at a domestic (inside the United States) out-of-network pharmacy location, are not authorized for reimbursement under the prescription drug Plan. Prescription drugs must be filled at a participating in-network pharmacy location.

Express Scripts offers helpful tools that allow participants to manage their prescriptions. Go to www.express-scripts.com or download the free mobile app and have your identification card available to register. The "Price a Medication" menu option under "Prescriptions" is used to determine estimated Out-of-Pocket cost. From this menu option, a prescription savings program called *My Rx Choices* is available to view side-by-side medication comparisons showing potential savings with lower-cost alternatives along with any applicable coverage alerts such as "prior authorization required". See the *Participant Contact Guide* section or go to the PEBP website at www.pebp.state.nv.ushttps://pebp.nv.gov/.

Out-of-Country Emergency Medication Purchases

This Plan may cover emergency prescription drugs purchased if you reside in the United States and travel to a foreign country. You will need to pay for the drug at the time of purchase and later submit for reimbursement from ~~the Pharmacy Benefit Manager~~[Express Scripts](#). Prescription drug purchases made outside of the United States are subject to Plan provisions, [Benefit Limitations](#) and [eExclusions](#), clinical review, and determination of medical necessity. The review ~~may include application of pertinent will also include regulations determined by the~~[Food and Drug Administration \(FDA\) regulations](#). Out-of-Country medication purchases are only eligible for

reimbursement while traveling outside of the US.

If your purchase is eligible for reimbursement, you must use the Direct Claim Form available from the prescription drug plan administrator. Direct Claim Forms may be requested from the prescription drug plan or obtained by logging in to www.express-scripts.com. In addition to the Direct Claim Form, you are required to provide:

- A legitimate, [legible](#) copy of the written prescription completed by your physician
- Proof of payment from you to the provider of service (typically your credit card invoice)
- Prescription and receipt must be translated to English and include the American equivalent National Drug Code for the prescription purchased
- Reimbursement request must be converted to United States dollars

The claim will be processed based on the American equivalent National Drug Code and charged based upon that drug copay tier. If an American equivalent National Drug Code does not exist, the claim will be denied.

Benefit Limitations and Exclusions

This Plan does not cover certain services. This chapter lists the general medical and pharmacy benefit exclusions of this Plan. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum. Additional exclusions that apply to only a service or benefit are listed in the description of that service or benefit in the *Schedule of ~~Medical~~ Benefits* sections. This list is not all-inclusive; if you have questions about a service or supply, contact the Claims Administrator listed in the *Participant Contact Guide*.

Expenses That Do Not Accumulate Toward Your Out-of-Pocket Maximum

The following services do not accumulate toward the out-of-pocket maximum, and you will be responsible for paying these expenses out of your own pocket.

- Expenses for medical and pharmacy services and supplies that are not covered by the Plan, to include but not limited to, expenses that exceed the CDHP network contract rate, services listed in the *Benefit Limitations and Exclusions* section.
- Charges in excess of the usual and customary charge determined by the Plan Administrator.
- Any additional amounts you must pay because you failed to comply with the utilization management requirements described in the *Utilization Management* section.
- Benefits exceeding those services or supplies subject to maximum individual or lifetime limit(s) for certain eligible medical expenses as listed in the *Schedule of ~~Medical~~ Benefits*; and
- Certain wellness or preventive services that are paid by this Plan at 100% do not accumulate towards the out-of-pocket maximum.

This list is not all-inclusive and may not include certain services and supplies that are not listed above.

Benefit Limitations

In addition to the exclusions listed below, refer to the *Schedule of ~~Medical~~ Benefits* sections for the maximum individual or lifetime limit(s) and any Plan Year limit applicable to certain covered expenses. Plan Year limits are met by days, hours, visits, or dollar limits paid under components of the Plan.

Lifetime Maximum

This Plan imposes a lifetime maximum on some health care services and procedures. For information on the lifetime maximums, refer to the *Schedule of ~~Medical~~ Benefits* sections.

Exclusions Under the ~~Medical~~ Plan

The following is a list of services and supplies or expenses not covered by this Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and terms of the Plan and determines eligibility and entitlement to Plan

benefits. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum.

Abortion: Elective termination of pregnancy (abortion) is excluded from the plan, other than medically indicated abortions that are medically necessary to save the life of the mother.

This plan provides abortion benefits in accordance with [NRS 422.250](#).

Alternative/Complimentary Health Care Exclusions: Expenses for chelation therapy (except as may be medically necessary for treatment of [mental health](#), acute arsenic, gold, mercury, or lead poisoning) and for diseases due to clearly demonstrated excess of copper or iron. Expenses for prayer, religious healing, or spiritual healing, except services provided by a Christian Science Practitioner. Expenses for naturopathic, Naprapathy services or treatment/supplies. Expenses for homeopathic treatments/supplies that are not FDA approved.

Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.

Bariatric and Overweight Surgery: The Plan's individual lifetime maximum is one (1) bariatric surgery while covered under any current or previous PEBP self-funded health plan.

Bariatric and Overweight Surgery Not Performed at a Center of Excellence Provider: Benefits are excluded for bariatric/weight loss surgery performed at an Out-of-Network facility, Out-of-Network surgeon, or when Out-of-Network ancillary providers are used, unless covered under the No Surprises Act. PEBP or its designee will determine the In-Network Center of Excellence facility.

Behavioral Health Care Exclusions

- ~~Expenses for hypnosis and hypnotherapy.~~
- Expenses for behavioral health care services related to:
 - adoption counseling;
 - non-medically necessary court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws);
 - custody counseling;
 - dance, poetry, or art therapy;
 - developmental disabilities;
 - dyslexia;
 - learning disorders;
 - attention deficit disorders (with or without hyperactivity, except when the services are for diagnosis, the prescription of medication as prescribed by a physician or other health care practitioner, or when accompanied by a treatment plan as submitted to the Plan or its designee) or the treatment is related to the management of ADD/ ADHD without prescription drugs and is approved by the Plan or its designee;
 - family planning counseling;

- marriage and/or, couples and or sex counseling (the exclusion for marriage/couples counseling will not limit individual mental health counseling for an otherwise covered mental health condition);
- intellectual disability;
- pregnancy counseling;
- vocational disabilities, and
- organic and non-organic therapies
 - including (but not limited to) crystal healing, EST, primal therapy, L-Tryptophan, vitamin therapy, religious/spiritual, etc.
- Expenses for tests to determine the presence of or degree of a person's dyslexia or learning disorder unless the visit meets the criteria for benefits payable for the diagnosis or treatment of Autism Spectrum Disorders.

Complications of a non-covered service: Expenses for care, services or treatment required because of complications from a treatment or service not covered under this Plan, except complications from an abortion.

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge medical practice to have access to the medical services provided by the concierge medical practice.

Controlled Substance or Intoxicated: ([NRS 695G.405](#)) Services/Treatments which involves an injury to which a contributing cause was the insured's commission of or attempt to commit a felony, except if a result of a medical or behavioral health condition, or domestic violence, even if the condition was not diagnosed at the time of the injury. See [NRS 695G.405](#).

Corrective Appliance, Orthotic Device Expenses, and Appliances: Any items that are not

- Corrective appliances,
- orthotic devices or orthotic braces that straighten or change the shape of a body part,
- prosthetic appliances, or
- durable medical equipment (as each of those terms is defined in the *Key Terms and Definitions* section)

This includes, including, but not limited to, personal comfort items like:

- -air purifiers,
- humidifiers,
- electric heating units,
- swimming pools,
- spas,
- saunas,
- escalators,
- lifts,
- motorized modes of transportation determined to be not medically necessary,

- pillows,
- orthopedic mattresses,
- water beds, and
- air conditioners are excluded.

Expenses for cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome. Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment are not covered. Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.

Cosmetic Services and Surgery: The Plan excludes expenses for cosmetic services and surgery, or any drugs used for cosmetic purposes, including but not limited to health and beauty aids unless explicitly noted in the Covered Services section.

Complications resulting from Cosmetic Services or Surgery are not covered.

~~There is no coverage for travel costs.~~

Breast augmentation/augmentation mammoplasty excluded, except as otherwise covered and described above.

Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken/missed appointments, general telephone calls not including telehealth, or photocopying fees.

Court-Ordered Treatment: Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, laboratory and other diagnostic testing and other services including hospitalizations or partial hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless the Plan Administrator or its designee determines that such services are independently medically necessary.

Custodial Care: Expenses for custodial care as defined in the *Key Terms and Definitions* section, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, including any service that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Services required to be performed by physicians, nurses or other skilled health care providers are not considered to be provided for custodial care services and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Dental Services: Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness, or injury affecting the mouth or another part of the body.

Except as described as an inclusion in the Schedule of ~~Medical~~ Benefits, services involving

- treatment to the teeth;
- extraction of teeth;
- repair of injured teeth;
- general dental services;
- treatment of dental abscesses or granulomas;
- treatment of gingival tissues (other than for tumors);
- dental examinations;
- restoration of the mouth, teeth, or jaws because of injuries from
 - biting, chewing, or accidents;
- artificial implanted devices;
- braces;
- periodontal care or surgery;
- teeth prosthetics and bone grafts regardless of etiology of the disease process; and
- repairs and restorations except for
 - appliances that are medically necessary to stabilize or repair teeth after an injury;
 - dental and or medical care including mandibular or maxillary surgery,
 - orthodontia treatment,
 - oral surgery,
 - pre-prosthetic surgery,
 - any procedure involving osteotomy to the jaw, and
- any other dental product or service except as set forth in the Schedule of ~~Medical~~ Benefits.

Coverage for dental services as the result of an injury to teeth may be extended under the medical Plan to a maximum of two (2) years following the date of the injury. Restorations past the two-year time frame will be considered under the dental benefits described in the PEBP Self-Funded Dental PPO Plan Master Plan Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthodontia is a specific Plan exclusion.

Drugs, Medicines, Nutrition or Devices:

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been prescribed for a medically necessary indication or are Experimental and/or Investigational as defined in the *Key Terms and Definitions* section.
- Non-prescribed, non-Legend and over the counter (OTC) drugs or medicines (except as preventive care medications required by the Affordable Care Act).
- Foods and nutritional supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs, and minerals (regardless of whether they can be purchased OTC or whether they require a prescription), except when provided during hospitalization; prenatal vitamins or minerals requiring a prescription;
- Special Food Product (as defined in the *Key Terms and Definitions* section), except for the benefit described as covered under Special Food Product in the *Schedule of Medical Benefits* section or elsewhere in this document under the section titled *Obesity Care Management Program*;
- Naturopathic, Naprapathy, or homeopathic treatments/substances.
- Weight control or anorexiant, except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy or where otherwise noted in this document under the section titled *Obesity Care Management Program*;
- Compounded Prescriptions in which there is not at least one ingredient that is a Legend Drug requiring a Prescription, as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, or other health care facility.
- Vaccinations, immunizations, inoculations, or preventive injections that are not covered under the Summary of *Medical Benefits* section.
- Marijuana and any derivative, including CBD, THC, edibles, etc. are not a covered benefit under this Plan.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the prescription drug program.
- Drugs to enhance athletic performance such as anabolic steroids (including off-labeled growth hormone). Coverage for human growth hormone or equivalent is excluded unless specifically covered and described in the *Summary of Medical Benefits*.
- Non-prescription male contraceptives, e.g., condoms.
- Dental products such as topical fluoride preparations and products for periodontal disease except as a preventive service required under the Affordable Care Act.
- Hair removal or hair growth products (*i.e.*, *Propecia*, *Rogaine*, *Minoxidil*, *Eflornithine*, etc.).
- Vitamin A derivatives (retinoids) for dermatologic use.
- Vitamin B-12 injections (except for treatment of Mental Health, pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (unless otherwise specified in the *Schedule of Medical Benefits*).

- Anti-aging treatments (even if FDA-Approved for other clinical indications)

Durable Medical Equipment:

See the exclusions related to Corrective Appliance, Orthotic Device Expenses, and Appliances.

Educational Services: Expenses for educational/vocational services, supplies or equipment including (but not limited to) computers, software, printers, books, tutoring, visual aids, auditory aides, and speech aides, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, or self-esteem, etc. (even if they are required because of an injury, illness, or disability of a covered individual).

Electronic cigarettes: The Plan does not cover electronic cigarettes.

Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by you or your covered dependents' employer; or for benefits otherwise provided under this Plan or any other plan that PEBP contributes to or otherwise sponsors (e.g., HMOs).

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefits as described in this document.

Expenses Exceeding Usual and Customary Charges, the Plan's Maximum Allowable Charge, Prevailing Rates and Plan Contracted Rates: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Plan's Maximum Allowable Charge, Usual and Customary Charge, prevailing rates or EPO contracted rate as defined in the *Key Terms and Definitions* section.

Expenses for Which a Third-Party Is Responsible: See "Third-Party Liability" of the Health and Welfare Wrap document that can be found on www.pebp.state.nv.us <https://pebp.nv.gov/> (NAC 287.755).

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided either before the patient became covered under the Plan or after the date the patient's coverage ends, except under those conditions described in COBRA Continuation Coverage.

Experimental and/or Investigational Services: Unless mandated by law, expenses for any medical services, supplies, drugs, or medicines that are determined by the Plan Administrator, UM company, or its designee to be experimental and/or investigational services.

Fertility and Infertility Treatment:

Except as otherwise specified in the Schedule of [Medical](#) Benefits section, other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) except services related to artificial insemination services up to the maximum benefit limit are excluded. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy; the promotion of fertility including,

but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the participant's ability to become pregnant or to carry a pregnancy to term; and any payment made by or on behalf of a participant who is contemplating or has entered into a contract for surrogacy to a provider or individual related to any services potentially included in the scope of surrogacy services; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are also excluded

Foot/Hand Care:

Expenses for non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and expenses for routine foot care (including but not limited to: trimming of toenails, removal of corns and callouses, preventive care with assessment of pulses, skin condition and sensation) or hand care, (including manicure and skin conditioning), unless the Plan Administrator or its designee determines such care to be medically necessary.

Routine foot care from a podiatrist for treatment of foot problems such as corns, calluses and toenails are payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

Gender Dysphoria and/or Gender Services: Certain procedures associated with gender dysphoria treatment and/or gender surgery found to be non-medically necessary in the Treatment for Gender Dysphoria section above are not covered.

The Plan provides benefits to individuals seeking services for the treatment of gender dysphoria and gender incongruence in accordance with [Senate Bill 163](#) from the 82nd Legislative Session in 2023.

~~There is no coverage for travel costs.~~

Genetic Testing and Counseling: Coverage is not available for tests solely for research, or for the benefit of individuals not covered under this Plan.

Expenses for genetic testing and counseling are excluded, unless otherwise specified in this Plan's Schedule of ~~Medical~~ Benefits.

Growth Hormone: Coverage for off-labeled growth hormone.

Gym Fees: Fees by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists, even if recommended by a professional to treat a medical condition.

Hair: Expenses for or related to hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Eflornithine; or for hair replacement devices, including (but not limited to) wigs, toupees and/or hairpieces or hair analysis. Patients undergoing chemotherapy may be able to receive benefits for some hair replacement devices, as listed above.

Hearing Care: Special education and associated costs in conjunction with sign language education for a patient or family members.

Hearing Aids: Over the Counter hearing aids are excluded from the Plan.

Home Birth/Delivery: Planned birth/delivery at home and associated services are not covered by this Plan. Guidelines for Perinatal Care published by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG) that the hospital, including a birthing center within the hospital complex, or a freestanding birthing center, provides the safest setting for labor, delivery, and the postpartum period. The use of other settings is not covered by this Plan. Facilities providing obstetrical care should have the services listed as essential components of a Level 1 hospital.

Home Health Care:

- Expenses for any home health care services that are not medically necessary, other than part-time, intermittent skilled nursing services and supplies.
- Expenses for a homemaker, custodial care, childcare, adult care, or personal care attendant, except as provided under the Plan's hospice coverage.
- Expenses for any home health care services that is not provided by an organization or professional licensed by the state to render home health services.
- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the Summary of ~~Medical~~ Benefits and Schedule of ~~Medical~~ Benefits.
- Expenses for any services provided substantially or primarily for the participant's convenience or the convenience of a caregiver.

Hospital Employee, Medical Students, Interns or Residents: Expenses for the services of an employee of a hospital, skilled nursing facility or other health care facility, when the facility is obligated to pay that employee.

Hypnosis and Hypnotherapy: (As defined by CMS) an artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility.

Illegal Act: Expenses incurred by a covered individual for injuries resulting from commission (or attempted commission by the covered individual) of an illegal act as determined by the plan administrator which involved violence or threat of violence to another person, or in which any weapon or explosive is used by the covered individual unless such injury is the result of a physical or mental health condition or domestic violence. The Plan Administrator's determination that this exclusion applies shall not be affected by any prosecution, or acquittal of (or failure to prosecute) the covered individual in connection with the acts involved.

Internet/Virtual Office Visit: Expenses related to an online internet consultation with an out-of-network physician or other health care practitioner (also called a virtual office visit/consultation), physician-patient web service or physician-patient e-mail service (including receipt of advice, treatment plan, prescription drugs or medical supplies obtained) from an online internet provider who is not a participating provider in the Plan network, except as specifically provided.

Maternity/Family Planning:

- Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms.
- Termination of Pregnancy: Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies the health of the mother would be endangered if the fetus were carried to term, and complications of such termination
- Childbirth courses.
- Expenses related to delivery associated with ~~a newborn~~ the newborn of a pregnant dependent-child.
- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs.
- For nondurable supplies.
- Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.

Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary, as defined in the *Key Terms and Definitions* section.

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required because of an injury, illness, or disability of a covered individual, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc.).

No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

No Provider Recommendation or Order: Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician or other licensed provider acting within the scope of their license.

Non-Emergency Hospital Admission: Care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.

Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses) of a health care provider, participant except where otherwise specified in the Utilization Management section for organ/tissue transplants and bariatric weight loss surgery or certain surgeries performed in a surgery center, inpatient hospital or outpatient setting as determined by the Plan Administrator or the

UM company.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: Expenses incurred by you or any of your covered dependents arising out of or during employment if the injury, illness, or condition is subject to coverage, in whole or in part, under any workers' compensation, or occupational disease (or similar) law.

Orthodontia: Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an injury or illness.

Personal Comfort Items: Expenses for patient convenience, including (but not limited to) care of family members while the covered individual is confined to a hospital (or other health care facility, or to bed at home), guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

Private Room in a Hospital or Health Care Facility: The use of a private room in a hospital or other health care facility, unless the facility has only private room accommodations, or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

Prophylactic Surgery or Treatment: Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery, as defined in the *Key Terms and Definitions* section of this document, when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for:

- Avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results, in certain circumstances; or
- Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder. Participants should use the Plan's UM company to assist in the determination of a proposed surgery to determine if it is or is not covered under this Plan.

NOTE: Some prophylactic surgeries may be covered under this Plan if certain criteria are met. Please refer to the *Schedule of ~~Medical~~ Benefits* section. For additional information, please contact this Plan's UM company or Claims Administrator.

Prophylactic drugs are excluded.

Rehabilitation Therapy (Inpatient or Outpatient):

- Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing, and related services.

- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
- Expenses for maintenance rehabilitation, as defined in the *Key Terms and Definitions* section.
- Expenses for speech therapy for functional purposes including (but not limited to) stuttering, and stammering ~~and conditions of psychoneurotic origin.~~
- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living or for Medically Necessary treatment of a mental health or substance use disorder.
- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment of that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency.

Service Animals: Purchase, training, or maintenance of any type of service animal, even if designated as medically necessary.

Smoking/Tobacco Cessation or Tobacco Withdrawal: Expenses for non-prescription (over the counter) tobacco/smoking cessation products such as nicotine gum or patches, unless prescribed by a physician. There are no benefits payable for the use of electronic cigarettes. Prescription smoking/tobacco cessation products are payable under the prescription drug benefit as described in the *Schedule of ~~Medical~~ Benefits* section.

Stand-By Physicians or Health Care Practitioners: Expenses for any physician or other provider who did not directly provide or supervise medical services to the patient, even if the physician or practitioner was available on a stand-by basis.

Taxes: Sales taxes, unless specifically covered in the Plan. See also CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, Chapter 21, Section 2122.2.G.

Telephone Calls: Expenses for telephone calls between a physician or other health care provider and any patient, other health care provider, UM company or vendor; or any representative of this Plan for any purpose whatsoever.

Transplant (Organ and Tissue) Experimental and/or Investigational:

Human organ and/or tissue transplants that are experimental and/or Investigational, including (but not limited to) donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post-operative services and drugs or medicines, and complications thereof.

Non-human (Engrafted) organ and/or tissue transplants or implants, except heart valves.

Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this Plan.

Travel Outside of the United States: Any services received outside the United States are excluded unless deemed to be urgent or emergency care.

Urgent Care: Any urgent care services that are received out-of-network are excluded unless the urgent care service is received out-of-area as defined in the *Key Terms and Definitions*.

Vision Care: Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery); and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded, except as otherwise specified in this Plan's *Summary of Medical Benefits and Schedule of Medical Benefits*.

War or Similar Event: Expenses incurred because of an injury or illness due to you or your covered dependent(s)' participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Weight Management and Physical Fitness:

- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs, and prescription drugs, except those services specified in the *Summary of Medical Benefits and Schedule of Medical Benefits*. Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Expenses for weight loss surgery performed without a precertification from the UM company will be denied.
- Expenses related to programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.
- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of an eating disorder (such as anorexia, bulimia, or acute starvation etc.). Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under any PEBP self-funded medical Plan (e.g., LD PPO Plan, CDHP and Exclusive Provider Organization Plan).

Other Benefit Exclusions

- Stress reduction therapy or cognitive behavior therapy for sleep disorders.

- The exclusion for cognitive therapy does not apply to Medically Necessary treatment of a mental health or substance use disorder.
- Sleep therapy (except for central or obstructive apnea when medically necessary and when a precertification has been received from the UM company), behavioral training or therapy, milieu therapy (unless the care is otherwise medically necessary), biofeedback (unless included with psychotherapy), behavior modification, sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.
- Charges that result from appetite control, ~~food addictions, or any treatment of obesity,~~ unless otherwise provided in the *Summary of [Medical Benefits](#) and Schedule of [Medical Benefits](#)*.
 - ~~Except as otherwise provided in the *Summary of Medical Benefits and Schedule of Medical Benefits*, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.~~
- Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (BEST), colonic irrigation, magnetic innervation therapy, and electromagnetic therapy.
- Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or Chiropractor's office, or at a retail location are excluded, unless otherwise specified in the *Summary of [Medical Benefits](#) and Schedule of [Medical Benefits](#)*.

Medical Claims Administration

How Medical Benefits are Paid

Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP's third-party claims administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or copayments apply, you are responsible for paying your share of these charges.

If services are provided through the EPO network, the EPO health care provider may submit the proof of claim directly to PEBP's third-party claims administrator; however, you will be responsible for the payment to the EPO health care provider for any applicable Deductible, Coinsurance, or copayments.

If a health care provider does not submit a claim directly to PEBP's third-party claims administrator and instead sends the bill to you, you should follow the steps outlined in this section regarding How to File a Claim. If, at the time you submit your claim, you furnish evidence acceptable to the Plan administrator or its designee (PEBP's third-party claims administrator) that you or your covered dependent paid some or all those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan Year Deductible and Coinsurance amounts are met.

How to File a Medical Claim

Claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

See also, [NAC 287.610](#).

Most providers send their bills directly to the PEBP's claims administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party claims administrator or PEBP's website (see the *Participant Contact Guide* in this document for details on address, phone, and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information is necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains the following information:
 - A description of the services or supplies provided including appropriate procedure codes.

- Details of the charges for those services or supplies.
- Appropriate diagnosis code.
- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Claims Administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny Deductible and Out-of-Pocket Maximum credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list:

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- Providers such as hospitals and facilities that bill for single or bulk items such as orthopedic devices/implants or other types of biomaterials shall provide to the third-party claim's administrator a copy of the manufacturer's/organization's invoice (that directly supplied the device/implant/biomaterial to the healthcare provider). This Plan will deny payment for such medical devices until a copy of the invoice is provided to this Plan's Claims Administrator.

Claims are processed by the third-party claims administrator in the order that they are received.

It is your responsibility to maintain copies of the EOB documents provided to you by PEBP's third-party claims administrator or prescription drug administrator. Copies of EOB documents are available on the Claims Administrator's website but cannot be reproduced. PEBP and its third-party claims administrator do not provide printed copies of EOB documents outside of the original mailing.

Where to Send the Claim Form

Send the completed claim form, the bill you received (retain a copy for your records) and any other required information to the Claims Administrator at the address listed in the *Participant Contact Guide* in this document.

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Appeals

You have the right to ask PEBP or its designees to reconsider a claim or Utilization Management Adverse Benefit Determination resulting in a denial, reduction, termination, failure to provide or make payments (in whole or in part) for a service or treatment, Rescission of coverage (retroactive cancellation), or HRA claim.

Discretionary Authority of PEBP and Designee

In carrying out their respective responsibilities under the Plan, PEBP and its designees have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in this document.

~~Medical and Dental~~ Claims Appeals

Written Notice of Adverse Benefit Determination

The Plan or its designee, the third-party administrator, will notify you in writing on an Explanation of Benefits (EOB) of an Adverse Claim Determination resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal. When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

You will be provided with:

- upon request and without charge, reasonable access to and copies of relevant documents, records, and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- a full and fair review that considers comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale.

The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

Level 1 Claim Appeal

NAC 287.670

If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third-party administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause can be demonstrated. The written request for appeal must include:

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit your own comments in writing. The third-party administrator will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The third-party administrator will issue a decision of your Level 1 Claim Appeal in writing within 20 days after receipt of your request for appeal.

You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:

- information that is sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
- the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review (when external review is applicable);
- the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
- reference the specific Plan provision(s) on which the determination is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

- an explanation of the Plan's appeal process and Level 2 appeal process and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol, or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
- disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

The notification will explain the steps necessary if you wish to proceed to a Level 2 Appeal if you are not satisfied with the response at Level 1.

Level 2 Claim Appeal

[NAC 287.680](#)

If you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request forms* are available at www.pebp.state.nv.us <https://pebp.nv.gov/> or by request by contacting PEBP Customer Service. Furthermore, you are welcome to submit Level 2 Claim Appeals online through a form that can be found under the subheading "Filing an Appeal" under PEBP's contact us web page. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal **must** include a copy of:

- Any document submitted with your Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use resources available to ensure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. A Level 2 Appeal determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.

External Claim Review

NAC 287.690

Standard Request

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. An *External Review Request Form* is available on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/). The OCHA will assign an independent external review organization within five (5) days after receiving the request. The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

A Request for External Claim Review must include:

- completed and signed External Review Request Form.
- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587, (888) 333-1597
Web:

[https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_\(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

Appealing a Utilization Management Determination

The utilization management (UM) company is staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer utilization review services. The review includes a process to determine the medical necessity, appropriateness, location, and cost effectiveness of health care services. Depending on the service, a review may occur before, during, or after the services are rendered, including, but not limited to precertification/pre-authorization; concurrent and/or continued stay review; discharge planning; retrospective review; and case management.

Pursuant to applicable [NRS 695G](#), you have the following appeal processes for any adverse benefit determination made during the precertification, concurrent review, retrospective review, or case management. An appeal may be initiated by the participant, treating provider, parent, legal guardian, or person authorized to make health care decisions by a power of attorney.

The UM company will utilize a physician (other than the physician who rendered the original decision) to review the appeal. This physician is Board Certified in the area under review and is in active practice. Refer to the *Participant Contact Guide* for the UM company's contact information.

Internal UM Appeal Review

Expedited Internal UM Appeal Review

You may request an expedited appeal review of a denied precertification of a hospital admission, availability of care, continued stay or health care service for which you received emergency services but have not been discharged from the facility providing the care; or if the physician certifies that failure to proceed in an expedited manner may jeopardize your life or health or the life or health of your covered dependent or the ability for you or your covered dependent to regain maximum function.

Requests for an expedited internal UM appeal review may be made by telephone or any other reasonable means to the UM company that will ensure the timely receipt of the information required to complete the appeal process. If your physician requests a consultation with the reviewing physician, this will occur within one business day. The UM company will decide on an expedited appeal within 72 hours of receipt of the information needed to complete the appeal. The results of the determination of an expedited appeal will be provided immediately to the managing physician by phone and in writing to the patient, managing physician, facility, and the third-party claim's administrator.

If the appeal review request is denied, the UM company will provide the member with an adverse benefit determination letter including the clinical rationale for the non-certification decision and the member may pursue an external appeal as described in [NRS 695G.241 - NRS 695G.275](#).

Standard Internal UM Appeal Review

If you have a denied precertification request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue) and you do not qualify for an expedited appeal, you may request a standard appeal review. Requests for standard appeal review may be made by writing to the UM company.

Requests for standard appeal review must be made within 180 days of the date of the denial/non-certification. Actual medical records are encouraged to be provided to assist the reviewer. Standard appeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service treatment will be completed within 20 days of the receipt of the request. The results of the determination of a standard appeal will be provided in writing to the patient, managing physician, facility, and third-party claim's administrator.

A participant or their designee can choose to bypass the internal appeals process from adverse benefit determinations resulting from the UM company and request a review by an external review organization.

External UM Appeal Review

An external review may be requested by a participant and/or the participant's treating physician after you have exhausted the internal UM appeal review process. This means you may have the right to have the Plan Administrator or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgement as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

Expedited Request for External Review (Pre-Service Urgent UM Appeal) [NRS 287.04335](#)

For adverse benefit determinations resulting from the UM company, a participant or their designee can choose to bypass the internal UM appeal process and request a review by an external review organization.

Expedited external review is available only if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination and the patient's treating provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered individual or would jeopardize the covered individual's ability to regain maximum function. Pursuant to [NRS 695G.271](#), the Office for Consumer Health Assistance (OCHA) will approve or deny a request for an external review of an adverse determination not later than 72 hours after receipt from the provider. If OCHA determines the request qualifies for expedited review, a final of the external review will be made by the external review organization within 72 hours of receipt and the provider and participant will be notified within 24 hours.

A participant may file a request for an expedited external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. An expedited external review request form, which includes a certification of treating provider for expedited consideration can be found on the PEBP website at www.pebp.state.nv.us<https://pebp.nv.gov/>.

The request must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587, (888) 333-1597
Web:

[https://adsd.nv.gov/Programs/CHA/Office for Consumer Health Assistance \(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

Standard Request for External UM Review

A standard request for external UM review may be filed with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. A standard external review request form can be found on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

A standard external review decision will be made within 45 days of OCHA's receipt of the request.

As with the expedited external review, a standard external review must be submitted to the Office for Consumer Health Assistance at the contact information listed above.

Experimental and/or Investigational Claim/UM External Review

If you received a denial for a service, durable medical equipment, procedure, or other therapy because the third-party administrator or the UM company determined it to be experimental and/or investigational, you may request an external review. To proceed with the experimental and/or investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.

A "Physician Certification of Experimental/Investigational /Denials" is located under "Forms" on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

After this form is completed by the treating physician, it should be attached to the Request for External Review" form and submitted to the Office for Consumer Health Assistance at:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587, (888) 333-1597
Web:

[https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_\(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

Prescription Drug Review and Appeals

A participant has the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. The Pharmacy Benefit Manager reviews both clinical and administrative coverage review requests, including those cases related to specialty drugs dispensed through Accredo specialty pharmacy.

Clinical Coverage Review

The initial clinical coverage review is a request for coverage or medication that is based on clinical conditions of coverage that are set by this Plan—for example, medications that require a prior authorization. To make an initial determination for a clinical coverage review request, the

prescribing physician must submit specific information for review.

How to Request a Clinical Coverage Review

The preferred method to request an initial clinical review is for the prescribing physician to submit the prior authorization request electronically. Alternately, the participant's prescribing physician or pharmacist may call Express Scripts at 1-800-753-2851 or the prescriber may submit a request in writing using a Benefit Coverage Review Form, which can be obtained by calling Express Scripts Member Services at 1-855-889-7708. (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

Administrative Coverage Review

The initial administrative coverage review is a request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Administrative Coverage Review

To request an initial administrative coverage review, the participant must submit the request in writing to Express Scripts to the attention of the Benefit Coverage Review Department (see *Participant Contact Guide* section).

For an administrative coverage review request, the participant must submit information to the pharmacy benefits manager to support the request.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy, or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by calling Express Scripts at 1-800-753-2851.

If the necessary information is provided to Express Scripts so that a determination can be made, the initial determination and notification for a clinical coverage or administrative coverage review will be made within the timeframe below:

- Standard Pre-Service: 15 days for retail pharmacy and five (5) days for home delivery; and
- Standard Post-Service: 30 days.

Level 1 Appeal or Urgent Appeal

When an initial administrative or clinical coverage review request has been denied, a request for appeal of the denial may be submitted by the participant within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to Express Scripts' Benefit Coverage Review Department:

- Name of patient.
- Participant ID number.

- Phone number.
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the initial adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including physician/prescriber statements/letters, bills, or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone at 1-800-753-2851 or fax 1-877-852-4070 to Express Scripts. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are by Express Scripts' pharmacist, physician, panel of clinicians, trained prior authorization staff member, or an independent third-party prescription drug utilization management company.

Level 1 Appeal Decisions and Notifications

Express Scripts will render Level 1 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 20 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse benefit determination. Standard Post-Service: [NAC 287.670](#)

Level 2 Appeal

When a Level 1 Appeal has been denied, a request for a Level 2 Appeal may be submitted by the participant within 35 days from receipt of notice of the Level 1 Appeal denial. To initiate a Level 2 Appeal, you must request by mail or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department.

An urgent Level 2 Appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or

would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department (see the *Participant Contact Guide* section). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Level 2 Appeal Decisions and Notifications

Express Scripts will render Level 2 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 30 days; and
- Urgent*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. Standard Post-Service: [NAC 287.680](#)

External Reviews

The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental and investigation. Generally, internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to the independent review organization (see *Participant Contact Guide*) within 4 (four) months of the date of the Level 2 Appeal denial. (If the date that is 4 (four) months from that date is a Saturday, Sunday, or a holiday, the deadline will be the next business day).

Standard External Review: the pharmacy benefit manager will review the external review request within 5 (five) business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and the patient will be notified within 1 (one) business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO, and the Appeal information will be compiled and sent to the IRO within 5 (five) business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgement or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the pharmacy benefit manager for

reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and the pharmacy benefit manager written notice of its decision. If the IRO has determined that the claim does not involve medical judgement or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regarding maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Coordination of Benefits

For detailed information, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” (NAC 287.755).

Which Benefits are Subject to Coordination?

When Participants have medical, dental or vision coverage from some other source, benefits are determined using Coordination of Benefits (COB). COB operates so that one of the plans (i.e., the primary plan) will pay its benefits first. The other plan or policy, (i.e., the secondary plan) may then provide additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

Participants must let the Plan Administrator, or its designee, know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and dental deductibles. This Plan’s prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.

For the purposes of this COB section, the word “plan” refers to any group or individual medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual either on an individual basis or as part of a group of employees, retirees or other individuals.

A Participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such fully insured plan and the rules and procedures described in such fully insured plan’s applicable Summary of Insurance.

A Participant in a self-insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures set forth in this Section 4.4. The PEBP delegates to the third-party administrator of such self-insured plan the duty to administer and interpret the provisions of this Section 4.4. and to adopt, document and communicate any rules and procedures necessary or appropriate to implement the COB procedures, as set forth herein:

Which Plan Pays First: Order of Benefit Determination Rules

PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any plan that does not use these same rules always pays its benefits first.

When two plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second).

If the first of the ~~following~~ rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

These rules are detailed in the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

Coordination with Medicare

Coordination with Medicare is not applicable for retirees and their dependents who are eligible for Medicare Part A and Medicare Part B and who are required to transition to the Medicare Exchange.

This Plan has coordination of benefits for Medicare as it relates to:

- Entitlement to Medicare Coverage,
- When the Participant Is Not Eligible for Premium Free Medicare Part A,
- Coverage Under Medicare and This Plan When a Participant has End-Stage Renal Disease (ESRD),
- How Much This Plan Pays When It Is Secondary to Medicare,
- When the Retiree or the Retiree’s Covered Spouse or Domestic Partner is Enrolled in Medicare Part B,
- When the Participant Enters Into a Medicare Private Contract

For details, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

Coordination with Other Government Programs

This Plan has coordination of benefits as it relates to:

- Medicaid,
- Medicare,
- Tricare,
- Veterans Affairs,
- Worker’s Compensation, and
- Medicare Disability.

For more details, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

Subrogation and Third-Party Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the injury, irrespective of the way they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). Payments made by the Plan for which it claims a right of subrogation are referred to as subrogated payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. Payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury.

The Participant must cooperate fully, always, and provide information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested to secure and protect the subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

- Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of subrogation.
- Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
- Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate *Health and Welfare Benefits Wrap Plan* document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) for more information regarding third-party liability and subrogation.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) 3427 Goni Road, Ste 109 Carson City, NV 89706 Customer Service: (775) 684-7000, (702) 486-3100, or (800) 326-5496 Fax: (775) 684-7028 www.pebp.state.nv.ushttps://pebp.nv.gov/	Plan Administrator • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR <u>Claims Submission</u> P O Box 30541 Salt Lake City, UT 84130-0541 EDI #39026 <u>Appeal of Claims</u> P O Box 30546 Salt Lake City, UT 84130-0546 <u>Customer Service</u> (888) 763-8232 www.UMR.com	Third-party Claims Administrator/Third-party Administrator/PPO Network/ Disease Management Administrator • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Sierra Health-Care Options, Inc PO BOX 15645 Las Vegas, NV 89144-5648 Customer Service : 888-323-1461 Fax : 800-288-2264	Utilization Management and Case Management Company • Pre-Certification/Prior Authorization • Utilization Management • Case Management • Transplants
Express Scripts Pharmacy <u>Customer Service</u> (855) 889-7708 www.Express-Scripts.com	Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and EPO Plan • Prescription drug information • Retail network pharmacies • Prior authorization

Participant Contact Guide	
<u>Accredo Patient Customer Service:</u> (800) 803-2523 <u>Accredo Physician Service Line</u> (800) 987-4904 option 5 <u>Express Scripts / Accredo Prior Authorization</u> (800) 753-2851 Electronic option: express-scripts.com/PA <u>Specialty Medication SaveonSP copay assistance</u> (800) 683-1074 www.saveonsp.com/pebp	• Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies • Accredo Specialty Drug Services • Coverage and Clinical reviews • Appeals • External Review Requests • Copay/Deductible/Coinsurance assistance
HSA Bank HRA Claim Submission PO Box 2744 Fargo, ND 58108-2744 hsaforms@hsabank.com Fax: 855-764-5689 www.hsabank.com Customer Service: 833-228-9364 askus@hsabank.com myaccounts.hsabank.com	HSA and HRA Claims Administrator • HSA/HRA Claims and claim appeals
Diversified Dental Services 5470 Kietzke Lane, Ste 300 Reno, NV 89511 ProviderRelations@ddsppo.com 1-866-270-8326 diversifieddental.com	PPO Dental Network • Statewide PPO Dental Providers • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 www.myhpnstateofnevada.com/	Southern Nevada Health Maintenance Organization (HMO) • Medical claims/provider network
VIA Benefits 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888)598-7545	Medicare Exchange and Medicare HRA administrator • Medigap (Supplemental) plans

Participant Contact Guide	
https://my.viabenefits.com/pebp Phone: (888) 598-7545; Fax: (402) 231-4310	• Medicare Advantage Plans (HMO and PPO) • Voluntary Vision • Voluntary Dental • HRA claims administrator
United Healthcare Specialty Benefits Group Number: 370074 Customer Service: 1-888-763-8232 UnitedHealthcare Specialty Benefits P.O. Box 7149 Portland, ME 04112-7149	• Basic Life Insurance for eligible active and retirees • Member Assistance Program • Global Travel Assistance
Office for Consumer Health Assistance 3320 W. Sahara Ave, Suite 100 Las Vegas, NV 89102 Customer Service: (702) 486-3587 or (888) 333-1597 https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/	Consumer Health Assistance • Concerns and problems related to coverage • Provider billing issues • External review information
Corestream PEBP+ Customer Care: (775) 249-0716 E-mail: pebpcustomercare@corestream.com www.corestream.com <u>Voluntary Life, Critical Illness, Accident, and Hospital Indemnity Insurance</u> The Standard Insurance Company (888) 288-1270 www.standard.com/mybenefits/nevada	PEBP+ Voluntary Benefits Administrator • Accident Insurance • Auto Insurance • Critical Illness • Disability Insurance (Long-term and Short-term) • Home Insurance • Hospital Indemnity • Identity Theft • Legal Services • Life Insurance (Supplemental) • Pet Insurance • Vision Care

Key Terms and Definitions

The following terms or phrases are used throughout this MPD. These terms or phrases have the following meanings. These terms and definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

Active Rehabilitation: refers to therapy in which a patient, who can learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Actively Engaged:

- Participation in regular office visits with your provider. The frequency of the office visits will be determined by your provider who will in turn report this information to the third-party administrator for monitoring.
- Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss provider including but not limited to routine exercise, proper nutrition and diet, and pharmacotherapy if prescribed. Commitment to your weight loss treatment will be measured by the third-party administrator who will review monthly progress reports submitted by the provider; and
- Losing weight at a rate determined by the weight loss provider.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding, or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

When benefits for the services of an acupuncturist are payable by this Plan, the acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, be certified by the National Certification Commission for Acupuncturists (NCCA).

Adverse Benefit Determination: [NRS 695G.012](#) - Means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity,

appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Air Ambulance: A medical transport by a rotary wing air ambulance, as defined in [42 CFR 414.605](#)~~42 CFR 414.605~~, or fixed wing air ambulance, as defined in [42 CFR 414.605](#)~~42 CFR 414.605~~, for patients.

Allogenic: Refers to transplants of organs, tissues, or cells from one person to another person. Heart Transplants are always Allogenic.

Allowable Expenses: The Maximum Allowable Charge for any medically necessary, eligible item of expense, at least a portion of which is covered under the Plan. When some other non-Medicare plan pays first in accordance with the application to benefit determinations provision in the *Coordination of Benefits* section, this Plan's allowable expenses shall in no event exceed the other non-Medicare plan's allowable expenses.

When some other non-Medicare plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of each service rendered, by determining the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other non-Medicare plan include the benefits that would have been payable had claim been duly made; therefore, whether or not it is made.

Ambulance: A vehicle or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated, and staffed primarily for performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or

Where licensing is not required, it meets the following requirements:

- It is operated under the supervision of a licensed physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area.
- It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthesiologist who is administering the anesthetic, and that the anesthesiologist or anesthesiologist remain present throughout the surgical procedure.
- It provides at least one operating room and at least one post-anesthesia recovery room.

- It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
- It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or x-rays), an operative report and a discharge summary.

An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.

Ancillary Services/Charges: Charges for services provided by a hospital or other facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Ancillary services: for purposes of the No Surprises Act, are with respect to a PPO health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary of Department of Health and Human Services; and

Items and services provided by a Non-PPO provider if there is no PPO provider who can furnish such item or service at such facility.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional, or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Annual/Annually: For the purposes of this Plan, annual and annually refers to the 12-month period starting July 1 through June 30.

Appliance (Dental): A device to provide or restore function or provide a therapeutic (healing) effect.

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Approved Clinical Trial: A phase I, II, III, or IV trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted.

An Approved Clinical Trial's study must be:

- (1) approved or funded by one or more of:
 - (a) the National Institutes of Health (NIH),
 - (b) the Centers for Disease Control and Prevention (CDC),
 - (c) the Agency for Health Care Research and Quality (AHCRO),
 - (d) the Centers for Medicare and Medicaid Services (CMS),
 - (e) a cooperative group or center of the NIH, CDC, AHCRO, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA),
 - (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or
 - (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;
- (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- (3) a drug trial that is exempt from investigational new drug application requirements.

Assistant Surgeon: A medically qualified doctor who assists the surgeon of record perform a procedure.

Autism Spectrum Disorders and related terms Have the meanings ascribed to them under [NRS 695G.1645](#) and [NRS 427A.875](#).

Autologous: Refers to transplants of organs, tissues, or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.

Average Wholesale Price (AWP): The average price at which drugs are purchased at the wholesale level.

Bariatric Surgery Center of Excellence: This provider has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program ([ACS NSQIP](#)) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program ([MBSAQIP](#)). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and

more effective surgical treatment. These ~~MBSAQIP~~ ~~MBSAQIP~~-accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

- Behavior modification program supervised by a qualified professional.
- Consultation with a dietician or nutritionist.
- Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen.
- Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise Therapist or other qualified professional.
- Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
- Reduced-calorie diet program supervised by dietician or nutritionist.

Base Plan: The self-funded Consumer Driven Health Plan (CDHP); the base plan is also defined as the “default plan” where applicable in this document and other materials produced by PEBP ([NRS 287.045](#)).

Behavioral Health Disorder: Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause.

Behavioral health disorders covered under this Plan may include, but are not limited to depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods and is provided by behavioral health practitioners as defined in this section. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the *Exclusions* section.

Behavioral Health Practitioner: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a master's degree and who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Behavioral Health Treatment: Services, including room and board, given by a behavioral health treatment facility or area of a hospital that provides behavioral or mental health or substance abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the illness that is identified under the DSM code is considered a behavioral health treatment

for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated, and staffed primarily for providing a program for diagnosis, evaluation, and effective treatment of behavioral health disorders and which fully meets one of the following two tests:

- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets the following requirements:
 - has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the direction of a full-time registered nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological, and
 - social needs of the patient.

A behavioral health treatment facility that qualifies as a hospital is covered by this Plan as a hospital and not a behavioral health treatment facility. A transitional facility, group home, halfway house or temporary shelter is not a behavioral health treatment facility under this Plan unless it meets the requirements above in the definition of behavioral health treatment facility.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, subject to the Plan's Maximum Allowable Charge, or negotiated fee schedule, after calculation of Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets the following requirements:
 - It is operated and equipped in accordance with any applicable state law for providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.
 - It is equipped to perform routine diagnostic and laboratory examinations, including (but not limited) to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
 - It has available to handle foreseeable emergencies, trained personnel, and necessary equipment, including (but not limited to) oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
 - It provides at least two beds or two birthing rooms.

- It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.
- It has a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It has the capacity to administer local anesthetic and to perform minor surgery.
- It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
- It is expected to discharge or transfer patients within 48 hours following delivery.

A birth (or birthing) center that is part of a hospital, as defined in this section, will be a birth (or birthing) center for the purposes of this Plan.

Business Day: Refers to weekdays, except Saturday or Sunday, or a Nevada holiday or federal holiday.

Case Management: A process administered by the UM company in which its medical professionals work with the patient, family, caregivers, providers, Claims Administrator, Pharmacy Benefit Manager and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential providers.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

Certified Surgical Assistant: A person who does not hold a valid health care license as an RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon, and who acts within the scope of their license or certification. Such individuals are payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

Chemical Dependency: This is another term for Substance Abuse. (See also the definitions of

Behavioral Health Disorders and Substance Abuse).

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC) and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal column (vertebrae); and who acts within the scope of his or her license.

Chiropractic Services: PEBP considers chiropractic services to be medically necessary when the following criteria are met:

- participant has objective medical findings of a neuro-musculoskeletal disorder; and
- a clearly defined treatment plan has been established including treatment and discharge goals; and
- services are not for maintenance purposes.

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings.

Chronic Medication Synchronization: [NRS 695G.1665](#) “Chronic medication” means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent, or lasting indefinitely.

“Synchronization” means the alignment of the dispensing of multiple medications by a single contracted pharmacy for improving a patient’s adherence to a prescribed course of medication. This includes providing coverage for less than a 30-day supply to enable synchronization. See also [NRS 695G.1665](#).

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Clinical Trials: See *Experimental and Investigational* in the *Key Terms and Definitions* section.

Coinsurance: That portion of *Eligible Medical Expenses* for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses more than the Plan’s Deductible. The Coinsurance varies depending on whether In-Network or Out-of-Network providers are used.

Complications of Pregnancy: Any condition that requires hospital confinement for medical treatment, and if the pregnancy is not terminated, is caused by an injury or sickness not directly

related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or, any condition that requires hospital confinement and if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.

Compound Drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Concierge Medicine: Is a relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of medical or dental care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care, and direct practice medicine. Most concierge medicine practices do not bill insurance.

Concurrent Review: A managed care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the utilization management company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility.

Continuing Care Patient: Under the NSA, an individual who, with respect to a provider or facility-

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how Plan benefits are payable when a person is covered by two or more health care plans.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. This can be in addition to Coinsurance amounts due on the same incurred charges. Copayments are limited to certain benefits under this program.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or device) and Prosthetic Appliance (or device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator, UM company, or its designee.

Cost-Efficient: See the definition of medically necessary for the definition of cost-efficient as it applies to medical services that are medically necessary.

Cost-Share or Cost sSharing: The amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Non-PPO providers, or the cost of items or services that are not covered under the plan.

Cost Sharing Amount: for Emergency and Non-emergency Services at PPO Facilities performed by Non-PPO Providers, and air ambulance services from Non-PPO providers will be based on the Recognized Amount.

Covered Individual: Any employee or retiree (as those terms are defined in this Plan), and that person's eligible spouse or dependent child who has completed required formalities for enrollment for coverage under the Plan and is covered by the Plan.

Covered Medical Expenses: See the definition of *Eligible Medical Expenses*.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible medical, prescription drug and dental expenses you are responsible for paying before the Plan begins to pay benefits. The dental Deductibles are discussed in the separate PPO Dental Master Plan Document.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the Temporomandibular Joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies coverage is provided in the PPO Dental Plan (refer to the separate PPO Dental Plan MPD available at [www.pebp.state.nv.us](https://pebp.nv.gov/)<https://pebp.nv.gov/>) and are not covered under the medical expense coverage of this Plan unless the medical Plan specifically indicates otherwise in the *Schedule of Medical Benefits*.

Dependent: Any of the following individuals: Dependent child(ren), spouse or domestic partner as those terms are defined in this document.

Dependent Child(ren): See also ([NAC 287.312](#))

For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),
- any other person who:
 - (1) Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
 - (2) Is unmarried.
 - (3) Has not attained the age set forth in 45 C.F.R. § 147.120(a).
 - (4) Either resides with the participant or is enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school or accredited trade or business school, on a full-time basis
 - (5) Satisfies one of the following conditions:

- a. Is currently under a permanent legal guardianship of the participant or his or her spouse or domestic partner pursuant to [chapter 159](#) of NRS; or
- b. Was eligible to be claimed as a dependent on the federal income tax return of the participant or his or her spouse or domestic partner for the immediately preceding calendar year; and
- Is in a relationship with the participant or his or her spouse or domestic partner that is like a child-parent relationship. The participant or his or her spouse or domestic partner must complete and submit to the Program an affidavit attesting to the fact of the relationship.

Disability: A determination by the Plan Administrator or its designee (after evaluation by a physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as intellectual disability, cerebral palsy, epilepsy, neurological disorder, or psychosis.

Domestic Partner: As defined by [NRS 122A.030](#).

Drug: See the definition for prescription drug.

Durable Medical Equipment: As defined by Centers for Medicare & Medicaid Services, the term DME is defined as equipment which, according to 42 CFR §414.202:

- Equipment that can withstand repeated use; and
- is primarily and customarily used for a medical purpose;
- generally, and is not generally useful in the absence of an injury or illness; and
- is not disposable or non-durable; and
- is appropriate for the patient's home.

Durable medical equipment includes (but is not limited to) apnea monitors, augmentation devices, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Elective Hospital Admission, Service or Procedure: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that they are medically necessary; and the charges for them are usual and customary and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule; and coverage for the services or supplies is not excluded (as provided in the *Exclusions* section); and the Plan Year maximum benefits for those services or supplies has not been reached.

Emergency: See the definition for Medical Emergency.

Emergency Medical Condition: A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Care: Medical and health services provided for an Emergency Medical Condition as defined above

This Plan does not require precertification for medically necessary emergency services provided at any hospital in accordance with [NRS 695G.170](#). For information, refer to the separate PEBP Health and Welfare Wrap Document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Emergency Services means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-PPO provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the Non-PPO provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO provider may result in greater cost to the participant or beneficiary.

See also [NRS 695G.170](#).

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness, or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.

Employer: Unless specifically indicated otherwise when used in this document, employer refers to an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

Enteral Formulas: Enteral Formulas is subject to [NRS 689B.0353](#).

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Experimental and/or Investigational Services: See also [NRS 695G.173](#): Required provision concerning coverage for treatment received as part of clinical trial or study.

Unless mandated by law, the Plan Administrator, UM company, or its designee has the discretion and authority to determine if a service or supply is, or should be, classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator, UM company, or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply.
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
- In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
- With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required for the service and supply to be

lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered experimental and/or investigational if it is:

- Approved by the FDA as an “Investigational new drug for treatment use”; or
- Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life threatening disease,” as that term is defined in FDA regulations; or
- Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
- The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

In determining if a service or supply is or should be classified as experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for precertification under the Plan’s utilization management program:

- Medical records of the covered person.
- The consent document signed, or required to be signed, to receive the prescribed service or supply.
- Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply.
- Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person’s diagnosis, including (but not limited to) “United States Pharmacopoeia Dispensing Information”; and “American Hospital Formulary Service”.
- The published opinions of the American Medical Association (AMA), such as “The AMA Drug Evaluations” and “The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
- Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.

NOTE: To determine how to obtain a precertification of any procedure that might be deemed to be experimental and/or investigational, see the *precertification* in the *Utilization Management* section.

Explanation of Benefits (EOB): When a claim is processed by the claims administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your Deductible, if your out-of-pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Expedited Appeal: If a participant appeals a decision regarding a denied request for precertification (pre-service claim) for an urgent care claim, the participant or participant's authorized representative can request an expedited appeal, either orally or in writing. Decisions regarding an expedited appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

External Review: An independent review of an adverse benefit determination conducted by an external review organization.

External Review Organization: An organization that

- conducts an external review of a final adverse benefit determination; and
- is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.

Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Free-Standing Laboratory Facility: Free-standing laboratory facilities are stand-alone facilities that are not affiliated with a hospital system. Examples of preferred free-standing laboratory facilities include Labor Corp or Quest.

Formulary: A list of generic and brand name drug products available for use by participants. This is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

Gender Dysphoria: In accordance with [Senate Bill 163](#) from the 82nd Legislative Session in 2023: "Gender dysphoria" means distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

- (1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.

- (2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.
- (3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.
- (4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.
- (5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.
- (6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

Generic; Generic Drug: A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the pharmacist as being generic. (See also the Prescription Drug section of the *Schedule of [Medical Benefits](#)* and the *Prescription Drug* subsection of the *Medical Exclusion* section).

Genetic Counseling: Counseling services provided before or in the absence of genetic testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of genetic testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from genetic testing, or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations. Tests that assist the health care practitioner in determining the appropriate course of action or treatment for a medical condition.

Gestational Carrier: Gestational carrier means an adult woman who is not an intended parent and who enters into a gestational agreement to bear a child conceived using the gametes of other persons and not her own. See also [NRS 126.580](#).

Government-Provided Services: Expenses for health care services provided to a covered participant that federal, state, or local law (e.g., Tricare/Champus, VA, except the Medicaid program), expenses for care required by a public entity and care for which there would not normally be a charge.

Health Care Facility: (for non-emergency services) is each of the following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, or other provider who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* section).

HIPAA: ~~Health Insurance Portability and Accountability Act of 1996~~~~Health Insurance Portability and Accountability Act of 1996~~. Federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency (as those terms are defined in this section).

Home Health Care Agency: An agency or organization that provides a program of Home Health Care and meets one of the following three tests:

- It is approved by Medicare; or

- It is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets the following requirements:
 - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or registered nurse to the home.
 - It has a full-time administrator.
 - It is run according to rules established by a group of professional health care providers including physicians and registered nurses.
 - It maintains written clinical records of services provided to patients.
 - Its staff includes at least one registered nurse, or it has nursing care by a registered nurse available.
 - Its employees are bonded.
 - It maintains malpractice insurance coverage.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." See also the *Exclusions* section of this document regarding homeopathic treatment and services. When the services of homeopaths are payable by this Plan (e.g., an office visit), the homeopath must be properly licensed to practice homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post-graduate courses or training in a program approved by the American Institute of Homeopathy.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a limited life expectancy. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family.

A hospice agency must meet one of the following tests:

- It is approved by Medicare; or is licensed as a hospice agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets the following requirements:
 - It provides 24-hour-a-day, 7 day-a-week service.
 - It is under the direct supervision of a duly qualified physician.
 - It has a full-time administrator.

- It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
- The main purpose of the agency is to provide hospice services.
- It maintains written records of services provided to the patient.
- It maintains malpractice insurance coverage.
- A hospice agency that is part of a hospital will be considered a hospice agency for the purposes of this Plan.

Hospital: A public or private facility or institution, other than one owned by the U.S Government, licensed and operating according to law, that:

- Is legally operated in the jurisdiction where it is located.
- Is engaged mainly in providing inpatient medical care and treatment for injury and illness in return for compensation.
- Has organized facilities for diagnosis and major surgery on its premises.
- Is supervised by a staff of at least two physicians.
- Has 24-hour-a-day nursing service by registered nurses; and
- Is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or skilled nursing facility or similar institution; or a Long-Term Acute Care Facility (LTAC).

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, birth (or birthing) center, hospice, skilled nursing facility, sub-acute care facility, or other place for rest, custodial care, or the aged shall not be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician, and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be an illness only for coverage under this Plan. However, infertility is not an illness for coverage under this Plan.

Independent Freestanding Emergency Department: A health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Inherited Metabolic Disorder: [See also NRS 689B.0353.](#) A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates, or fats, as diagnosed by a physician using standard blood, urine, spinal fluid, tissue, or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an Inherited Metabolic Disorder under this Plan. See Special Food Products.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth (ISNT): An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to teeth are payable under the medical Plan (see also the definition of Teeth).

In-Network Provider: Means an In-Network provider that the network or one of its rental networks have contracted with or have arrangements with to provide health services to covered individuals. An In-Network provider has agreed to charge participants a discounted rate. To determine if a provider is an In-Network provider log on to [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/). You may also call the number on the back of your ID card and a customer service representative can help you locate an In-Network provider.

In-Network Services: Services provided by a health care provider that is a member of the Plan's Exclusive Provider Organization (EPO), as distinguished from Out-of-Network services that are provided by a health care provider that is not a member of the EPO network.

In-Network Contracted Rate: The negotiated amount determined by the EPO network to be the maximum amount charged by the EPO provider for a covered service. In some cases, the In-Network contracted amount may be applied to Out-of-Network provider charges.

Inpatient Services: Services provided in a hospital or other health care facility during the period when charges are made for room and board.

Intensive Care Unit: A section, ward, or wing within the hospital which:

- Is separated from other hospital facilities.
- Is operated exclusively for providing professional care and treatment for critically ill patients.
- Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use.
- Provides room and board; and
- Provides constant observation and care by registered nurses or other specially trained hospital personnel.

Intensive Outpatient Program: An intensive outpatient program (IOP) is a kind of treatment service and support program used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification. IOP operates on a small scale and does not require the intensive residential or partial day services typically offered by the larger, more comprehensive treatment facilities.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance Rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and or preserve the patient's functional level. Maintenance rehabilitation is not covered by the Plan.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are costlier than others that can achieve the same result.

Maximum Amount; Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Plan Administrator considering and after having analyzed:

- The reasonable and appropriate amount.
- The terms of the Plan:
- Plan negotiated and contractual rates with provider(s).
- The actual billed charges for the covered services; and
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with a service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s).
- Medicare Allowable

The Plan will reimburse the actual charge(s) if they are less than the Plan's Maximum Allowable Charge amount(s). The Plan has the discretionary authority to decide if a charge is reasonable and appropriate, as well as medically necessary. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary: Has the meaning ascribed to it in accordance with [NRS 695G.055](#): "Medically necessary" means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

1. Provided in accordance with generally accepted standards of medical practice;
2. Clinically appropriate with regard to type, frequency, extent, location and duration;
3. Not primarily provided for the convenience of the patient, physician or other provider of health care;
4. Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and
5. The most clinically appropriate level of health care that may be safely provided to the insured.

A medical or dental service or supply will be appropriate if:

- It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility:
- The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

Medically Necessary for External Review: Means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.

Medical management technique: Has the meaning ascribed to it within [NRS 695G](#) which means a practice which is used to control the cost or use/utilization of health care services, prescription drugs, or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Part A: Hospital insurance provided by the federal government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the federal government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the federal government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.

Medi-Span: A national drug pricing information database for drug pricing analysis and comparison.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a Midwife or certified as a Certified Nurse Midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Morbid Obesity: Characterized by body mass index $>40 \text{ kg/m}^2$ as defined by the National Library of Medicine.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage, or herbal tea. Note: Naturopathy providers, treatment, services, or substances are not a payable benefit under this Plan.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap, or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the *Schedule of ~~Medical~~ Benefits* are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Non-PPO emergency facility: An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively

Non-PPO Provider or Non-Participating Provider: A health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA) and authorized to administer Anesthesia in collaboration with a physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners under the laws of the state or jurisdiction where the services are rendered.

Obesity: Body mass index of 30 kg/m² or higher is used to identify individuals with obesity as defined by the National Library of Medicine.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills to regain independence.

Office Visit: A direct personal contact between a physician or other health care practitioner and a patient in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is an office visit for the purposes of this Plan.

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism, Retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Orthotic (Appliance or Device): A type of corrective appliance or device, either customized or available “over-the-counter,” designed to support a weakened body part, including (but not limited to) crutches, custom designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical Plan, this definition does not include dental orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

Other Prescription Drugs: Drugs that require a prescription under state law but not under federal law.

Out-of-Network Rate: With respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process;
- or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system

Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan’s Preferred Provider Organization (PPO), as distinguished from In-Network services that are provided by a health care provider that is a member of the PPO. Greater expense could be incurred by the participant when using Out-of-Network providers.

Out-of-Pocket Maximum (OOPM): The maximum amount of Coinsurance each covered person or family is responsible for paying during a Plan Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of eligible covered expenses for the remainder of the Plan Year. See the section on Out-of-Pocket Maximum in the *Medical Expense Coverage* section for details about what expenses do not count toward the Out-of-Pocket Maximum.

Outpatient Hospital Laboratory and Outpatient Hospital-Based Laboratory Draw Station: Outpatient hospital-based laboratory facilities include lab services performed in a hospital outpatient setting. Outpatient hospital-based laboratory draw stations are hospital affiliated

whereby the draw station collects specimens and sends them to the central hospital lab for processing.

Outpatient Services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Partial Hospitalization Service: Also known as PHP, is a type of program used to treat mental illness and substance abuse in which the patient continues to reside at home but commutes to a treatment center up to seven days a week. This service model focuses on the overall treatment of the individual and is intended to avert or reduce in-patient hospitalization. Services are typically provided in either a hospital setting or by a free-standing community mental health center. Treatment during a typical day may include group therapy, psych-educational groups, skill building, individual therapy, and psychopharmacological assessments, and check-ins. Programs are available for the treatment of alcoholism and substance abuse, Alzheimer's disease, anorexia and bulimia, depression, bipolar disorder, anxiety disorders, schizophrenia, and other mental illnesses.

Participant: The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse or dependent of a retiree. [NAC 287.095](#)

Participating Provider: A health care provider who participates in the Plan's Exclusive Provider Organization (EPO).

Passive Rehabilitation: Refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until the patient can achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be medically necessary for the purposes of this Plan.

Pharmacy: A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery, or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform Activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician Assistant (PA): A person legally licensed as a physician assistant, who acts within the scope of his or her license and acts under the supervision of a physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising physician; under the laws of the state or jurisdiction where the services are rendered.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

Plan Year Deductible: The amount you must pay each Plan Year before the Plan pays benefits.

Plan Year Maximum Benefits: The maximum amount of benefits payable each Plan Year for certain medical expenses incurred by any covered Plan participant (or covered family member of the Plan participant).

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

Positive Annual Open Enrollment Period: This process requires that each eligible employee or eligible retiree affirmatively make his or her benefit elections during the PEBP annual enrollment period. Even if you do not want to make any coverage changes, you must affirmatively make your elections, or you will be defaulted to self-coverage only under the PEBP base Plan.

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis, 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury.

Precertification (preauthorization, prior authorization): Is a process used by the UM company and Pharmacy Benefit Manager to determine if a prescribed procedure, including, but not limited to inpatient admission, concurrent review, DME, outpatient services, or medication are medically

necessary before the services and supplies are received. A precertification is not a guarantee of payment.

Exclusive Provider Organization (EPO): A group or network of health care providers (e.g., hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted or reduced rates.

Prescribed for a Medically Necessary Indication: The term medically necessary indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

Prescription Drugs: For the purposes of this Plan, prescription drugs include:

- Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug, and Cosmetic Act requires to be labeled, “Caution - Federal law prohibits dispensing without prescription”.
- Other prescription drugs: drugs that require a prescription under state law but not under federal law; or
- Compound drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prescription Prior Authorization (PA): Also known as “coverage review,” this is a process the Plan’s Pharmacy Benefit Manager might use to decide if your prescribed medicine will be covered. The Plan uses this to help control costs and to ensure the medicine being prescribed is an effective treatment for the condition.

Primary Care Doctor or Primary Care Physician (PCP): Per NRS 695G.060, “Primary care physician” means a physician or group of physicians who:

1. Provides initial and primary health care services to an insured;
2. Maintains the continuity of care for the insured; and
3. May refer the insured to a specialized provider of health care.

This may include a ~~A~~ physician in family practice, internal medicine, obstetrics and gynecology and pediatrics.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: Means the Public Employees’ Benefits Program established in accordance with [NRS 287.0402 to 287.049](#), inclusive.

Prophylactic Surgery: A surgical procedure performed for

- avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or
- treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages.

An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth are performed by a dentist or dental hygienist.

Prospective Payment System (PPS): This Plan follows CMS's Prospective Payment System (PPS) where the Plan's payment is based on a predetermined, fixed amount payable to a facility for inpatient or outpatient hospital services. The Plan will not allow separate reimbursement for specific HCPCS supplies, DME, orthotics, prosthetics, biological, and drugs billed on a HCFA claim form by any physician or other qualified healthcare professional in the following facility POS (place of service) 19, 21, 22, 23, and 24, see the following POS descriptions:

- **POS 19 Off Campus – Outpatient Hospital:** A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **POS 21 Inpatient Hospital:** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
- **POS 22 On Campus – Outpatient Hospital:** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision physicians to patients admitted for a variety of medical conditions.
- **POS 23 Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness and injury is provided.
- **POS 24 Ambulatory Surgery Center:** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Prosthetic Appliance (or Device): A type of corrective appliance or device designed to replace all

or part of a missing body part, including (but not limited to) artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* Section).

Qualified Individual: A covered individual who is eligible, according to clinical trial protocol, to participate in an approved clinical trial and either: (i) the referring health care professional is an in-network provider and has concluded that the covered individual's participation in the clinical trial would be appropriate; or (ii) the covered individual provided medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

Qualified Medical Child Support Orders (QMCSO): QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce, and also include a National Medical Support Notice. A QMCSO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- Specifies your last known name and address and the child's last known name and address.
- Describes the type of coverage to be provided, or how the type of coverage will be determined.
- States the period to which it applies; and
- Specifies each plan to which it applies.

The QMCSO cannot require the Plan to cover any type or form of benefit that they do not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions. You and the affected child will be notified if an order is received.

Quantity Limit: The maximum amount of a medication the Plan covers during a period of time. These limits are set for safety reasons and to help reduce costs.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in [29 CFR 716-6\(c\)](#) ~~29 CFR 716-6(e)~~.

Reasonable and/or Reasonableness: Means charges for services or supplies which are necessary

for the care and treatment of an illness or injury. The determination that charges are reasonable will be made by the Plan Administrator taking into consideration the following:

- The facts and circumstances giving rise to the need for the service or supply.
- Industry standards and practices as they are related to similar scenarios; and
- The cause of the injury or illness necessitating the service or charge.

The Plan Administrator's determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities:

- (a) The National Medical Associations, Societies, and Organizations;
- (b) The Centers for Medicare and Medicaid Services (CMS);
- (c) Centers for Disease Control and Prevention; and
- (d) The Food and Drug Administration.

To be reasonable, charges must follow generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether a charge is reasonable. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charges that are not reasonable and therefore not eligible for payment by the Plan.

Recognized Amount: means (in order of priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

For air ambulance services furnished by Non-PPO providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease, or tumor, or for breast reconstruction following a total or partial mastectomy.

Reference Based Pricing/Reference Price: A methodology that determines the cost for a covered service based on a market or industry benchmark or reference price. The Plan Administrator may utilize this method in determining the Maximum Allowable Charge.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness, surgery, or medically necessary treatment of a behavioral health condition and

that is performed by a licensed therapist acting within the scope of his or her license. See the *Schedule of ~~Medical~~ Benefits* and the *Exclusions* section of this document to determine the extent to which rehabilitation therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

Reimbursable Payments: Payments made by this Plan for benefits, including any payment for a covered pre-existing condition that are or become the responsibility of another party under the subrogation provisions as described in this MPD.

Rescission: A cancellation or discontinuance of coverage under the Plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the Plan if

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or
- fraud.

Retiree: Unless specifically indicated otherwise, when used in this document, Retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule.

Second Opinion: A consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

Serious and Complex Condition: With respect to a participant, beneficiary, or enrollee under the Plan one of the following:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;

in the case of a chronic illness or condition, a condition that is—

- is life-threatening, degenerative, potentially disabling, or congenital; and
- requires specialized medical care over a prolonged period of time.

Service Area: The geographic area serviced by the In-Network providers who have agreements with the Plan's network.

Sickle Cell Disease: An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable. See also [NRS 439.4927](#).

Significantly Inferior Coverage: The PEBP Board has defined Significantly Inferior Coverage as either:

- A mini-med or other limited benefit plan; or
- Catastrophic coverage plans with a Deductible equal to or greater than \$5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility or Extended Care/Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, sick people or people with disabilities, and that meets the following requirements:

- Is licensed pursuant to state and local laws.
- Is operated primarily for providing skilled nursing care and treatment for individuals convalescing from injury or illness.
- Is approved by and is a participating facility with Medicare.
- Has organized facilities for medical treatment.
- Provides 24-hour-a-day nursing service under the full-time supervision of a physician or registered nurse.
- Maintains daily clinical records on each patient.
- Has available the services of a physician under an established agreement.
- Provides appropriate methods for dispensing and administering drugs and medicines.
- Has transfer arrangements with one or more hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one physician; and
- Is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

A skilled nursing facility that is part of a hospital, as defined in this document, will be considered a skilled nursing facility for the purposes of this Plan.

Special Food Product: ([NRS 689B.0353](#)) A food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Specialist Physician: A doctor who has completed advanced education and training in a specific field of medicine. Per CMS, a specialist is a doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication.

Spinal Manipulation / Chiropractic Care: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by physicians.

Spouse: The employee's lawful spouse. The Plan will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

Standard Plan Benefits (Standard Benefits): Standard Plan Benefits or Standard Benefits under this Plan means the participant is covered under the Plan's Standard Benefits and is not eligible for enhanced benefits due to non-participating and or engaging in other programs such as the Obesity Care and Overweight Management Programs.

State: When capitalized in this document, the term State means the State of Nevada.

Step Therapy: See also "Medical Management technique." A process designed to help control high medicine costs. If the Plan applies step therapy to your medication, it will require that you try a lower-cost medication that is proven effective to treat your condition, before it will cover a higher-cost medicine. If the lower cost medicine does not treat your condition effectively, the Plan's coverage will "step" you to a higher-cost medicine to find a medicine that treats your condition effectively at the lowest possible cost.

The Plan also complies with step therapy per [NRS 695G.1675](#).

Sub-acute Care Facility: A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide sub-acute care, that primarily provides, immediately after or instead of acute care, comprehensive

inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, to the patient's home or to a suitable skilled nursing facility, and that meets the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Sub-Acute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and
- It maintains on its premises facilities necessary for medical care and treatment; and
- It provides services under the supervision of physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse; and
- It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
- It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of behavioral health disorders and chemical dependency.

Surgery/Surgeries: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the claims administrator will determine which multiple surgical procedures will be considered as primary, secondary, bilateral, add-on, or separate (incidental) procedures for determining benefits under this Plan.

Multiple Surgical Procedure Allowances:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: usual and customary, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Bilateral secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Add-on to secondary procedure in same operative area: limited to 100% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.

- Separate (incidental) procedure in same operative area as any of the above: not covered.
- Separate operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.

Telehealth: Telehealth means the delivery of services from a provider of health care to a patient at a different location using information and audio-visual communication technology, not including facsimile, or electronic mail. See also [NRS 629.515](#).

Telehealth is a general term used to describe clinical services provided to patients through electronic communications not through a vendor. This can be patient-to-physician. Examples include patient consultation with a specialist that is out of the patient's geographical area or patient has a virtual visit with their primary care physician. Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health.

Telemedicine: Telemedicine (vendor/virtual visit) is the practice of medicine using technology to deliver care at a distance via electronic communications through a vendor.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome:

The Temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring, or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Therapist: A person trained in and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy. *See the Occupational, Physical and Speech Therapy section.*

Termination: Under the No Surprises Act, includes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, which injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. (See the

Schedule of ~~Medical~~ Benefits and Exclusions section for additional information regarding transplants. See also the *Utilization Management* section of this document for information about precertification requirements for transplantation services).

Xerographic: Refers to transplants of organs, tissues, or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xerographic transplants are not covered by this Plan, except heart valves.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate, even though health and life are not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include (but are not limited to) fever, sprains, bone, or joint injuries, continuing diarrhea, vomiting, or bladder infections.

Urgent Care Claim: Means a claim for benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not urgent care claims could seriously jeopardize the participant's life, health, or the ability to regain maximum function by waiting for a routine appeal decision. An urgent care claim also means a claim for benefits that, in the opinion of a physician with knowledge of the participant's medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for precertification of an urgent care service was denied, the participant could request an expedited appeal for the urgent care claim.

Urgent Care Facility: A public or private hospital-based or free-standing facility, that includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance when the facility is open.

Usual and Customary: Covered expenses which are identified by PEBP, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) most patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, country, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made.

To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or

equipment suppliers of similar standing, which are in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, subject to the Plan’s Maximum Allowable Charge or negotiated fee schedule for any procedure, service, or supply, and whether a specific procedure, service or supply is usual and customary. Usual and customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, Average Wholesale Price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

Utilization Management (UM): A managed care process to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include (but is not limited to): precertification; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM, utilization review services, UR services, utilization management, concurrent review, or retro review services) are provided by licensed health care professionals employed by the utilization management company operating under a contract with the Plan.

Utilization Management Company (UM company): The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan’s utilization management services.

Visit: See the definition of office visit.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary, even though they are not provided because of illness, injury, or congenital defect. The Plan’s coverage of well-baby care is described under *Preventive Care/Wellness Services* and in the *Schedule of ~~Medical~~ Benefits*.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.

Public Employees' Benefits Program



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Exclusive Provider Organization: PEBP Self-Funded Health Plan

Coverage Period: 07/01/2023 – 06/30/2024
Coverage for: Employee and Family | **Plan Type:** EPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pebp.state.nv.us. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 775-684-7000 1-800-326-5496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-Network</u> : Employee only: \$100 Family: \$200, Individual within the Family: \$100 <u>Out-of-Network</u> : N/A	Generally, you pay all costs up to the <u>deductible</u> , except <u>preventive services</u> and certain <u>copayments</u> . Individuals within the family must meet their own individual <u>deductible</u> until the total expenses paid by all family members meets the overall family <u>deductible</u> . <u>In-network</u> and <u>Out-of-Network Deductibles</u> accumulate separately. Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>In-network Preventive care</u> services are covered before you meet your <u>deductible</u> .	Some items and services covered if the <u>deductible</u> has not been met; however, a <u>copayment</u> or <u>coinsurance</u> may apply. Example: <u>preventive services</u> and medications on the preventive drug list. For more additional limitations, refer to the EPO Master <u>Plan</u> Document (MPD). For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No	The <u>Plan</u> does not include separate <u>deductibles</u> for specific services. You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<u>In-network</u> : Individual: \$5,000/Family \$10,000, Individual within Family: \$5,000. <u>Out-of-network providers</u> : N/A	The <u>Out-of-pocket limit</u> is the most an Individual or a Family will pay in a <u>Plan</u> Year for Eligible Medical Expenses. The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Penalties, <u>premiums</u> , <u>balance-billing</u> charges, <u>excluded services</u> , <u>prescription drug copay</u> assistance, non-covered services, and health	<u>Out-of-pocket limit</u> excludes penalties you pay for failure to obtain required <u>preauthorization</u> , <u>premiums</u> , <u>copay</u> surcharge for not using Express Advantage <u>Network</u> for short-term medications, failure to use 90-day retail/mail order for long-term medications, <u>copay</u> assistance dollars, failure to participate in the SaveonSP (for non-essential <u>specialty drugs</u>);

	care this <u>plan</u> doesn't cover.	<u>balance billing</u> and non-covered supplies and services. Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.pebp.state.nv.us or 1-888-763-8232 for a list of participating <u>providers</u> .	You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay more if you use an <u>out-of-network provider</u>, and you may receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
If you visit a health care provider's office or clinic	<u>Primary care</u> visit to treat an injury or illness	\$20 <u>copay</u> /visit	Not Covered	None.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	Not Covered	None.
	<u>Preventive care/screening/immunization</u>	No charge	Not Covered	You may have to pay for services that are not <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not Covered	Routine labs covered only when performed at a free-standing lab facility.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not Covered	May require <u>preauthorization</u> depending on the imaging type.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.pebp.state.nv.us	Generic	30-day/\$10 <u>copay</u> /prescription 90-day/\$20 <u>copay</u> /prescription	Not Covered	30-day supply for short-term medications must be filled at Express Advantage <u>Network</u> (EAN) pharmacy to avoid a <u>copay</u> surcharge. Penalty applies if you do not use a Smart90 retail pharmacy or home delivery for long-term medications. Some <u>drugs</u> require <u>preauthorization</u> . Penalty applies for not participating in the SaveOnSp for drugs on the Non-Essential Benefit <u>Specialty drug</u> List. <u>Copay</u> assistance for <u>specialty drugs</u> do not apply to <u>deductible</u> or <u>out-of-pocket limit</u> . Must use the <u>Plan's</u> specialty pharmacy.
	Preferred brand	30-day/\$40 <u>copay</u> /prescription 90-day/\$80 <u>copay</u> /prescription	Not Covered	
	Non-preferred brand	30-day/\$75 <u>copay</u> /prescription 90-day/ \$150 <u>copay</u> /prescription	Not Covered	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	Not Covered	
If you have outpatient surgery	Facility fee (ambulatory surgery center)/physician /surgeon fees	\$350 <u>copay</u> /visit	Not Covered	Requires <u>preauthorization</u> . If you do not get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network provider</u> (You will pay the least)	<u>Out-of-Network provider</u> (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$600 <u>copay</u> /visit	\$600 <u>copay</u> /visit	<u>Emergency room care</u> , <u>emergency medical transportation</u> , paid as <u>in-network</u> ; <u>Balance billing</u> applies to <u>out-of-network emergency medical transportation</u> , subject to the Plan's Maximum Allowable Charge, except as provided by federal or state law. See the EPO MPD.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	<u>Balance billing</u> applies to <u>out-of-network urgent care</u> , except as provided by federal or state law.
If you have a hospital stay	Facility fee (e.g., hospital room)/physician/surgeon fees	\$600 <u>copay</u> /admit	Not Covered	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
If you need mental health, behavioral health, or substance abuse services	Outpatient Visit	\$20 <u>copay</u> /visit	Not Covered	None.
	Inpatient services	\$600 <u>copay</u> /admit	Not Covered	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> , benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	\$0 <u>copay</u> /visit	Not Covered	Routine prenatal care obtained from <u>Plan Provider</u> is covered at no charge. Maternity care, including non-routine maternity care, may include tests and services subject to <u>cost sharing</u> as described elsewhere in this SBC. (i.e., Ultrasound, Lab). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a [<u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u>] may apply.
	Childbirth/delivery professional services	Surgical: No charge Anesthesia: No charge	Not Covered	
	Childbirth/delivery facility services	\$600 <u>copay</u> /admit	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required. 60 visits/ <u>plan</u> year.
	<u>Rehabilitation service</u>	\$40 <u>copay</u> /visit \$600 <u>copay</u> /admit	Not Covered	<u>Preauthorization</u> required for visits exceeding 90 combined (OT, PT, ST) per year.
	<u>Habilitation services</u>	\$40 <u>copay</u> /visit \$600 <u>copay</u> /admit	Not Covered	<u>Preauthorization</u> required.
	<u>Skilled nursing care</u>	\$600 <u>copay</u> /admit	Not Covered	<u>Preauthorization</u> required. 100 visits/ <u>plan</u> year.

	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> required for equipment over \$1,000.
	<u>Hospice services</u>	\$600 <u>copay</u> /admit	Not Covered	<u>Preauthorization</u> required after 185 days.
If your child needs dental or eye care	Children's eye exam	\$10 <u>copayment</u>	\$10 <u>copayment</u>	Limited to 1 routine <u>preventive care/screening</u> per <u>plan</u> year; \$100 maximum benefit.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Coverage available under separate dental <u>plan</u> .

Excluded Services & Other Covered Services:

<u>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</u>			
• Cosmetic surgery • Long-term care	• Non-emergency care when traveling outside the U.S.	• Orthodontia expenses • Private-duty nursing • Routine foot care	
<u>Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)</u>			
• Acupuncture • Bariatric surgery	• Chiropractic care • Dental Care (Adult) • Hearing aids	• Infertility treatment • Routine eye care (Adult) • Weight Loss Programs	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-326-5496 or 775-684-7000. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about benefits, contact HealthSCOPE Benefits Customer Service at 1-888-763-8232

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan does not meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: See Attachment A

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan *might* cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$100
■ <u>Specialist</u> [<u>copay per visit</u>]	\$40
■ Hospital (facility) [<u>copay</u>]	\$600
■ Other [<u>coinsurance</u>]	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700

In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$640
<u>Coinsurance</u>	\$230
<u>What is not covered</u>	
Estimated limits or exclusions	\$0
The total Peg would pay is	\$970

Managing Joe's type 2 Diabetes*

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$100
■ <u>Specialist</u> [<u>copay per visit</u>]	\$40
■ Hospital (facility) [<u>copay</u>]	\$600
■ Other [<u>coinsurance</u>]	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600

In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$640
<u>Coinsurance</u>	\$900
<u>What is not covered</u>	
Estimated limits or exclusions	\$60
The total Joe would pay is	\$1,700

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$100
■ <u>Specialist</u> [<u>copay per visit</u>]	\$40
■ Hospital (facility) [<u>copay</u>]	\$600
■ Other [<u>coinsurance</u>]	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation service (*physical therapy*)

Total Example Cost	\$2,800

In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$640
<u>Coinsurance</u>	\$390
<u>What is not covered</u>	
Estimated limits or exclusions	\$0
The total Mia would pay is	\$1,130

The plan would be responsible for the other costs of these EXAMPLE covered services.

Attachment A

Language Access Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-763- 8232 (TTY Users, Dial 7-1-1)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-763- 8232 (TTY Users, Dial 7-1-1)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-763- 8232 (TTY Users, Dial 7-1-1)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-763- 8232 (TTY Users, Dial 7-1-1) 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-763- 8232 (TTY Users, Dial 7-1-1)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በገጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-763- 8232 (መስማት ለተሳናቸው፡(TTY Users, Dial 7-1-1)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถ ใช้นี้ รกิ ารช่วยเหลือ ทางภาษา ได้ฟรี โทร 1-888-763- 8232 (TTY Users, Dial 7-1-1)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-763- 8232 (TTY Users, Dial 7-1-1) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-1-7 (رقم هاتف الصم والبكم: 8232-763-888-1)

В Н И М А Н И Е : Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-763- 8232 (телетайп: 7-1-1).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-763- 8232 (ATS: 7-1-1).

تماس بگیرید 1-888-763-8232 (TTY: 7-1-1) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-888-763- 8232 (TTY Users, Dial 7-1-1)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-763- 8232 (TTY Users, Dial 7-1-1)

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-888-763- 8232 (TTY Users, Dial 7-1-1)



Access.
Quality.
Affordability.



PEBP PPO DENTAL PLAN AND SUMMARY OF BENEFITS FOR LIFE INSURANCE

MASTER PLAN DOCUMENT

PLAN YEAR 20245

(EFFECTIVE JULY 1, 202~~43~~ – June 30, 202~~54~~)

DRAFT





Public Employees' Benefits Program
3427 Goni Road, Suite 109
Carson City, Nevada 89706

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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

~~Basic Life Insurance~~

~~“Coverages” — update and clarify “Legislatively approved enhancements, such as HSA/HRA funding and enhanced basic life insurance amounts may be subject to change in subsequent plan years.”~~

DRAFT

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP provides a variety of benefits such as medical, dental, life insurance, flexible spending accounts, and other voluntary benefits for eligible state and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may enroll in whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and Plan requirements. These plans include the Consumer Driven Health Plan (CDHP), Exclusive Provider Organization (EPO) Plan, Low Deductible PPO Plan, and Health Plan of Nevada HMO Plan. You are encouraged to research plan provider access and quality of care in your service area.

This document describes PEBP's PPO Dental Plan and Life Insurance Benefits. Members enrolled in a PEBP-sponsored medical plan (CDHP, EPO Plan, Low Deductible PPO Plan, or Health Plan of Nevada HMO Plan) receive dental and basic life. Retirees enrolled in a PEBP-sponsored medical plan receive dental coverage and, if eligible, basic life insurance coverage. Eligible retirees enrolled in a medical plan through PEBP's Medicare Exchange receive the choice to enroll in PEBP's voluntary PPO Dental Plan option and, if eligible, basic life insurance.

PEBP participants should examine this document to become familiar with the PPO Dental Plan and basic life insurance benefits. In addition to examining this document, participants are encouraged to read the Master Plan Documents or Evidence of Coverage Certificates (EOCs), Summary Plan Descriptions, and Summary of Benefits and Coverage applicable to their medical plan.

Participants should also examine the PEBP Enrollment and Eligibility, PEBP Active Employee Health and Welfare Wrap Plan Document, PEBP Retiree Health and Welfare Wrap Plan Document, Section 125, Medicare Exchange Health Reimbursement Arrangement Summary Plan Description, Health Reimbursement Arrangement Summary Plan Document, and other plan materials relevant to their benefits. These documents and other materials are available at <https://pebp.nv.gov/> ~~www.pebp.state.nv.us~~ or to request a particular document by mail, contact PEBP at 775-684-7000, (702) 486-3100, or 800-326-5496 or email member services by selecting the contact us feature in your E-PEBP portal member account.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the plan provisions and other requirements described in PEBP's Master Plan Document and related materials.

Sincerely,

Public Employees' Benefits Program

Introduction

This Master Plan Document describes PEBP's self-funded PPO Dental Plan benefits offered to eligible ~~employees~~participants, retirees, and their covered dependents. Additional benefits for life insurance are summarized in this document.

This PEBP plan is governed by the State of Nevada.

The Plan and this document ~~is~~are intended to comply with Chapter 287 of the Nevada Revised Statutes (NRS) ~~Chapter 287~~, Chapter 287 of and the Nevada Administrative Code (NAC), ~~287 as amended~~ and all other applicable provisions of Nevada law~~certain provisions of NRS 695G and NRS 689B~~. Additionally, PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA).

The Plan described in this document is effective **July 1, 2023**~~24~~, and unless stated differently, replaces ~~all~~ other self-funded Dental Benefit Plan documents and summary plan descriptions previously provided to you.

This document will help you understand and use the benefits provided by the PEBP. You should review it and show it to members of your family who are or will be covered by the Plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan. Be sure to read the *Exclusions*, and *Key Terms and Definitions* Sections. Remember, not every expense you incur for health care is covered by the Plan.

The provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, please contact PEBP at the number listed in the *Participant Contact Guide*.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

The benefits offered with the CDHP, EPO Plan, Low Deductible PPO Plan, and Health Plan of Nevada include prescription drug benefits, dental coverage, and basic life insurance as applicable. The medical and prescription drug benefits are described in separately in the applicable plan's Master Plan Document or Evidence of Coverage certificate. An independent third-party claims administrator pays the claims for the PPO Dental Plan.

Per NRS 287.0485, no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.

Suggestions for Using this Document

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The *Table of Contents* provides you with an outline of the sections.
- The *Participant Contact Guide* to become familiar with PEBP vendors and the services they provide.
- The *Participant Rights* section located in the Introduction of this document.
- The *Key Terms and Definitions* section explains many technical, medical, and legal terms that appear in the text.
- The *Eligible Dental Expenses*, *Schedule of Dental Benefits* and *Exclusions* sections describe your benefits in more detail.
- How to *File a Dental Claim* section to find out what you must do to file a claim.
- The *Appeals Process* section to find out how to request a review (appeal) if you are dissatisfied with a claims decision.
- The section on *Coordination of Benefits* discusses situations where you have coverage under more than one health care plan including Medicare. This section also provides you with information regarding how the plan subrogates with a third party who wrongfully caused an injury or illness to you.

Accessing Other Benefit Information:

Refer to the following plan documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA Privacy and Security and mandatory notices. These documents are available at <https://pebp.nv.gov/>. www.pebp.state.nv.us.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan; Retiree Health and Welfare Wrap Plan
- CDHP Master Plan Document (MPD); CDHP Summary of Benefits and Coverage (SBC) for Individual and Family
- Low Deductible (LD) PPO Plan MPD; LD PPO Plan SBC for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Basic Life Insurance MPD
- Exclusive Provider Organization (EPO) Plan Master Plan Document; SBC for Individual and Family
- Health Reimbursement Arrangement Summary Plan Document
- Health Plan of Nevada Evidence of Coverage of Benefits; Summary of Benefits and Coverage for Individual and Family
- PEBP Enrollment and Eligibility MPD
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

Participant Rights

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with State and Federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and providers and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's participants' rights and policies.
- Express respectfully and professionally any concerns you may have about PEBP or any benefit or coverage decisions the Plan (or the Plan Administrator or its designee) makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing future treatment and be informed by your physician(s) of the medical consequences.

Summary of PPO Dental Benefits

Eligible Dental Expenses

You are covered for expenses you incur for most, but not all, dental services and supplies provided by a dental care provider as defined in the *Key Terms and Definitions* section of this document that are determined by PEBP or its designee to be “medically necessary,” but only to the extent that:

- The charges for them are “usual and customary (U&C)” (see Usual and Customary in the *Key Terms and Definitions* section).

Non-Eligible Dental Expenses

The plan will not reimburse you for any expenses that are not eligible dental expenses or medically unnecessary. That means you must pay the full cost for expenses that are not covered by the Plan, as well as any charges for eligible dental expenses that exceeds this Plan’s Usual and Customary determination.

Out-of-Country Dental Purchases

The PPO Dental Plan provides you with coverage worldwide. Whether you reside in the United States and you travel to a foreign country, or you reside outside of the United States, permanently or on a part-time basis and require dental care services, you may be eligible for reimbursement of the cost.

Typically, foreign countries do not accept payment directly from PEBP. You may be required to pay for dental care services and submit your receipts to PEBP’s third party administrator for reimbursement. Dental services received outside of the United States are subject to Plan provisions, limitations and exclusions, clinical review if necessary and determination of medical necessity. The review may include application of pertinent Food and Drug Administration (FDA) regulations~~The review may include regulations determined by the FDA.~~

Prior to submitting receipts from a foreign country to PEBP’s third party administrator, you must complete the following (PEBP and this Plan’s third-party administrator reserve the right to request additional information if needed):

- Proof of payment from you to the provider of service.
- Itemized bill to include complete description of the services rendered.
- Itemized bill must be translated to English.
- Any costs associated with the reimbursement request must be converted to United States dollars; and

Any foreign purchases of dental care and services will be subject to Plan limitations such as:

- Benefits and coverage under the Plan
- Deductibles

- Coinsurance
- Frequency maximums
- Annual benefit maximums
- Medical necessity
- FDA approval
- Usual and Customary (U & C)

Once payment is made to you or to the out of country provider, PEBP and its vendors are released from any further liability for the out of country claim. PEBP has the exclusive authority to determine the eligibility of dental services rendered by an out of country provider. PEBP may or may not authorize payment to you or to the out of country provider if the requirements of this provision are not satisfied.

Note: Please contact this Plan's third-party administrator before traveling or moving to another country to discuss any criteria that may apply to a dental service reimbursement request.

Deductibles

Each Plan Year, you must satisfy the Plan Year Deductible before the Plan will pay benefits for Basic or Major dental services. Eligible dental expenses for preventive services are not subject to the Plan Year Deductible or the annual maximum benefit. Benefits for some services are available four times each Plan Year, for example preventive cleanings and periodontal maintenance cleanings. Oral examinations and bitewing x-rays are available twice per Plan Year. If a person covered under this Plan changes status from an employee or retiree to a dependent, or from a dependent to an employee and the person is continuously covered under this Plan before, during and after the change in status, credit will be given for portions of the Deductible already met, and accumulation of benefit maximums will continue without interruption.

There are two types of Deductibles: Individual and Family. The Individual Deductible is the maximum amount one covered person must pay each Plan Year before plan benefits are available for Basic or Major dental services. **The Plan's Individual Deductible is \$100.** The Family Deductible is the maximum amount a family of three or more is required to pay in a Plan year. **The plan's family Deductible is \$300.** The Family Deductible is cumulative meaning that one member of the family cannot satisfy the entire Family Deductible. Both in- and out-of-network services are combined to meet your Plan Year Deductible.

Coinsurance

There is no Coinsurance amount for preventive services unless a non-PPO dental provider renders services. For Basic or Major dental services, once you have met your Plan Year Deductible, the Plan pays its percentage of the eligible Usual and Customary dental expenses, and you are responsible for paying the rest (the applicable percentage paid by the Plan is shown in the Schedule of Dental Benefits). The part you pay is called the Coinsurance. Note: Your out-of-pocket expenses will be less if you use the services of a dental care provider who is part of the Preferred Provider Organization (PPO), also called in-network.

Plan Year Maximum Dental Benefits

The Plan Year maximum dental benefits payable for any individual covered under this Plan is **\$2,000**. The Plan Year maximum dental benefit is combined to include both in-network and out-of-network services. Under no circumstances will the combination of in-network and out-of-network benefit payments exceed the Plan Year maximum benefit. This maximum does not include your Deductible or any amounts over Usual and Customary. Benefits paid for eligible preventive dental services do not apply to the annual maximum dental benefit.

There is no plan year maximum for dependent children under age 19.

Payment of Dental Benefits

When charges for dental services and supplies are incurred, services and supplies are considered to have been incurred on the date the services are performed or on the date the supplies are furnished. However, this rule does not apply to the following services because they must be performed over a period of time.

- Fixed partial dentures, bridgework, crowns, inlays and onlays: ~~All~~ sServices related to installation of fixed partial dentures, bridgework, crowns, inlays and onlays are considered to have been incurred on the date the tooth (or teeth) is (or are) prepared for the installation.
- Removable partial or complete dentures: ~~All~~ sServices related to the preparation of removable partial or complete dentures are considered to have been incurred on the date the impression for the dentures is taken.
- Root canal treatment (endodontics): ~~All~~ sServices related to root canal treatment are considered incurred on the date the tooth is opened for the treatment.

Extension of Dental Coverage

If dental coverage ends for any reason, the Plan will pay benefits for you or your covered dependents through the last day of the month in which the coverage ends. The Plan will also pay benefits for a limited time beyond that date for the following:

- A prosthesis (such as a full or partial denture) if the dentist took the impressions and prepared the abutment teeth while you or your dependents were covered and installs the device within 31 days after coverage ends.
- A crown, if the dentist prepared the crown while you or your dependent(s) were covered and installs it within 31 days after coverage ends.
- Root canal treatment, if the dentist opened the tooth while you or your dependent(s) were covered and completes the treatment within 31 days after coverage ends.

Dental Pretreatment Estimates

Whenever you expect that your dental expenses for a course of treatment will be more than **\$300**, you are encouraged to obtain a pretreatment estimate from the third-party claims administrator. This procedure lets you know how much you will have to pay before you begin treatment.

To obtain a pretreatment estimate, you and your dentist should complete the regular dental claim form (available from and to be sent to the third-party claims administrator, whose name

and address are listed on the *Participant Contact Guide* in this document), indicating the type of work to be performed also referred to as a treatment plan, along with supporting x-rays and the estimated cost (valid for a 60-day period following the submission of the pretreatment estimate request). Once it is received, the third-party claims administrator will review the treatment plan and then send your dentist a statement within the next 60 days showing what the Plan may pay. Your dentist may call the third-party claims administrator for a prompt determination of the benefits payable for a dental procedure.

Prescription Drugs Needed for Dental Purposes

Necessary prescription drugs needed for a dental purpose, such as antibiotics or pain medications, should be obtained using the prescription drug benefit provided under your medical plan.

NOTE: Some medications for dental purposes are not payable, such as fluoride or periodontal mouthwash. See the *Medical Exclusions* section under Drugs for more information.

Voluntary PPO Dental Plan Option for Medicare Retirees Enrolled through VIA Benefits

Medicare retirees enrolled in a medical plan through VIA Benefits (Medicare Exchange) and those retirees with Tricare for Life and Medicare Parts A and B who are eligible for a Medicare Exchange Health Reimbursement Arrangement (HRA) have the option to enroll in PEBP's PPO Dental Plan. Enrollment in PEBP's PPO Dental Plan requires automatic dental premium reimbursement from the retiree's Health Reimbursement Arrangement (HRA). The dental premium will only be reimbursed up to the amount in retiree's HRA. When the amount of the dental premium is more than the unused amount in the retiree's HRA, the amount of the premium will be carried forward in the retiree's HRA until the unused amount in the HRA is sufficient to reimburse for the dental premium.

Dental Network

In-Network Services

In-network dental care providers have agreements with the Plan under which they provide dental care services and supplies for a favorable negotiated discount fee for Plan participants. When a Plan participant uses the services of an in-network dental care provider, except with respect to any applicable deductible, the Plan participant is responsible for paying only the applicable Coinsurance for any medically necessary services or supplies. The in-network dental care provider generally deals with the Plan directly for any additional amount due.

The Plan's Preferred Provider Organization (PPO) is contracted with PEBP to provide a network of dental care providers located within a "service area" and who have agreed to provide dental care services and supplies for favorable negotiated discount fees applicable only to Plan participants. Because providers are added and dropped from the PPO network periodically throughout the year, it is the participant's responsibility to verify provider participation each time before seeking services by contacting the PPO network. The PPO dental network's telephone number and website are listed on the *Participant Contact Guide* in this document.

If you receive medically necessary dental services or supplies from a PPO dental care provider, you will pay less money out of your own pocket than if you received those same services or supplies from a dental provider who is not a PPO provider because these providers discount their fees. Using PPO dental care providers means that you can obtain more dental services before reaching your Plan Year dental benefit maximum. In addition to receiving discounted fees for dental services, the PPO provider has agreed to accept the Plan's allowed payment, plus any applicable Coinsurance that you are responsible for paying, as payment in full.

The directory of dental care providers is available at <https://pebp.nv.gov/.www.pebp.state.nv.us>. To request a hard copy of the directory, please call the PPO Dental Network shown in the *Participant Contact Guide* in this document.

Out-of-Network Services

Out-of-network (non-network) dental care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. For participants receiving services outside of Nevada, the Plan will reimburse the Plan participant for the usual and customary charge for any medically necessary services or supplies, subject to the Plan's Deductibles, Coinsurance, copayments, limitations, and exclusions.

If a participant travels to an area serviced by the Plan's PPO network, the participant should use an in-network provider to receive benefits at the in-network benefit level. If a participant uses an out-of-network provider within this service area, benefits will be considered as out-of-network. In-network provider contracted rates for the Diversified Dental Las Vegas service area will apply to ~~all~~ out-of-network dental claims in Nevada. The participant may be responsible for any amount billed by the out-of-network provider that exceeds the in-network provider contracted rate. Plan participants may be required to submit proof of claim before any such reimbursement is made.

Non-network dental care providers may bill the Plan participant for any balance that may be due in addition to the amount payable by the Plan, also called balance billing. You can avoid balance billing by using in-network providers.

[When Out-of-Network Providers May be Paid as In-Network Providers?](#)

If a participant lives more than 50 miles from an in-network PPO provider, resides, or travels outside of Nevada, benefits for an out-of-network provider will be considered at the in-network benefit level. Usual and customary allowance will apply. The participant may be responsible for any amount billed by the provider that exceeds the usual and customary allowance.

A “service area” is a geographic area serviced by the in-network dental care providers who have agreements with the Plan’s PPO dental network. If you and/or your covered dependent(s) live more than 50 miles from the nearest in-network dental care provider, the Plan will consider that you live outside the service area. In that case, your claim for services by an out-of-network dental care provider will be treated as if the services were provided in-network.

Schedule of Dental Benefits

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)

See also the *Exclusions*, and *Key Terms and Definitions* sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Preventive Services - Oral examination - Prophylaxis (routine cleaning of the teeth without the presence of periodontal disease) - Bitewing X-Rays - Topical application of sodium or stannous fluoride - Space maintainers - Application of sealants	No Deductible 100% of the discounted allowed fee schedule	No Deductible 80% of the in-network provider fee schedule for the Las Vegas service area For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Preventive services are not subject to the individual Plan Year maximum dental benefit.
- Oral examinations are limited to four times per Plan Year.
- Prophylaxis, scaling, cleaning, and polishing limited to four times per Plan Year. Even if your dentist recommends more than four routine prophylaxes, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan Year.
- Bitewing x-rays limited to twice per Plan Year.
- Fluoride treatment for individuals aged 18 years and under is payable twice per Plan Year.
- Application of sealants for children under the age of 18 years.
- Initial installation of a space maintainer (to replace a primary tooth until a permanent tooth comes in) is payable for individuals under the age of 16 years. Plan allows fixed, unilateral (band or stainless-steel crown type), fixed cast type (distal shoe), or removable bilateral type.
- Benefits for preventive dental services do not apply to the annual maximum dental benefit.

Out-of-Network: The Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area.

For services outside of Nevada, the Plan will reimburse at the U&C rates.

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)

See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Basic Services	After the Deductible is met, the Plan pays 80% of the discounted allowed fee schedule	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Plan Year Deductible applies
- Dental visit during regular office hours for treatment and observation of injuries to teeth and supporting structures (other than for routine operative procedures)
- After hours for emergency dental care
- Consultation by a specialist for case presentation when a general dentist has performed diagnostic procedures
- Emergency treatment
- Film fees, including examination and diagnosis, except for injuries
- Dental CT scans are allowed at varying frequencies depending on the type of service.
- Periapical, entire dental film series (14 films), including bitewings as necessary every 36 months **or** panoramic survey covered once every 36 months
- Basic services are subject to the individual Plan Year maximum dental benefit.
- Full-mouth periodontal maintenance cleanings, payable four times per Plan Year. Even if your dentist recommends more than four periodontal maintenance cleanings, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan Year
- Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition
- For multiple restorations, one tooth surface will be considered a single restoration
- Out-of-Network: After deductible, the Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.
- Biopsy, examination of oral tissue, study models, microscopic exam.
- Emergency palliative treatment for pain.
- Uncomplicated oral surgery is surgery not identified as "complex oral surgery." Oral surgery is limited to removal of teeth, incision, and drainage.

- Complex oral surgery means procedures including surgical extractions of teeth, impactions, alveoloplasty or alveolectomy, vestibuloplasty, and residual root removal, including local anesthesia and postoperative care.
- Amalgam restorations for primary and permanent teeth, synthetic, silicate, plastic and composite fillings, retention pin when used as part of restoration other than a gold restoration
- Appliance for thumb sucking (individuals under 16 years of age)
- Occlusal guard or night guard.
- Dental CT scans, depending on the type and necessity, are allowed by the Plan. Contact the claims administrator for more information. You must have the CDT code of your requested procedure before calling
- Initial installation of a removable, fixed or cemented inhibiting appliance to correct thumb sucking is payable for individuals under age 16 years
- No coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan began

Out-of-Network: After deductible, the Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area.

For services outside of Nevada, the Plan will reimburse at the U&C rates.

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)

See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Major Services	After the Deductible is met, Plan pays 50% of the discounted allowed fee schedule.	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Plan Year Deductible applies to Major services
- Major services are subject to the individual Plan Year maximum dental benefit
- No coverage for a crown, bridge, or gold restoration when the tooth was prepared before coverage under the dental Plan began
- Facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered. Gold restorations (inlays and onlays) covered only when teeth cannot be restored with a filling material
- Repair or re-cementing of inlays, crowns, bridges, and dentures which are 5 years old or more and cannot be repaired.
- Initial installation of fixed or removable bridges, dentures and full or partial dentures (except for special characterization of dentures) including abutment crowns
- Bridgework, dentures, and replacement of bridgework and dentures which are 5 years old or more and cannot be repaired. Covered expenses for temporary and permanent services cannot exceed the usual and customary fees for permanent services
- Dental implants (endosseous, ridge extension, and ridge augmentation only) which are 5 years old or more and cannot be repaired.
- Post and core on non-vital teeth only
- Denture relining and/or adjustment more than six months after installation
- Prosthodontics (artificial appliance of the mouth). No coverage of fees to install or modify an appliance for which an Impression was made before coverage under this dental plan began
- Crown (acrylic, porcelain, or gold with gold or non-precious metal), including crown build up only when teeth cannot be restored with a filling material
- Teeth added to a partial denture to replace extracted natural teeth, including clasps if needed
- If payment is requested for temporary appliances, the cost of the temporary appliance will be deducted from the benefits payable for the permanent appliance, meaning the Plan will not pay for both a temporary and a permanent appliance

- Under no circumstances will the benefit paid for a temporary appliance and permanent appliance exceed the PPO allowed amount or usual and customary allowance

Out-of-Network: After deductible, the Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area.

For services outside of Nevada, the Plan will reimburse at the U&C rates.

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Benefit Limitations and Exclusions: PPO Dental Plan

The following is a list of dental services and supplies or expenses not covered by the PPO Dental Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

Analgesia, Sedation, Hypnosis, etc.: Expenses for analgesia, sedation, hypnosis, and/or related services provided for apprehension or anxiety.

Any treatment or service for which you have no financial liability or that would be provided at no cost in the absence of dental coverage.

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge dental practice to have access to the dental services provided by the concierge dental practice.

Cosmetic Services: Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to ~~all~~ veneers regardless of medical necessity, and facings. However, the following will be covered if they otherwise qualify as covered dental expenses and are not covered under your medical expense coverage:

- Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part.
- Surgery or treatment to correct deformities caused by sickness.
- Surgery or treatment to correct birth defects outside the normal range of human variation.
- Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child resulting in a functional disorder.

Costs of Reports, Bills, etc.: Expenses for preparing dental reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefits (as described in the *Dental Expense Coverage* section).

Drugs and Medicines: Expenses for prescription drugs and medications that are covered under your medical expense coverage, and for any other dental services or supplies if benefits as otherwise provided under the Plan's medical expense coverage; or under any other plan or program that the PEBP contributes to or otherwise sponsors (such as HMOs); or through a medical or dental department, clinic or similar facility provided or maintained by the PEBP.

Duplication of Dental Services: If a person covered by this Plan transfers from the care of one dentist to the care of another dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one dentist rendered ~~all~~ the services during each course of treatment, nor will the Plan be liable for duplication of services.

Duplicate or Replacement Bridges, Dentures or Appliances: Expenses for any duplicate or replacement of any lost, missing, or stolen bridge, denture, or orthodontic appliance, other than replacements described in the *Major Services* section of the *Schedule of Dental Benefits*.

Education Services and Home Use: Supplies and/or expenses for dental education such as for plaque control, oral hygiene or diet or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick type device, fluoride, mouthwash, dental floss, etc.

Expenses Exceeding Usual and Customary or the PPO Allowable Fee Schedule: Any portion of the expenses for covered dental services or supplies that are determined by the Plan Administrator or its designee to exceed the usual and customary charge or PPO fee schedule (as defined in the Definitions section of this document).

Expenses for Which a Third Party Is Responsible: Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party (see the provisions relating to Third Party Liability in the section on *Coordination of Benefits*).

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided before the patient became covered under the dental program, or after the date the patient's coverage ends (except under those conditions described in the Extension of Dental Benefits in the *Dental Expense Coverage* section or under the COBRA provisions of the Plan).

Experimental and/or Investigational Services: Expenses for any dental services, supplies, drugs, or medicines that are determined by the claims administrator or its designee to be experimental and/or investigational (as defined in the *Key Terms and Definitions* section of this document).

Frequent Intervals Services: Services provided at more frequent intervals than covered by the PPO Dental Plan as described in the *Schedule of Dental Benefits*.

Gnathological Recordings for Jaw Movement and Position: Expenses for gnathological recordings (measurement of force exerted in the closing of the jaws) as performed for jaw movement and position.

Hospital Expenses Related to Dental Care Expenses: Expenses for hospitalization related to dental surgery or care, except as otherwise explained in this document. Contact the claims administrator for more information if you require this service.

Illegal Act: Expenses incurred by any covered individual for injuries resulting from commission, or attempted commission by the covered individual, of an illegal act that PEBP determines

involves violence or the threat of violence to another person or in which the covered individual uses a firearm. PEBP's discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.

Installation or Replacement of Appliances: Restorations or procedures for altering vertical dimensions.

Medically Unnecessary Services or Supplies: As determined by PEBP or its designee not to be medically necessary (as defined in the *Definitions* section of this document.) This includes procedures that are not indicated due to insufficient evidence of efficacy, including, but not limited to, Adjunctive Pre-Diagnostic Tests, Oral Cancer screenings, etc.

Mouth Guards: Expenses for athletic mouth guards and associated devices.

Myofunctional: Therapy expenses for myofunctional therapy.

Non-Dental Expenses: Services rendered or supplies provided that are not recommended or prescribed by a dentist.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: ~~All~~ expenses incurred by you or any of your covered dependents arising out of or in the course of employment (including self-employment) if the injury, illness, or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law.

This applies even if you or your covered dependent were not covered by workers' compensation insurance, or if the covered individual's rights under workers' compensation or occupational disease or similar law have been waived or qualified.

Orthodontia: Expenses for any dental services relating to orthodontia evaluation and treatment.

Periodontal Splinting: Expenses for periodontal splinting (tying two or more teeth together when there is bone loss to gain additional stability).

Personalized Bridges, Dentures, Retainers or Appliances: Expenses for personalization or characterization of any dental prosthesis, including but not limited to any bridge, denture, retainer, or appliance.

Reconstructive Dental Surgery: When that service is:

- Incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part.
- Surgery or treatment to correct deformities caused by sickness.
- Surgery or treatment to correct birth defects outside the normal range of human variation.

- Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child resulting in a functional disorder.

Services Not Performed by a Dentist or Dental Hygienist: Expenses for dental services not performed by a dentist (except for services of a dental hygienist that are supervised and billed by a dentist and are for cleaning or scaling of teeth or for fluoride treatments).

Treatment of Jaw or Temporomandibular Joints (TMJ): Expenses for treatment, by any means, of jaw joint problems including temporomandibular joint (TMJ) dysfunction disorder and appliances.

Treatment of Disturbances of the temporomandibular joint, craniomandibular dysfunctions, myofascial pain syndrome, or any other disorder of the joint linking the jaw to the skull and the associated muscles. This exclusion does not pertain to temporomandibular joint radiographs.

War or Similar Event: Expenses incurred as a result of an injury or illness due to you or your covered dependents participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Self-Funded PPO Dental Claims Administration

How Dental Benefits are Paid

Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP's third-party administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or copayments apply, you are responsible for paying your share of these charges.

If services are provided through the PPO dental network, the PPO dental provider may submit the proof of claim directly to PEBP's third-party administrator; however, you will be responsible for the payment to the PPO dental care provider for any applicable Deductible, Coinsurance, or copayments.

If a dental care provider does not submit a claim directly to PEBP's third-party administrator and instead sends the bill to you, you should follow the steps outlined in this section regarding *How to File a Claim*. If, at the time you submit your claim, you furnish evidence acceptable to the Plan Administrator or its designee (PEBP's third-party administrator) that you or your covered dependent paid some or all of those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan Year Deductible, Coinsurance and copayment amounts are met.

How to File a Dental Claim

~~All~~ Claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

Most providers send their bills directly to the PEBP's third-party administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party administrator or in your E-PEBP portal member account (see the *Participant Contact Guide* in this document for details on address, phone, and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains ~~all~~ the following information:
 - A description of the services or supplies provided including appropriate procedure codes.
 - Details of the charges for those services or supplies.
 - Appropriate diagnosis code.

- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the third-party administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's explanation of benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny deductible credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list.

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.

NOTE: Claims are processed by PEBP's third-party administrator in the order they are received.

NOTE: It is your responsibility to maintain copies of the explanation of benefits provided to you by PEBP's third party administrator or prescription drug administrator. Explanation of benefits documents are available on the third-party administrator's website application but cannot be reproduced.

[Where to Send the Claim Form](#)

Send the completed claim form, a copy of the bill you received, and any other required information to the third-party administrator at the address listed in the *Participant Contact Guide* in this document.

Dental Appeal Process

Written Notice of Denial of Claim

The Plan's third-party administrator will notify you in writing on an Explanation of Benefits (EOB) of an Adverse Claim Determination (see *Adverse Determination* in the *Key Terms and Definitions* section) resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal.

You will be provided with:

- upon request and without charge, reasonable access to and copies of ~~all~~ relevant documents, records, and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- a full and fair review that considers ~~all~~ comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

The appeal process works as follows:

Level 1 Claim Appeal

NAC 287.670

If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third-party administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause can be demonstrated. The written request for appeal must include:

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit your own comments in writing. The third-party administrator will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The third-party administrator will issue a decision of your Level 1 Claim Appeal in writing within 20 days after receipt of your request for appeal.

You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:

- (a) information that is sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
- (b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review (when external review is applicable);
- (c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
- (d) reference the specific Plan provision(s) on which the determination is based;
- (e) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- (f) an explanation of the Plan's appeal process and Level 2 appeal process and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- (g) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol, or criteria that was relied upon will be provided free of charge to you, upon request;
- (h) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

- (i) the statement that “You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;” and

disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

The notification will explain the steps necessary if you wish to proceed to a Level 2 Appeal if you are not satisfied with the response at Level 1.

[Level 2 Claim Appeal](#) [NAC 287.680](#)

If you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. Claim Appeal Request forms are available at <https://pebp.nv.gov/> ~~www.pebp.state.nv.us~~ or by request by contacting PEBP Customer Service at 775-684-7000, [702-486-3100](tel:702-486-3100), or 800-326-5496. Furthermore, you are welcome to submit Level 2 Claim Appeals online through a form that can be found under the subheading “Filing an Appeal” under PEBP’s contact us web page. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal must include a copy of:

- Any document submitted with your Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use ~~all~~ resources available to ensure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. A Level 2 Appeal determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.

[Standard Request for External Claim Review](#) [NAC 287.690](#)

An External Claim Review may be requested by a participant and/or the participant’s treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan’s or its designee’s decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim

Appeal decision. An *External Review Request Form* is available on the PEBP website at <https://pebp.nv.gov/>. ~~www.pebp.state.nv.us~~. The OCHA will assign an independent external review organization within five (5) days after receiving the request. The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

A Request for External Claim Review must include:

- completed and signed External Review Request Form.
- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance
555 East Washington #4800
Las Vegas, NV 89101
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web:

[https://adsd.nv.gov/Programs/CHA/Office for Consumer Health Assistance \(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)
~~[http://dhhs.nv.gov/Programs/CHA/Contact GovCHA/](http://dhhs.nv.gov/Programs/CHA/Contact_GovCHA/)~~

Coordination of Benefits (COB)

For information, refer to the separate PEBP Health and Welfare Wrap Document available at <https://pebp.nv.gov/> ~~www.pebp.state.nv.us~~ under “4.4 Coordination of Benefits” ([NAC 287.755](#)).

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Which Benefits are Subject to Coordination?

When Participants have medical, dental or vision coverage from some other source, benefits are determined using Coordination of Benefits (COB). COB operates so that one of the plans (i.e., the primary plan) will pay its benefits first. The other plan or policy, (i.e., the secondary plan) may then provide additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

Participants must let the Plan Administrator, or its designee, know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and dental deductibles. This Plan's prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.

For the purposes of this COB section, the word "plan" refers to any group or individual medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual either on an individual basis or as part of a group of employees, retirees or other individuals.

A Participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such fully insured plan and the rules and procedures described in such fully insured plan's applicable Summary of Insurance.

A Participant in a self-insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures set forth in this Section 4.4. The PEBP delegates to the third-party administrator of such self-insured plan the duty to administer and interpret the provisions of this Section 4.4. and to adopt, document and communicate any rules and procedures necessary or appropriate to implement the COB procedures, as set forth herein:

Which Plan Pays First: Order of Benefit Determination Rules

PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any plan that does not use these same rules always pays its benefits first.

When two plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

These rules are detailed in the separate PEBP Health and Welfare Wrap Document available at <https://pebp.nv.gov/> under "4.4 Coordination of Benefits" (NAC 287.755).

Coordination with Medicare

Coordination with Medicare is not applicable for retirees and their dependents who are eligible for Medicare Part A and Medicare Part B and who are required to transition to the Medicare Exchange.

This Plan has coordination of benefits for Medicare as it relates to:

- Entitlement to Medicare Coverage,
- When the Participant Is Not Eligible for Premium Free Medicare Part A,
- Coverage Under Medicare and This Plan When a Participant has End-Stage Renal Disease (ESRD),
- How Much This Plan Pays When It Is Secondary to Medicare,
- When the Retiree or the Retiree's Covered Spouse or Domestic Partner is Enrolled in Medicare Part B,
- When the Participant Enters Into a Medicare Private Contract

For details, refer to the separate PEBP Health and Welfare Wrap Document available at <https://pebp.nv.gov/> under "4.4 Coordination of Benefits" (NAC 287.755).

Coordination with Other Government Programs

This Plan has coordination of benefits as it relates to:

- Medicaid,
- Medicare,
- Tricare,
- Veterans Affairs,
- Worker's Compensation, and
- Medicare Disability.

For more details, refer to the separate PEBP Health and Welfare Wrap Document available at <https://pebp.nv.gov/> under "4.4 Coordination of Benefits" (NAC 287.755).

Third Party Liability and Subrogation

Subrogation and Rights of Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the way they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). Any and all payments made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. Any and all payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury.

The Participant must cooperate fully, at all times, and provide ~~all~~ information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

- 1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation.
- 2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
- 3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate PEBP Active Employee Health and Welfare Benefits Wrap Plan Document and PEBP Retiree Health and Welfare Benefits Wrap Plan Document available at <https://pebp.nv.gov/> ~~www.pebp.state.nv.us~~ for more information regarding third party liability and subrogation.

Basic Life Insurance

This section provides a summary of the fully insured group basic life insurance available from PEBP. Since this is only a summary, for complete information you must refer to the Certificate of Coverage Booklet available from the insurance company who insures this benefit. Their name and contact information are listed in the *Participant Contact Guide* section of this document.

Eligibility for Life Insurance

To be eligible for the basic life insurance, you must be enrolled under the PEBP sponsored medical Plan, and be in one of the following classes:

- Full-time employees of the State of Nevada, professional full-time employees of the Nevada System of Higher Education (under annual contract), and members of the Nevada Senate or Assembly are ~~all~~ eligible for this benefit. Your employer pays the full cost of Basic Life Insurance.
- Full-time employees of any non-State agency approved by the PEBP board. Your employer pays the full cost of Basic Life Insurance.
- Retirees of the State of Nevada receiving PERS, judicial and legislative retirement systems (in accordance with [NRS 287.045](#)), professional employees qualifying per [NAC 287.135](#), and retirees eligible to join PEBP upon retirement pursuant to [NRS 287.023](#) are eligible for this benefit. Certain retirees pay a contribution toward the cost of basic life insurance.

Reinstated retirees are not eligible for basic life insurance benefits or voluntary life Insurance coverage ([NRS 287.0475](#)).

Coverage

Basic Life Insurance Benefits are as follows:

Basic Life Insurance	Life insurance Benefit Amount
Full-time employees of the State	\$25,000
Full-time employees of non-State agency	\$15,000
Retirees of the State of Nevada	\$12,500
Retirees of non-State agency	\$7,500

Basic Life Insurance claim payouts are subject to resolution of any outstanding financial responsibilities (premiums or Health Reimbursement Arrangement funds) with PEBP or its vendors.

The 82nd Legislature (2023 Session) has increased the Basic Life Insurance benefit amount for State employees and retirees for the 2024-2025 biennium.

Legislatively approved enhancements, such as HSA/HRA funding and enhanced basic life insurance amounts may be subject to change in subsequent plan years.

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Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) 3427 Goni Road, Ste 109 Carson City, NV 89706 Customer Service: (775) 684-7000, (702) 486-3100, or (800) 326-5496 Fax: (775) 684-7028 https://pebp.nv.gov/www.pebp.state.nv.us	Plan Administrator • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR <u>Claims Submission</u> P O Box 30541 Salt Lake City, UT 84130-0541 EDI #39026 <u>Appeal of Claims</u> P O Box 30546 Salt Lake City, UT 84130-0546 <u>Customer Service</u> (888) 763-8232 www.UMR.com <u>Diabetes Care Management form submission</u> UMR 27 Corporate Hill Drive Little Rock, AR 77205 Fax: 800-458-0701 Email: diabetes@HealthscopeBenefits.com	Third-party Claims Administrator/Third-party Administrator/PPO Network/ Disease Management Administrator • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Disease Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Sierra Health-Care Options, Inc PO BOX 15645 Las Vegas, NV 89144-5648 Customer Service : 888-323-1461 Fax : 800-288-2264	Utilization Management and Case Management Company • Pre-Certification/Prior Authorization • Utilization Management • Case Management • Transplants

Participant Contact Guide	
Express Scripts <u>Customer Service</u> (855) 889-7708 www.Express-Scripts.com <u>Accredo Patient Customer Service:</u> (800) 803-2523 <u>Accredo Physician Service Line</u> (800) 987-4904 option 5 <u>Express Scripts / Accredo Prior Authorization</u> (800) 753-2851 Electronic option: express-scripts.com/PA <u>Specialty Medication SaveonSP copay assistance</u> (800) 683-1074 www.saveonsp.com/pebp	Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and EPO Plan • Prescription drug information • Retail network pharmacies • Prior authorization • Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies • Accredo Specialty Drug Services • Coverage and Clinical reviews • Appeals • External Review Requests • Copay/Deductible/Coinsurance assistance
HSA Bank HRA Claim Submission PO Box 2744 Fargo, ND 58108-2744 hsaforms@hsabank.com Fax: 855-764-5689 www.hsabank.com Customer Service: 833-228-9364 askus@hsabank.com myaccounts.hsabank.com	HSA and HRA Claims Administrator • HSA/HRA Claims and claim appeals
Diversified Dental Services 5470 Kietzke Lane, Ste 300 Reno, NV 89511 ProviderRelations@ddsppo.com 1-866-270-8326 diversifieddental.com	PPO Dental Network • Statewide PPO Dental Providers • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 www.myhpnstateofnevada.com/	Southern Nevada Health Maintenance Organization (HMO) • Medical claims/provider network

Participant Contact Guide	
VIA Benefits 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888)598-7545 https://my.viabenefits.com/pebp Phone: (888) 598-7545 Fax: (402) 231-4310	Medicare Exchange and Medicare HRA administrator • Medigap (Supplemental) plans • Medicare Advantage Plans (HMO and PPO) • HRA claims administrator
United Healthcare Specialty Benefits Group Number: 370074 Customer Service: 1-888-763-8232 UnitedHealthcare Specialty Benefits P.O. Box 7149 Portland, ME 04112-7149	• Basic Life Insurance for eligible active and retirees • Member Assistance Program • Global Travel Assistance
Office for Consumer Health Assistance 3320 W. Sahara Ave, Suite 100 Las Vegas, NV 89102 Customer Service: (702) 486-3587 or (888) 333-1597 https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/	Consumer Health Assistance • Concerns and problems related to coverage • Provider billing issues • External review information
Corestream PEBP+ Customer Care: (775) 249-0716 E-mail: pebpcustomer@corestream.com www.corestream.com <u>Voluntary Life, Critical Illness, Accident, and Hospital Indemnity Insurance</u> The Standard Insurance Company (888) 288-1270 www.standard.com/mybenefits/nevada	PEBP+ Voluntary Benefits Administrator • Accident Insurance • Auto Insurance • Critical Illness • Disability Insurance (Long-term and Short-term) • Home Insurance • Hospital Indemnity • Identity Theft • Legal Services • Life Insurance (Supplemental) • Pet Insurance • Vision Care

Key Terms and Definitions

The following terms or phrases are used throughout the MPD. These terms or phrases have the following meanings. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

Adverse Benefit Determination: A determination that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed, and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

Allowable Expense: A health care service or expense, including Deductibles or Coinsurance, that is covered in full or in part by any of the plans covering a plan participant (see also the *COB section* of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense.

Ancillary Services: Services provided by a hospital or other health care facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Annual: For the purposes of this Plan, annual refers to the 12-month period starting July 1 through June 30.

Appliance (dental): A device to provide or restore function or provide a therapeutic (healing) effect.

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Average Wholesale Price (AWP): the average price at which drugs are purchased at the wholesale level.

Base Plan: The Self-Funded Consumer Driven Health Plan (CDHP). The base Plan is also defined as the “default Plan” where applicable in this document and other communication materials produced by PEBP ([NRS 287.045](#)).

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, after calculation of ~~all~~—Deductibles, Coinsurance, and or copayments, and after determination of the Plan’s exclusions, limitations, and maximums.

Bitewing X-Rays (dental): Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework (dental) Fixed: A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more pontics and one or more retainers (crowns or inlays). The patient cannot remove the prosthesis.

Business Day: Refers to ~~all~~ weekdays, except Saturday or Sunday, or a Nevada Holiday or federal holiday.

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Coinsurance: That portion of eligible medical expenses for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses in excess of the Plan’s Deductible. The Coinsurance varies depending on whether in-network or out-of-network providers are used.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how plan benefits are payable when a person is covered by two or more health care plans. (See also the *Coordination of Benefits* section).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes (but is not limited to) removal of tattoos, breast augmentation, or other medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Course of Treatment (Dental): The planned program of one or more services or supplies, provided by one or more dentists, to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment begins when a dentist first renders a service to correct or treat the diagnosed dental condition.

Covered Dental Expenses: See the definition of *Eligible Dental Expenses*.

Crown (Dental): The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible dental expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles is discussed in the *Dental Expense Coverage* section of this document.

Dependent Child(ren): See also ([NAC 287.312](#)). For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),
- any other person who:
 - Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
 - Is unmarried.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, decay, malformation, disease or infection. Dental services and supplies are covered under the dental expense coverage plan and are not covered under the medical expense coverage of the Plan unless the medical plan specifically indicates otherwise in the Schedule of Medical Benefits.

For injury to teeth see *Injury to Sound and Natural Teeth*, below.

Dental Care Provider: A dentist, dental hygienist nurse, or other health care practitioner (as those terms are specifically defined in this section of the document) who is legally licensed and who is a dentist or performs services under the direction of a licensed dentist; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas:

Subspecialty Area	Services related to the diagnosis, treatment, or prevention of diseases
Endodontics	The dental pulp and its surrounding tissues.
Implantology	Attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	Extractions and surgical procedures of the mouth.
Orthodontics	Abnormally positioned or aligned teeth.
Pedodontics	Treatment of dental problems of children.
Periodontics	Structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	Construction of artificial appliances for the mouth (bridges, dentures, crowns, implants).

Dental Hygienist: A person who is trained, legally licensed, and authorized to perform dental hygiene services (such as prophylaxis, or cleaning of teeth), under the direction of a licensed dentist; and who acts within the scope of his or her license; and is neither the patient, the parent, spouse, sibling (by birth or marriage) nor child of the patient.

Dental Implant: A dental implant is an artificial tooth root that is placed into your jaw to hold a replacement tooth or bridge.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Denture: A device replacing missing teeth.

Domestic Partner: As defined by [NRS 122A.030](#).

Eligible Dental Expenses: Expenses for dental services or supplies, but only to the extent that they are medically necessary, as defined in this *Key Terms and Definitions* section; and the charges for them are usual and customary, as defined in this *Key Terms and Definitions* section; and coverage for the services or supplies is not excluded, as provided in the *Dental Exclusions*

section of this document and the Plan Year maximum dental benefits for those services or supplies has not been reached.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Explanation of Benefits (EOB): When the claims administrator processes a claim you will be sent a form called an explanation of benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, if your Out-of-Pocket Maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

FAIR Health: FAIR Health is an independent nonprofit organization that collects data for and manages the nation's largest database of privately billed health insurance claims and is entrusted with Medicare Parts A, B and D claims data for 2013 to the present. This data is widely used in the industry to determine market appropriate benchmark pricing for medical and dental services. (<https://www.fairhealth.org/about-us>)

Fixed Appliance: A device that is cemented to the teeth or attached by adhesive materials.

Fluoride: A solution applied to the surface of teeth, or a prescription drug (usually in pill form) to prevent dental decay.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Government-Provided Services (Tricare/CHAMPUS, VA, etc.): Expenses for services when benefits are provided to the covered individual under any plan or program in which any government participates (other than as an employer), unless the governmental program provides otherwise.

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency,

hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Definitions* section).

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal Regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Impression: A negative reproduction of the teeth and gums from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Injury to Teeth: An injury to the teeth caused by trauma from an external source.

Benefits for injury to teeth are payable under the medical plan.

Inlay: A restoration made to fit a prepared tooth cavity and then cemented into place (see the definition of restoration).

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from out-of-network services that are provided by a health care provider that is not a member of the PPO network.

In-Network Contracted Rate: The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the in-network contracted amount may be applied to out-of-network provider charges.

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:

- is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
- is determined by the Plan Administrator or its designee to meet ~~all~~ the following requirements:
 - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
 - It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
 - It is an "appropriate" service or supply given the patient's circumstances and condition; and

- o It is a level of service that can be safely provided to the patient; and
- o It is safe and effective for the illness or injury for which it is used.

A hospitalization or confinement to a health care facility will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be considered to be medically necessary if it is furnished in a hospital or health care facility or other more costly facility.

- The non-availability of a bed in another health care facility, or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital or health care facility.

Non-Network: See Out-of-Network Services.

Non-Participating Provider: A health care provider who does not participate in the Plan's Preferred Provider Organization (PPO).

Office Visit: A direct personal contact between a dentist or other dental care practitioner and a patient in the dental care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CDT coding.

Onlay: An inlay restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthodontics, Orthodontia: The science of the movement of teeth to correct a malocclusion or "crooked teeth."

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as prognathism, retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Out-of-Network, Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan's Preferred Provider Organization (PPO), as

distinguished from in-network services that are provided by a health care provider that is a member of the PPO. The participant could incur greater expense when using out-of-network providers.

Outpatient Services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Partial Denture: A Prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The denture may be removable or fixed.

Participating Provider: A health care provider who participates in the Plan's Preferred Provider Organization (PPO).

Periodontal Disease: Bacterial gum infections that destroy gum tissue and supporting bone that hold teeth in place.

Pharmacy: A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, ~~all the~~ deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

Plan Year Deductible: The amount you must pay each Plan Year before the Plan pays benefits.

Plan Year Maximum Benefits: The maximum amount of benefits payable each Plan Year for certain dental expenses incurred by any covered plan participant (or any covered family member of the plan participant) under this Plan.

Plan Participant; Participant: The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse of a retiree.

Pontic: The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Post-Service Claim: Means any claim for benefits under a health benefit plan regarding payment of benefits that is not considered a pre-service claim or an urgent care claim.

Preferred Provider Organization (PPO): A group or network of health care providers (*e.g.*, hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Pre-Service/Dental Pre-Estimate: Means any estimate for benefits under a health benefit plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

Prescribed for a Medically Necessary Indication: The term medically accepted indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

Prescription Drugs: For the purposes of this Plan, prescription drugs include:

- **Federal Legend Drugs:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
- **Other Prescription Drugs:** Drugs that require a prescription under state law but not under federal law.
- **Compound Drugs:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: The Public Employees' Benefits Program established in accordance with [NRS 287.0402](#) to [287.049](#), inclusive.

Prophylaxis: The removal of tartar and stains from the teeth. A dentist or dental hygienist performs the cleaning and scaling of the teeth.

Prosthesis (dental): An artificial replacement of one or more natural teeth and/or associated structures.

Prosthetic Appliance (dental): A removable device that replaces a missing tooth or teeth.

Provider: See the definition of health care provider.

Removable: A prosthesis that replaces one or more teeth and which are held in place by clasps. The patient can remove the prosthesis.

Restoration: A broad term applied to any filling, crown, bridge, partial denture, or complete denture that restores or replaces loss of tooth structure, teeth, or oral tissue. The term applies to the result of repairing and restoring or reforming the shape and function of part or all the tooth or teeth.

Retiree: Unless specifically indicated otherwise, when used in this document, retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Root Canal (Endodontic) Therapy: Treatment of a tooth having damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Root Planning and Scaling: Also known as conventional periodontal therapy, non-surgical periodontal therapy, or deep cleaning, is the process of removing or eliminating dental plaque and calculus, which cause inflammation.

Service Area: The geographic area serviced by the in-network health care or dental providers who have agreements with the Plan's PPO networks. Refer to the *Participant Contact Guide* for additional information regarding the PPO networks.

Sound and Natural Teeth: Natural teeth (not dentures, bridges, pontics or artificial teeth) that are free of active or chronic clinical decay; and have at least 50% bone support; and are functional in the arch; and have not been excessively weakened by previous dental procedures.

Spouse: The employee's lawful spouse (opposite sex or same sex) as determined by the laws of the State of Nevada. The Plan will require proof of the legal marital relationship. A former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

State: When capitalized in this document, the term State means the State of Nevada.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the *Third Party Liability* section of this document for an explanation of how the Plan may use the right of subrogation to be substituted in place of a covered individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical benefits paid if the covered individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

Tier of Coverage: The category of rates and premiums or contributions for coverage that correspond to either an eligible participant only, or an eligible participant and one or more eligible dependents.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome:

The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Topical: Painting the surface of teeth, as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, which injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Usual and Customary Charge (U&C): While your medical or dental care provider may charge whatever they feel services are worth, the Plan has the right to determine what it will allow as the usual and customary charge, sometimes referred to as usual and customary fee or allowable fee or prevailing fee. The usual and customary charge for medically necessary services or supplies will be determined by the claims administrator or Plan Administrator and will be the lowest of:

- With respect to a PPO (in-network) participating medical health care or dental care provider, the fee set forth in the agreement between the PPO network or the claims administrator or the Plan Administrator and the participating medical health care or dental care provider. or
- The medical health care or dental care provider's actual charge; or
- The usual charge by the medical health care or dental care provider for the same or similar service or supply.
- For out-of-network medical or dental services, no more than the 70th percentile of fair health. FAIR Health is a national schedule of prevailing health care charges that is updated twice per year. Information regarding FAIR Health is located on the PEBP website.
- For services provided by an out-of-network medical or dental care provider that are not addressed by FAIR Health, the claims administrator, or the Plan Administrator may refer to the PPO (in-network) fee schedule of the nearest (geographically) or the most prevalently used PPO provider of the nearest

(geographically) for the same or similar service when determining the usual and customary charge by the out-of-network provider.

The “prevailing charge” of most other health care or dental care providers in the same or similar geographic area for the same or similar health care service or supply will be determined by the claims administrator using proprietary data that is provided by a reputable company or entity and is updated no less frequently than annually. The Plan will not always pay benefits equal to or based on the health care or dental care provider’s actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the usual and customary charge for health care services or supplies. Any amount in excess of the usual and customary charge does not count toward the Plan Year’s Out-of-Pocket Maximum. The usual and customary charge is sometimes referred to as the U & C charge, the reasonable and customary charge, the R & C charge, the usual, customary, and reasonable charge, or the UCR charge. Note: to obtain the most current, usual and customary amount, please contact PEBP’s claims administrator, listed in the *Participant Contact Guide* in this document. You must provide the claims administrator with the specific procedure code, provider name and the zip code for the location where the procedure will take place. This service is only available to PEBP plan participants.

NOTE: The Claims Administrator has the discretionary authority to determine the usual and customary charge based upon standards set forth by the Plan Administrator.

Visit: See the definition of Office Visit.

You, your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.



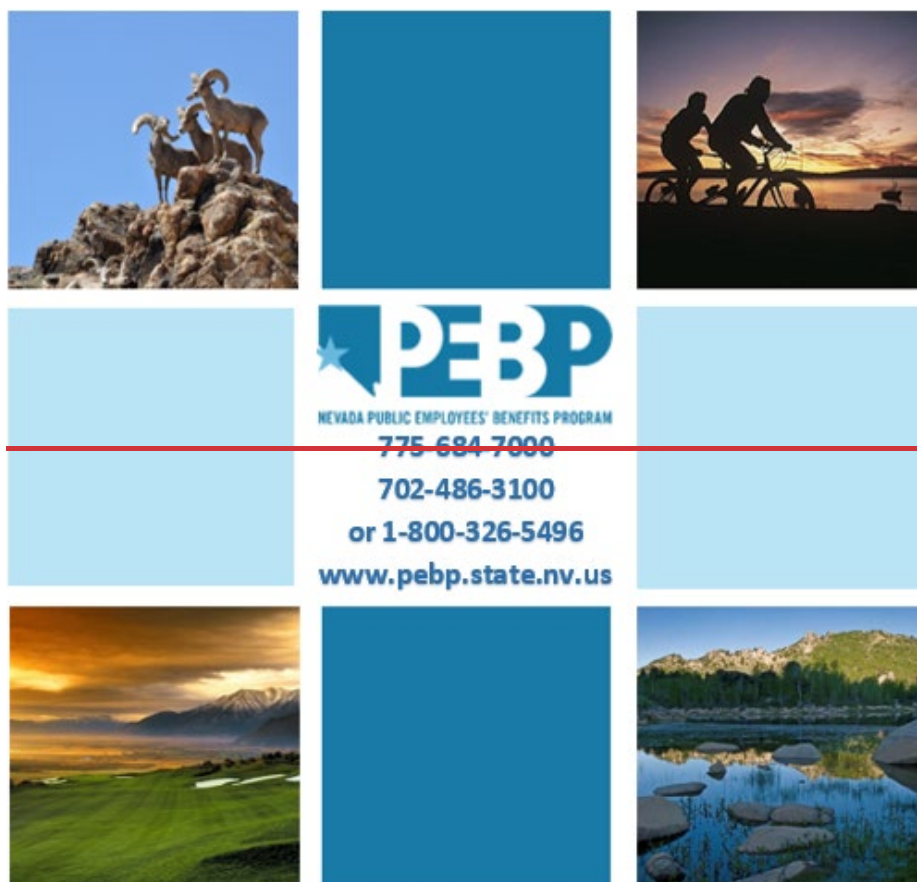
Access.
Quality.
Affordability.



HEALTH REIMBURSEMENT ARRANGEMENT (HRA) SUMMARY PLAN DESCRIPTION (SPD)

PLAN YEAR 202~~4~~⁵

Effective July 1, 202~~4~~³ – June 30, 202~~5~~⁴





Administered By



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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP provides a variety of benefits such as medical, HRA, HSA, dental, life insurance, flexible spending accounts, and other voluntary insurance benefits for eligible State and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may access whichever benefit plan (the Consumer Driven Health Plan, Low Deductible PPO Plan (LD PPO), the Exclusive Provider Organization (EPO) Plan, or Health Maintenance Organization (HMO) Plan) is offered in your geographical area that best meets your needs, subject to specific eligibility and Plan requirements. You are also encouraged to research Plan provider access and quality of care in your service area.

All PEBP participants choosing a Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the PEBP Active Employee Health and Welfare Wrap Plan Document, PEBP Retiree Health and Welfare Wrap Plan Document, the Section 125 Document, and the PEBP Enrollment and Eligibility MPD. These documents are available at [https://pebp.nv.gov/. ~~www.pebp.state.nv.us~~](https://pebp.nv.gov/. www.pebp.state.nv.us).

MPD's are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted throughout this document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the Participant Contact Guide.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,

Public Employees' Benefits Program

Accessing Other Information

You will also want to access the following documents for information related to dental, life, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA and Privacy and Security and mandatory notices. These documents are available on your member E-PEBP portal account which can be accessed at <https://pebp.nv.gov/> ~~www.pebp.state.nv.us~~ and clicking on the orange log in icon, or by contacting PEBP at 775-684-7000 or 800-326-5496.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan (CDHP) Master Plan Document; CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO (LD PPO) Master Plan Document; Low Deductible PPO Plan Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- EPO Plan Master Plan Document; EPO Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Health Reimbursement Arrangement Summary Plan Description (SPD)
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

This Plan is administered in accordance with regulations of Section 125, 105 and 106 of the Internal Revenue Code. For information regarding Section 105, 106, and 125, please see the Active Employee Health and Welfare Wrap Plan Document available at <https://pebp.nv.gov/>. ~~www.pebp.state.nv.us~~

Introduction

Health Reimbursement Arrangement

This Summary Plan Description (SPD) provides, in general terms, the main features of the State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement ("HRA"), how it can work for you, and how it can benefit you. Definitions of ~~all~~-capitalized terms in this SPD are contained in the Definitions section of this document.

The purpose of the Health Reimbursement Arrangement (HRA) is to reimburse Eligible Employees', up to certain limits, for their own, and their Eligible Spouse' and Dependents' qualifying Health Care Expenses. Reimbursements for Health Care Expenses paid by the HRA generally are excluded from taxable income.

You should read this Summary Plan Description carefully so that you understand the provisions of the HRA and the benefits you will receive. PEBP wants you to be fully informed of the benefits available to you under the HRA while you are a Participant. You should direct any questions you have to PEBP (Plan Administrator) or the HRA Administrator. A copy of the HRA Summary Plan Description is available at <https://pebp.nv.gov/> ~~www.pebp.state.nv.us~~ or by request by calling the PEBP office at 775-684-7000 or 800-326-5496.

PEBP's HRA benefits are subject to IRS Publication 969.

Administrative Information

The Public Employees' Benefits Program (PEBP) is the Plan Administrator for the HRA. The HRA is intended to qualify as an Employer-funded Health Care reimbursement plan under IRS Code §105 and 106 and the regulations issued thereunder, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45. The Plan Administrator's failure to enforce any provision of the HRA shall not affect its rights to later enforce that provision or any other provision of the HRA.

PEBP has retained HSA Bank as the HRA the third-party administrator and provide certain administrative services associated with the HRA. HSA Bank is not a fiduciary of the HRA. HSA Bank has no discretionary authority to interpret HRA provisions or issues arising under the HRA, such as issues with eligibility, coverage, and benefits.

Nothing herein will be construed to require PEBP or HSA Bank to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the PEBP from which any payment under this HRA may be made. The HRA is paid for by the State of Nevada Public Employees' Benefits Program and funded with contributions from participating Employers and Eligible Participants, held in an internal service fund. There is no trust or other fund from which benefits are paid. HSA Bank does not finance or insure the HRA. While PEBP has complete responsibility for the payment of benefits out of its internal service fund, it may hire an unrelated third-party HRA Administrator to make Benefit payments on its behalf.

If there is a conflict between this Summary Plan Description and the Master Plan Document, the Master Plan Document will take precedence.

The provisions of the HRA, as initially adopted or subsequently amended and restated are effective July 1, 202~~3~~⁴ – June 30, 202~~5~~⁴.

Per NRS 287.0458 no officer or employee has an inherent right to benefits provided under the PEBP.

General Information About the HRA

What is the amount PEBP will contribute to the HRA?

~~For Plan Year 2024, (July 1, 2023 – June 30, 2024), PEBP will contribute \$600 for each Eligible Employee covered on the PEBP Consumer Driven Health Plan with a Health Reimbursement Arrangement on July 1, 2023. The contribution amount for Employees hired after July 1, 2023, who enroll in the Consumer Driven Health Plan, the contribution amount is prorated based on the coverage effective date and the remaining months in the Plan Year. This is the base HRA contribution amount.~~

~~Additionally, f~~For Plan Year **2024⁵**, (July 1, 202~~3~~⁴ – June 30, 202~~5~~⁴), PEBP will provide Legislatively approved supplemental funding for active State employees covered on the CDHP, LD, EPO, and HPN plans on **July 1, 202~~3~~⁴**. The contribution amount for Employees enrolled in these plans who are hired after **July 1, 202~~3~~⁴**, receive a prorated contribution based on the employee's coverage effective date and the remaining months in the Plan Year. The funding will be as follows:

Tier	One-Time Contribution
PEBP Funded Contribution	
~~State Active Employee Only~~	~~\$300~~
~~State Active Employee + Spouse/Domestic Partner~~	~~\$300~~
~~State Active Employee + Child(ren)~~	~~\$300~~
~~State Active Employee + Family~~	~~\$300~~
Legislature Appropriated One-Time Contribution	
State Active Employee Only	\$300
State Active Employee + Spouse/Domestic Partner	\$400
State Active Employee + Child(ren)	\$400
State Active Employee + Family	\$500

What is the HRA?

The HRA is a PEBP funded reimbursement account. The HRA works as follows:

- PEBP establishes a notional account called a Health Reimbursement Arrangement for each Eligible Employee enrolled in a PEBP-sponsored medical plan (CDHP, LD, EPO, and HPN) with coverage effective on or after **July 1, 2023~~4~~**.
- Each Plan Year, PEBP has the discretion to set the HRA funding amount. HRA funding is not guaranteed from one Plan Year to the next Plan Year.
- HRAs are employer-funded accounts.
- Employees do not contribute to the HRA.
- Unlike Health FSA amounts, Employees do not forfeit unused HRA dollars while covered under a PEBP-sponsored medical plan.

What is the purpose of the HRA?

The HRA is intended to reimburse Eligible Employees, up to certain limits, for their own and their Spouses' and Dependents' qualified Health Care Expenses in accordance with Section 213(d) of the IRS code.

Are there any limitations on benefits available from the HRA?

A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of Health Care Expenses include, but are not limited to, (a) insulin; (b) prescribed drugs and medications (whether or not the drug or medicine could be purchased without a prescription), (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses € dermatology; (f) physical therapy; and (g) contact lenses or gasses used to correct a vision impairment.

Some examples of expenses that are not eligible for reimbursement include the following:

- Over-the-counter drugs or medicines that are purchased without a prescription.
- Health insurance premiums for any other plan. (Notwithstanding the foregoing, the HRA Account may reimburse COBRA premiums that a Participant pays on an after-tax basis under the Employer's major medical or other health insurance plan.)
- Cosmetic surgery not covered under a Plan.
- The salary expenses of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's, Spouse's, or Dependent's inability to perform physical housework).
- Home or automobile improvements.

- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under IRS Code §213(d).

HRA funds must be used on a prospective basis from the date of funding.

Is the HRA offered separately as a stand-alone option?

The HRA is not offered as a stand-alone option. Instead, it is integrated with a PEBP-sponsored medical plan (CDHP, EPO, LD, and HPN), this means, Employees must be enrolled in a PEBP-sponsored medical plan to qualify for the HRA.

Are the HRA dollars transferrable to another PEBP medical plan?

The HRA funds are transferrable from the Consumer Driven Health Plan (CDHP), Low Deductible Plan (LD), Exclusive Provider Organization Plan (EPO), and Health Plan of Nevada (HPN). HRA funds are not transferrable to the Via Benefits (Medicare Exchange) HRA.

Who is eligible for the HRA?

Eligible Employees enrolled in a PEBP-sponsored medical plan (CDHP, LD, EPO, and HPN) with coverage effective on or after **July 1, 2023**.

Eligible Employees are permitted to enroll in a PEBP-sponsored medical plan during their new hire initial enrollment period, the annual open enrollment period, or during the Plan Year to the extent permitted by the PEBP-sponsored medical plan (e.g., due to a Qualifying Event or a Special Enrollment Period). For information regarding Qualifying Events and Special Enrollment Opportunities, refer to the Enrollment and Eligibility Master Plan Document available at <https://pebp.nv.gov/>. www.pebp.state.nv.us.

Are my spouse and dependents eligible for reimbursement of Eligible Medical Expenses under the HRA?

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

- Employees,
- Spouses and dependents of those employees,
- Any person you could have claimed as a dependent on your return except that:
 - The person filed a joint return.
 - The person had a gross income of \$4,400 or more; or
 - You, or your spouse if filing jointly, could be claimed as dependent on someone else's tax return.
 - Your child under age 27 at the end of the tax year.
 - 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 benefits are offered through the HRA?

The HRA will maintain an "HRA Account" for Eligible Employees to keep a record of the amounts available for reimbursement of Eligible Health Care expenses. The HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid by HSA Bank from PEBP's internal fund), and it does not bear interest or accrue earnings.

Are there limitations on prescriptions under the HRA?

Reimbursement for prescriptions is limited to IRS Code 213(d) eligible expenses.

How will the HRA work?

The HRA will reimburse you for eligible Health Care Expenses to the extent that you have a positive balance in your HRA Account. If you have a claim under your PEBP medical plan or other health insurance plan, you should follow the claims procedure applicable to that plan, as described in the Master Plan Document or Summary Plan Description.

For claims associated with the HRA, you should file your claim for reimbursement as soon as possible after you have incurred the expense. All claims must be substantiated or verified as an eligible expense. Submitting claims can be done online, mobile app, or by mail. HSA Bank issues a debit card with the HRA which provides easy access to HRA dollars, especially at pharmacies and doctors' offices.

Claims must be submitted within 365 days of the incurred expense date in accordance with NAC 287.610. For information regarding how to file a claim, visit the HSA Bank website at www.hsabank.com/

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 receive an overpayment?

If you receive reimbursement and it is later determined that you received an overpayment or payment was made in error (e.g., you were reimbursed for an expense that is later paid by an insurance plan), you will be required to refund the improper payment to HSA Bank. If you do not refund the improper payment, the Plan Administrator reserves the right to offset future reimbursement equal to the improper payment. If all other attempts to recoup the improper payment are unsuccessful, PEBP may treat the overpayment as a bad debt, which may have income tax consequences for you.

What if I have a Flexible Spending Account (FSA) in addition to my HRA?

If an expense is eligible for reimbursement under both the HRA and a FSA, reimbursement should be requested first from the FSA before the HRA.

What is a carryover of Account Balance of unused funds?

The HRA allows for a carryover of the account balance for employees enrolled in a PEBP-sponsored medical plan. Note: HRA funds associated with a PEBP-sponsored medical plan are not transferrable to the Medicare Exchange HRA. For details on the Medicare Exchange HRA, refer to the Medicare Exchange HRA SPD available at <https://pebp.nv.gov/>. ~~www.pebp.state.nv.us~~.

May I elect to permanently opt out of your HRA Account?

You may elect to permanently opt out of and waive any right to future reimbursement from your HRA Account. The opt out option will be offered at initial new hire enrollment, open enrollment, and at termination. Opting out of the HRA also includes declining coverage under a PEBP medical plan.

What if I terminate my employment or lose eligibility during the Plan Year?

If you cease to be an Eligible Employee (for example, if you die, retire, and transition to an individual qualified Medicare plan through the Medicare Exchange, or terminate employment without continuing coverage under COBRA, your participation in the HRA will terminate and any remaining funds will be forfeited.

What if I go out on Family Medical Leave Act (“FMLA”) or the Uniformed Services Employment and Reemployment Rights Act (“USERRA”)?

If you decline coverage while on an FMLA or USERRA leave, you may have rights 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 if I go out on unpaid Leave Without Pay or Workers’ Compensation?

Your coverage under a Plan with an HRA during a paid or unpaid leave of absence will be treated in the same manner that your coverage under the medical plan is treated during a leave of absence. Upon returning from leave, you must be enrolled in the same medical plan prior to taking leave. For details regarding leave of absences, refer to the Enrollment and Eligibility Master Plan Document available at <https://pebp.nv.gov/>. ~~www.pebp.state.nv.us.~~

What is COBRA continuation coverage? What happens if terminate my employment during the Plan Year? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue coverage under the same medical plan?

Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that gives certain Employees, Spouses, and Dependent children of Employees the right to temporarily continue health care coverage under the medical plan. If you, your Spouse, or your Dependent children incur an event known as a “Qualifying Event,” and if such individual is covered under the PEBP’s medical plan when the Qualifying Event occurs, the individual incurring the Qualifying Event will be entitled under COBRA to elect to continue his or her coverage under the medical plan if he or she pays the applicable premium for such coverage. “Qualifying Events” are certain types of events that would cause, except for the application of COBRA’s rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours.
- Your divorce or legal separation from your Spouse.
- You’re You become eligible to receive Medicare benefits.
- Your Dependent child ceases to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation of coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing your Employer of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage

initially arose and who continues to be disabled at the end of the 18 months. (In the event that family coverage is continued under COBRA, the Employee, Spouse, and Dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

For more information, refer to the Enrollment and Eligibility Master Plan Document at <https://pebp.nv.gov/. www.pebp.state.nv.us>

Are my HRA benefits taxable?

The HRA is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the HRA generally are not taxable to you. However, PEBP and HSA Bank cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax advisor.

Claim Denials and Appeal Process

What happens if my claim for HRA Benefits is denied?

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits under the HRA are discussed below.

When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after HSA Bank receives the claim. This 30-day period may be extended if necessary due to conditions beyond HSA Bank's control, such as situations where a claim is incomplete. HSA Bank is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then HSA Bank will notify you regarding what additional information you are required to submit. If you do not submit the additional information, HSA Bank will make the decision based on the information that it has.

What information will a notice of denial of claim contain?

If your claim is denied, the notice that you receive from HSA Bank will include the following information:

- The specific reason and references for the denial.
- Any denial code (and its corresponding meaning) that was used in denying the claim.
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary.
- A description of the HRA's internal appeal process and external review procedures and the time limits applicable to such procedures, including a statement of your rights following a denial on review; and
- If HSA Bank relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you, free of charge, upon request.

Do I have a right to appeal a denied claim?

Yes, you have the right to file an appeal with HSA Bank. Additional information regarding your review rights is available by request from PEBP or HSA Bank.

What are the requirements of my Level 1 appeal?

Your internal appeal must be in writing, must be provided to HSA Bank and must include the following information:

- Your name and address.
- The fact that you are disputing a denial of a claim or HSA Bank's act or omission.
- The date of the notice that HSA Bank informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or HSA Bank's act or omission. You should also include any documentation that you have not already provided to HSA Bank.

Is there a deadline for filing my Level 1 appeal?

Yes. Your internal appeal must be delivered to HSA Bank within 180 days after reviewing the denial notice or HSA Bank's act or omission. If you do not file your internal appeal within this 180-day period, you lose your right to appeal. Your internal appeal will be heard and decided by HSA Bank. (NAC 287.670)

How will my Level 1 appeal be reviewed?

Prior to the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to HSA Bank. The HRA is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, HSA Bank will consider all relevant documents, records, comments, and other information that you have provided regarding the claim, regardless of whether such information was submitted or considered in the initial determination. If HSA Bank receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for HSA Bank's notice of final internal adverse benefit determination. Similarly, if HSA Bank identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you, and you will be given a reasonable opportunity to respond to that new rationale before the due date for HSA Bank's notice of final internal adverse benefit determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the HRA who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by

the results of his or her decision. If the internal appeal determination will be based on the medical judgment of a health care professional retained by HSA Bank, the health care.

When will I be notified of the decision of my Level 1 appeal?

You will be notified of the decision of your appeal generally within 60 days following receipt of your request for review.

What information is included in the notice of denial of my Level 1 appeal?

If your Level 1 appeal is denied, the notice that you receive from HSA Bank will include supplemental information for the denial. This may include, but is not limited to:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial upon review;
- A reference to the specific HRA provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to request a Level 2 appeal.

Do I have the right to seek review of a denied claim to an external review?

You have the right to an external review of the denial of your claim, and any subsequent internal appeals process determination to uphold that denial, unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the HRA's eligibility requirements.

What are the requirements of an external review?

After exhausting the initial appeal process, you may file a request for external review. which is done by calling HSA Bank's Client Assistance Center at 1-833-228-9364 or writing an appeal on the internal appeal denial letter and submitting it to HSA Bank. The appeal will then be sent to a third party for review and decision making

When will I be notified of the decision on my external appeal?

The external reviewer must notify you and PEBP of its decision on your external appeal within 45 days after it receives the complete information. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

Definitions

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

Benefits. The reimbursement benefits for Health Care Expenses described in the HRA.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CODE. The Internal Revenue Code of 1986, as amended.

Dependent. A Dependent is a Participant's child as defined in Code §152(f)(1) who has not attained age 27, or a Dependent as defined in Code §105(b); provided, however, that any child to whom Code §152(e) applies shall be treated as a dependent of both parents. Note that the Code §105(b) definition is similar to the Code §152 definition that is used to determine your tax dependents, except that an individual's status as a Dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of Code §152. The HRA will provide Benefits in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of Dependent.

Electronic Protected Health Information or EPHI. Has the meaning described in 45 CFR §160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information (as such terms are defined in HIPAA).

Eligible Employee. For purposes of this document, a State active employee who has met the eligibility requirements to enroll in a PEBP-sponsored medical plan.

Employee. An Employee of the Employer who receives Compensation from the Employer.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Health FSA. A Health Flexible Spending Account as defined in Prop. Treas. Reg. §1.125- 5(a)(1).

HIPAA. The Health Insurance Portability and Accountability Act of 1996, as amended.

HRA Account. The recordkeeping account established in your name by the Plan Administrator based on which eligible Health Care Expenses will be paid or reimbursed.

HRA. The Public Employees' Benefits Program Health Reimbursement Arrangement (HRA) Plan, as amended or restated from time to time.

HRA Third-Party Administrator. HSA Bank.

Health Care Expenses. A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of Health Care Expenses are (a) insulin; (b) prescribed drugs and medicines (whether the drug or medicine could be purchased without a prescription); (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses; (e) dermatology; (f) physical therapy; and (g) contact lenses or glasses used to correct a vision impairment.

Participant. An Eligible Employee who becomes a Participant in the HRA.

PEBP-Sponsored Medical Plan. The Consumer Driven Health Plan (CDHP), Low Deductible Plan (LD), Exclusive Provider Organization (EPO), and Health Plan of Nevada (HPN).

Plan Administrator. Public Employees' Benefits Program.

Protected Health Information or PHI. This generally includes all information, whether written or oral, in connection with the HRA that (1) is created or received by the HRA; (2) relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present, or future payment for the provision of health care; and (3) identifies you or could be used to identify you.

Privacy Rule. The regulations that were issued by the Department of Health and Human Services are in accordance with the requirements of HIPAA. Information regarding the HIPAA Privacy and Security of Protected Health Information is available in the Active Employee Health and Welfare Wrap Plan Document at <https://pebp.nv.gov/>. ~~www.pebp.state.nv.us~~.

Spouse. An individual of same-sex or opposite sex who is legally married to a Participant as determined under applicable federal and/or state law (and who is treated as a Spouse under the Code).

Third Party Administrator. An organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. For the purposes of this document, the Third-Party Administrator is HSA Bank.

Miscellaneous

Effect of the HRA on Your Employment Rights

The HRA is not to be construed as giving you any rights against the HRA except those expressly described in this document. The HRA is not a contract of employment between you and the Employer.

Prohibition Against Assignment of Benefits

No Benefit payable at any time under the HRA shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Overpayments or Errors

If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA. If you do not refund the overpayment or erroneous payment, the HRA and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the improper payment are unsuccessful, PEBP may treat the overpayment as a bad debt, which may have income tax consequences for you.

Family and Medical Leave Act and USERRA (if applicable)

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA), then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain HRA Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee. If you go on a leave of absence that is not subject to the FMLA or USERRA, you will be treated as having terminated participation.

Reinstatement and Reinstated Employees

Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing from a plan with an HSA to a plan with an HRA or vice versa.

Reinstated employees who return to active employment within the same Plan Year and who re-enroll in an HRA shall have their remaining HRA fund balance reinstated. Reinstated employees who re-enroll in the HRA more than one year after termination are not eligible for reinstatement of HRA balance reinstatement. No additional prorating of HRA funds is available to reinstatements unless the reinstated employee is eligible for additional prorated funding due adding new dependent(s).

Other Notices Which May be Required by Law

Mandatory notices can be found on PEBP's website.

Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Michelle's Law

"Michelle's Law", enacted October 9, 2008, requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prohibits discrimination by health insurers and Employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions prohibits the use of genetic information in making employment decisions restricts the acquisition of genetic information by Employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

HITECH was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

This law amends ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.

Effective Date of the HRA

The Effective Date of the modifications herein is **July 1, 2023~~4~~**.

Plan Administrator

The Plan is administered by PEBP and has been established and shall be maintained for the exclusive benefit of the employees of the employer. PEBP is the Plan Administrator and functions as the Plan Administrator, unless another individual or entity is appointed by the Plan Administrator. The Plan Administrator shall have full charge of the operation and management of the plan. The Plan Administrator has retained the services of HSA Bank to administer the HRA benefits described in this Summary Plan Description.

HRA Third Party Administrator

PEBP has contracted with HSA Bank to process claims for the HRA program. Contact HSA Bank if you have questions regarding claims or eligible expenses.

Address:	HSA Bank HRA Claim Submission PO Box 2744 Fargo, ND 58108-2744
Web:	www.hsabank.com
Phone:	833-228-9364

Plan Fiduciary

PEBP is the Plan Fiduciary under the plan. The Plan Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the plan, to review all denied claims for benefits under the Plan with respect to which it has been designated named Fiduciary, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a participant's rights, and to decide questions of Plan interpretation and those of fact relating to the plan. The decisions of the Plan Fiduciary will be final and binding on all interested parties. Every Fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

Plan Changes

PEBP reserves the right to amend the HRA at its sole discretion. Any amendments to the Plan will be incorporated in writing into the master copy of the Plan on file with PEBP, or a written copy will be kept with the master copy of the plan.

Prohibition Against Rescission

Under Section 2712 of the PHSA, the Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a cover person under a Benefit Option that is a group health plan that is not excepted or exempt under Section 2712 of the PHSA, unless such covered person commits and at, practice, omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; provided, however, that the foregoing prohibition shall not prohibit retroactive termination in the event: (i) a Participant fails to timely pay premiums towards the cost of coverage; (ii) the Plan erroneously covers an ex-spouse of a Participant because the Participant failed to timely report a divorce to the Plan Administrator; (iii) the Plan erroneously covers a Participant due to a reasonable administrative delay in terminating coverage; or (iv) any other circumstance under which retroactive termination would not violate PPACA.

No Guarantee of Tax Consequences

Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid or allocated to or for the benefit of a Participant under the Plan, HRA or any component benefit will be excludable from Participant's gross income for federal, state, and/or local income tax purposes, or that any federal, state, and/or local tax treatment will apply or be available to a Participant. It shall be the obligation of each Participant to determine whether any coverage, benefit, or other payment under the Plan is excludable from the Participant's gross income for federal, state, and/or local income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment treated by the Employer if the Participant has reason to believe that any such payment by the Employer as nontaxable is, in fact, not so excludable.

Nondiscrimination

The Plan Administrator shall not operate the Plan in a manner that causes discrimination in favor of those Participants or Employees who are (or were) officers or highly compensated Employees or key Employees of the Employer. In addition, whenever, in the administration of the Plan any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise authority in a nondiscriminatory manner so that all persons similarly situated shall receive substantially the same treatment.

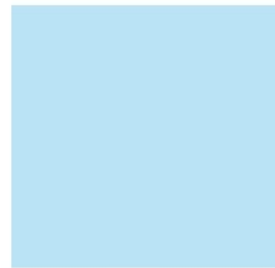
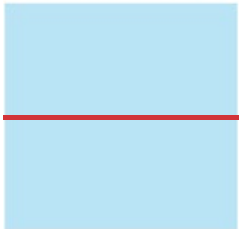


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PEBP FLEXIBLE SPENDING ACCOUNT (FSA)
HEALTH CARE FSA (HCFSA)
DEPENDENT CARE FSA (DCFSA)
LIMITED PURPOSE FSA (LPFSA)
PLAN YEAR 202~~4~~5

(EFFECTIVE JULY 1, 202~~3~~3 – JUNE 30, 202~~5~~4)



Administered By



P O Box 30541
Salt Lake City, UT 84130-0541
EDI #39026
www.UMR.com

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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP provides a variety of benefits such as medical, dental, life insurance, flexible spending accounts, and other voluntary insurance benefits for eligible State and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may enroll in whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and Plan requirements. These plans include the Consumer Driven Health Plan (CDHP), Exclusive Provider Organization (EPO) Plan, Low Deductible PPO Plan, and Health Plan of Nevada HMO Plan. You are encouraged to research plan provider access and quality of care in your service area.

This document describes PEBP's flexible spending account benefits. Members enrolled in a PEBP-sponsored medical plan (CDHP, EPO Plan, Low Deductible PPO Plan, or Health Plan of Nevada HMO Plan) may elect a qualifying flexible spending account.

PEBP participants choosing a Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the PEBP Active Employee Health and Welfare Wrap Plan Document, PEBP Retiree Health and Welfare Wrap Plan Document, the Section 125 Document, Health Reimbursement Arrangement Master Plan Document, and the PEBP Enrollment and Eligibility MPD. These documents are available at <https://pebp.nv.gov/.www.pebp.state.nv.us>. MPD's are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted throughout this document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the Participant Contact Guide.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,

Public Employees' Benefits Program

Accessing Other Information

Refer to the following plan documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA Privacy and Security and mandatory notices. These documents are available at <https://pebp.nv.gov/>. ~~www.pebp.state.nv.us~~.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan (CDHP) Master Plan Document; CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO (LD PPO) Master Plan Document; Low Deductible PPO Plan Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- EPO Plan Master Plan Document; EPO Plan Summary of Benefits and Coverage for Individual and Family
- Health Reimbursement Arrangement Summary Plan Document
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

This Plan is administered in accordance with regulations of Section 125 of the Internal Revenue Code. For information regarding Section 125, please see the Section 125 Health and Welfare Benefits Plan Document available at <https://pebp.nv.gov/>. ~~www.pebp.state.nv.us~~.

Flexible Spending Accounts (FSA)

There are three types of flexible spending accounts: A Health Care FSA, Limited-Purpose FSA, and Dependent Care FSA. PEBP's FSA benefits are subject to IRS Publication 969.

Health Care FSA

Health Care Flexible Spending Account (HCFSAs) is a PEBP-sponsored plan by which participants may obtain reimbursement for medical expenses that are not reimbursed through insurance or any other arrangement. HCFSAs are funded through pre-tax salary reductions.

A HCFSAs, sometimes referred to as a medical FSA or general-purpose FSA, is a voluntary option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP) with a Health Reimbursement Arrangement (HRA), Low Deductible PPO Plan (LD PPO), EPO Plan, or HMO plan. In accordance with IRS provisions, the Healthcare FSA is not available to active employees covered under the Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA).

Flexible spending accounts permit reimbursement for eligible expenses incurred by the taxpayer or their eligible dependents incurred during the plan year for medical, dental, vision, and some over-the-counter expenses if the expense is not reimbursed by insurance. Eligible health care expenses are defined in Section 213(d) of the Internal Revenue Code. For additional information regarding what medical expenses are includible, refer to IRS Publication 502 available at <https://www.irs.gov/forms-pubs/about-publication-502>. For information related to Health Savings Accounts and other tax-favored plans, refer to IRS Publication 969 at <https://www.irs.gov/forms-pubs/about-publication-969>

Limited Purpose FSA

The Limited Purpose Flexible Spending Account (LPFSA) is an option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA). A LPFSA is much like a Health Care FSA; the main difference is the LPFSA is set up to reimburse only eligible FSA dental and vision expenses, such as:

- Vision exams, LASIK surgery, contact lenses, and eyeglasses
- Dental cleanings, X-rays, fillings, crowns, and orthodontia

IRS provisions do not permit contributions to a HSA and a HCFSAs since both the HSA and the HCFSAs apply funds toward medical expenses. However, IRS provisions do permit enrollment in both an HSA and a LPFSA as LPFSA reimbursement is restricted to only vision and dental expenses.

Dependent Care FSA

To qualify for this account, both you and your spouse must be gainfully employed (unless you are a single parent). If your spouse is a full-time student, actively looking for full-time employment, or disabled, you may also qualify if you meet strict IRS eligibility guidelines.

The Dependent Care FSA covers expenses if you claim the person being cared for as a dependent on your income tax return and the person is either:

- Younger than 13; or
- Physically or mentally incapable of self-care and regularly spends at least eight hours a day in your household. Regularly does not mean daily, but frequently, on a regular basis. A DCFSA is an option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP), HMO, or EPO Plan that allows you to pay for dependent care expenses and lower your taxable income.

Here is how it works:

- You direct part of your before-tax pay into a special account to help pay work-related dependent care costs.
- You can use your dependent care account throughout the Plan Year to help pay for eligible expenses.
- Your expense must be for the purpose of allowing you and, if married, your spouse to be employed.

Refer to the section titled, '*Dependent Care FSA*' for more information.

Who Qualifies for Reimbursement of Expenses for these Plans?

Since these plans are authorized by the Internal Revenue Code, medical expenses of any family member who is a dependent for tax purposes (special rules apply to children of divorced parents) qualify for the tax savings under the FSA (HCFSA, Limited Purpose FSA and/or DCFSA), even if they are not covered under one of the health/dental plans offered by PEBP.

FSA & Participants on Family Medical Leave Act (FMLA) Leave

Plan participants on FMLA leave are entitled to maintain coverage for the HCFSA. Coverage and claims reimbursement will not be disrupted if monthly contributions are received (either by payroll deduction or by direct payment to the plan) by the end of each month.

The participant must contact their agency representative before going on leave, to arrange for prepayment of contributions. Reimbursements will be discontinued if the contribution is not received by the end of any month. A participant who terminates coverage prior to going on family medical leave may immediately reinstate coverage for qualifying expenses upon return to work. Such reinstatement of coverage and continuation of the original election must be made within 60 days of returning to work.

FSA Tax Benefits

"Before Tax" or "Pre-Tax"

FSA deductions from your paycheck are exempt from federal tax. These deductions reduce your taxable income reported on your income tax return. The HCFSA or Limited Purpose FSA can save

you up to **10% - 37%** in taxes on each dollar that you spend for your share of insurance deductibles, co-pays, or other eligible health care and/or dental expenses. Also, the DCFSA may save you more in taxes than the day-care tax credit (filed with your federal income tax return).

Tax Savings

By electing to direct a portion of your salary through an FSA, you essentially bank your money in a TAX-FREE account. The money is used to pay for expenses that would otherwise be paid out of your take-home pay. The following example illustrates how a Health Care or Limited-Purpose FSA could save this employee \$375,150 in taxes! Savings will vary for each participant depending on variable information such as marital status, number of exemptions, and marginal tax bracket. Consult with your tax advisor to determine your actual potential savings.

Tax Filing Status	Head of Household		Savings
	Without FSA	With FSA	
Annual Compensation	\$ 40,000	\$ 40,000	
Tax Free Expenses	\$ -	\$ 1,500	
Adjusted Gross Income	\$ 40,000	\$ 38,500	
Standard Deduction	\$ ~~1820~~ ,800	\$ ~~1208~~ ,800	
Taxable Income	\$ ~~2119~~ ,200	\$ 197,700	
Estimated Federal Tax (see Tax Tables)	\$ ~~21,257~~ 920	\$ ~~21,077~~ 0	\$ 1850
Estimated Paycheck	\$ ~~378,740~~ 803	\$ 36,423	
After Tax Expenses	\$ 1,500	\$ -	
Net Pay	\$ 36,580 243	\$ 36,423 730	\$ 1850

FSA Eligibility and Enrollment

Eligibility Criteria

To be eligible for an FSA you must be:

- An employee in one of the State of Nevada payroll centers -- excluding the Nevada System of Higher Education employees who have a separate plan;
- Working at least 80 hours each month; and,
- Enrolled in health benefits with active coverage through PEBP.

Enrollment

The FSA Plan Year is **July 1, 202~~34~~**, through **June 30, 202~~54~~**. The **202~~54~~** FSA open enrollment (OE) is typically held in **May** preceding the start of the plan year. To participate in an FSA, you must enroll within 60 days of your hire date or during open enrollment each year for the upcoming Plan Year.

New-hire enrollments may be effective on the first day of the month concurrent with their health coverage effective date if the FSA enrollment request is received by the Third-Party Administrator (“TPA”) prior to the health insurance effective date. If the FSA enrollment request is received after the health insurance effective date, the FSA effective date will be determined by the TPA.

- A new benefits-eligible employee must submit an enrollment election with the TPA within 60 days of the initial health coverage effective date to participate in the FSA plan.
- Elections are irrevocable. However, employees may change or revoke their election mid-year due to a qualifying life status event (QLSE). The HCFSAs and Limited Purpose FSA have slightly different rules regarding enrollment elections and mid-year changes. Mid-year enrollment and changes must be requested within 60 days of the QLSE.
- Employees enrolling for the first time should only include reimbursable expenses for services received from FSA effective date through the end of the Plan Year (June 30th).

See the charts on the following pages which outline mid-year qualifying life status events and their applicability.

[illegible]

Events Permitting Election Change	Mid-Year change is Applicable	
	Dependent Care FSA	Health Care & Limited Purpose FSA's
Significant Curtailment of Coverage This change applies when coverage for the employee, spouse or dependent is significantly curtailed with or without loss of coverage (e.g., an increase in deductible or HMO option is eliminated).	Applicable	Not Applicable
Addition or Significant Improvement of Benefit Package Option	Applicable	Not Applicable
Change in Coverage under another Employer Cafeteria Plan or Qualified Benefits Plan This change applies when the other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted; or the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.	Applicable	Not Applicable
Loss of Coverage under Group Health Plan of Governmental or Educational Institution	Applicable	Not Applicable
Changes in 401(k) Contributions	Not Applicable	Not Applicable
HIPAA Special Enrollment Rights	Not Applicable	Applicable
COBRA Qualifying Events	Not Applicable	Applicable
Judgment, Decree or Order This change applies when a dependent becomes eligible as the result of a judgment, decree or order resulting from divorce, legal separation, annulment or change in legal custody that requires accident or health coverage for a dependent child.	Not Applicable	Applicable

Events Permitting Election Change	Mid-Year change is Applicable	
	Dependent Care FSA	Health Care & Limited Purpose FSA's
Medicare or Medicaid Eligibility	Not Applicable	Applicable
FMLA Leaves of Absence	Applicable	Applicable
Pre-Tax HSA Contributions	Not Applicable	Not Applicable
As used herein, "Applies" either means that the election can be revoked, or it may be changed. Any change or revocation must be (a) consistent with the events described in this section to the extent that it is necessary or appropriate as the result of such change and (b) consistent with Treasury Regulation § 1.125-3, Treasury Regulation § 1.125-4, IRS Notice 2004-50 and 2004-33 I.R.B. 196.		

Claims Processing

You must submit a completed claim form along with copies of invoices or statements to serve as proof that you have incurred a qualified expense to receive payment. Statements are required to be from the provider/store stating the date of service/purchase, a description of services/products, the expense amount, the name of the service provider/store and the person for whom the service was provided.

For over the counter (OTC) items, the receipt or documentation from the store must include the name of the item printed (by the store) on the receipt. You must indicate the existing or imminent medical condition for which the item will be used on the receipt, on the claim form, or on a separate enclosed statement each time these items are claimed.

- Purchases for general good health will not be accepted.
- For items covered by insurance, copies of insurance explanations of benefits statements may be used instead of original physician bills if the date of service and charges are shown, including copies of payment receipts.
- Documentation and/or copies will not be returned.

Orthodontic expenses may be assumed to be incurred at the time a payment is made. To claim orthodontic down payments, you must include a copy of the treatment contract and payment schedule along with proof of payment or a receipt of payment stating the date the braces were placed.

Claim Forms

- Claim forms available by logging on to your E-PEBP Portal at <https://pebp.nv.gov/www.pebp.state.nv.us> or by calling **UMR** at 1-888-763-8232.
- Mail or fax claims to **UMR** (see address or fax number above) or submit online.
- Claims are typically processed within 1 business day of submission
- Direct deposit and email authorization form
- On-line account information

NOTE: Claims must be filed by October 31st following the end of the Plan Year.

Coverage under both Health FSA and HRA

If you have coverage under both the Health FSA and HRA, claims should be submitted to the Health FSA first until you have exhausted that amount.

Coverage under both Limited-Purpose FSA and HSA

If you have coverage under both the Limited Purpose FSA and HSA, qualifying claims should be submitted to the Limited Purpose FSA first until you have exhausted that amount.

Reimbursement

The Third-Party Administrator (TPA) will review your claim and any necessary supporting documentation. If approved, the TPA will reimburse you for the medical care expenses. Claim reimbursements are typically issued within one business day of receipt of your claim.

You may be paid the full amount of your claim or the balance of your annual election, whichever is less, whenever you file a qualifying claim. Payment under the medical FSA is not limited to the amount in your account at the time of your claim. Your monthly contributions will continue for the remainder of the Plan Year.

Claim reimbursements may be made by direct deposit into the bank account of your choice. By using direct deposit, you will not need to wait for a check to arrive or get it deposited. A notice that a payment was made will be sent to you. This direct deposit notice is available by U.S. Mail or by e-mail. If you prefer, a check can be mailed to you instead of payment by direct deposit.

Health care expenses are eligible for payment from the Plan based on when incurred, not when paid. An expense is incurred when you or one of your eligible dependents is provided with medical care or purchases a qualifying product, and not when you are billed, are charged, or pay for the expense.

Allowable expenses must be incurred during the portion of the Plan Year that you were a participant. Claims for expenses incurred during the Plan Year must be submitted to the TPA by October 31st following the end of the Plan Year.

Establishing & Using Your Health Care FSA or Limited Purpose FSA

Estimate you and your Family's Annual Out-of-Pocket Health Care Expenses

You may include expenses for anyone who qualifies as a dependent for your federal tax return (spouse, children, etc.). Include predictable expenses only.

Enroll in the Health Care FSA or Limited Purpose FSA

Download the Flexible Spending Form by logging onto the E-PEBP Portal at www.pebp.state.nv.us <https://pebp.nv.gov/> or contact PEBP to request a form. Enter your contribution amount for the Plan Year; submit your enrollment agreement to the TPA.

Incur Medical Care Expenses

A medical care expense is incurred on the date a service is provided or a product is purchased to create that expense. You must incur medical care expenses *before* you file a claim for those expenses.

File Claims

After you have incurred the medical care expenses and know the amount of your responsibility for the bill, you may submit a claim for those expenses to the TPA.

Using the FSA Debit Card to pay for your Medical expenses

The FSA debit card provides a convenient method to pay for Out-of-Pocket medical expenses for you, your spouse, and/or any tax dependents. The IRS has stringent regulations regarding appropriate use of the FSA debit card, such as where the card can be used, and when follow-up documentation is required (use of the card DOES NOT necessarily eliminate paperwork). The card is a great benefit, but it is important that you take a moment and understand how it works.

Is there a Cost for the Card?

No. There is no cost for the initial FSA debit card. However, there is a **\$5** fee to replace a lost card or to request additional cards. You pay an administration fee of **\$3.15** per month to participate in either one or both (medical and/or dependent care) flexible spending accounts.

How do I Request a Card?

Current cardholders who renew for the following Plan Year will automatically have their card reloaded with the next year's election amount as of July 1. New enrollees will receive a welcome packet in the mail that includes an application for the debit card.

Can I Request a Replacement Card if I Lose One?

Yes. Everyone who requests a card will receive two FSA debit cards in the mail. If you need to replace a lost card, they are available by calling the TPA directly at 1-888-763-8232 and placing your request. There is a **\$5** fee for each replacement card request. Please note that cards will be in the name of the FSA participant.

Where Can the Cards be used?

Per IRS regulations, the FSA debit card can only be used at health care providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS).

- **Health Care Merchant Category Codes (MCC):** Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The FSA debit card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).
- **Inventory Information Approval System (IIAS):** The IRS also allows the FSA debit card to be used at retail stores that have IIAS in place. IIAS restricts purchases with your FSA debit card to eligible expenses, and you will never be prompted for follow-up documentation for purchases at these stores. Please note that if you have a medical condition that allows you to claim expenses that are not normally eligible, the card will not be able to pay for these expenses at these stores. You will have to pay with a separate form of payment and submit a claim. The card will work at these stores, even if the MCC does not indicate it is a health care provider. Purchases at these stores will never require follow-up documentation.

Please note that as of July 1, 2009, IRS regulations require pharmacies to have the IIAS in place, or your card may be declined at the point-of-sale.

When Do I Have to Turn in Paperwork?

Debit card transactions can be accepted by the FSA administrator without any follow up if the merchant is an acceptable merchant type such as a physician's office or hospital and at least one of four other criteria are met. Transactions are electronically substantiated if:

- The dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment or any combination of any known co-pays up to five times the highest known co-pay, for the employer-sponsored medical, vision or dental plan that participant has elected;
- The expense is a recurring expense that matches expenses previously approved as to amount, provider, and time period (e.g., for an employee who pays a monthly fee for orthodontia at the same provider for the same amount); or
- The merchant maintains a compliant Inventory Information Approval System (IIAS) for over-the-counter supplies and prescription medication (this system is allowable only if the merchant approves only qualifying items; other purchased items must be paid for in a split tender transaction.)

Any transaction that does not meet the above criteria will prompt a request for follow-up documentation.

What Happens if I Do Not Submit Requested Documentation?

Federal regulations require the cards be deactivated if follow-up documentation is not provided when requested by the TPA. You will receive several notifications before the cards are deactivated and can always call the TPA for assistance in working through any concerns that come up.

Minimum Plan Election

The IRS minimum annual election for Health Care FSA (HCFSA) and Limited-Purpose FSA (LPFSA) is **\$100**.

Maximum Plan Election

The IRS limits your annual elections to certain maximums. Refer to the applicable section within this document for more information.

Does this Plan provide a Carryover Provision?

If your HCFSA or Limited Purpose FSA contains an unused balance at the end of the Plan Year you may carry over up to the IRS allowable ~~\$610~~ to the following Plan Year, \$640. Any unused balance in excess of ~~\$610~~ at the end of the Plan Year is not subject to carryover and will be forfeited. The carryover amount does not affect the maximum Plan election. See the *Frequently Asked Questions* section for questions regarding HSA eligibility and the HCFSA carryover.

Health Care/Limited Purpose FSA

The reimbursement limit for a HCFSAs plan is established by the [Internal Revenue Service](#). The limit for calendar year ~~2023~~ is ~~\$3,020~~ **\$3,052** for the medical FSA or the Limited Purpose FSA. The ~~\$3,020~~ **\$3,052** limit does not include the potential carryover remaining in your HCFSAs or Limited Purpose FSA from one Plan Year to another.

NOTE: This is a per participant deduction limitation, not a household limitation, so if an employee and his or her spouse each have a HCFSAs, they could each establish a HCFSAs with a ~~\$3,020~~ **\$3,052** deduction.

Qualifying Expenses

Only the portion of the expenses you owe after insurance payments can be claimed. Qualifying expenses are those expenses which are incurred by the taxpayer or their eligible dependents during the Plan Year for medical care as defined in Section 213(d) of the Internal Revenue Code, excluding insurance premiums and long-term care expenses.

Qualifying medical care expenses include amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. Refer to IRS Publication 502 for additional information (www.irs.gov/pub/irs-pdf/p502.pdf). However, expenses qualify for the medical FSA based on when incurred, not when paid and federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA. Please contact the TPA if you have a question on specific qualifying items.

Below is a partial listing of qualified expenses:

Deductibles	Insulin
Copays	Orthodontics (braces)
Coinsurance	Hearing aids, including batteries
Over-the-counter treatment products such as bandages, blood-pressure monitors, diabetic supplies, carpal tunnel wrist supports	Ambulance, transportation expenses if the transportation is primarily for and essential to medical care.
Menstrual products such as tampons, pads, and liners	Dental expenses (except cosmetic dental expenses)
Vision care expenses such exams, prescription contact lenses/glasses, corrective eye surgery	Usual and customary charges, excess; qualifying medical expenses in excess of the plan's usual, customary, and reasonable charges.

Non-Qualifying Expenses

Below is a partial listing of non-qualified expenses:

- Cosmetic procedures: Most cosmetic procedures do not qualify. This includes cosmetic surgery or other procedures that are directed at improving the patient's appearance and do not meaningfully promote the proper function of the body or prevent or treat illness or disease. Examples include face lifts, hair transplants, hair removal (electrolysis), teeth whitening, and liposuction. There is an exception, however, for procedures that are necessary to ameliorate a deformity arising from congenital abnormality, personal injury from accident or trauma, or disfiguring disease—these may qualify.
- Diet foods: Special foods to treat a specific disease (such as obesity) do not qualify to the extent that they stratify ordinary nutritional requirements. Thus, food associated with a weight-loss program, such as special pre-packaged meals, would not qualify, since it just meets normal nutritional needs.
- Insurance premiums are not qualifying expenses.
- Late fees (e.g., for late payments of bills for medical services).
- Marijuana (or other controlled substance in violation of federal law. Won't qualify, even if a state law allows its use with a physician's prescription (for example, to treat a medical condition).
- Toothbrushes: Will not qualify even if a dentist recommends special toothbrushes (such as electric or battery-powered) to treat a medical condition like gingivitis.
- The cost of a weight-loss program, if the purpose of the weight control is to maintain your general good health.
- Health club dues.

Changes Due to the CARES Act

The CARES Act, passed by Congress on March 27, 2020, repealed a rule from the 2010 Affordable Care Act that disallowed tax-free reimbursement of over-the-counter drugs or medicines (collectively "OTC") without a prescription. With this change, HCFSA's and HSAs can cover OTC without prescriptions. Eligible OTC includes any drugs or medications that are primarily for treatment (not cosmetic or for general health). Most medical devices and supplies are already eligible without prescription, so there is no change with respect to those.

If you use the FSA debit card at merchants that have implemented the Inventory Information Approval System (IIAS), you will not be able to pay for OTC medicine with the FSA debit card, even if you have a prescription on file with the TPA. You will be required to submit a reimbursement request, along with a copy of the prescription and the cash register receipt in order to be reimbursed for these expenses.

Dependent Care FSA

Day care expenses are limited to care for children under age 13, for whom you have more than 50% custody, or for a spouse or dependent who is physically or mentally incapable of caring for himself or herself and who lives in your home at least 8 hours each day.

The expenses may not be paid to a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

Qualifying Expenses

Expenses necessary for you to be gainfully employed:

- Expenses paid to a dependent care center.
- Expenses paid to a "babysitter".
- Expenses paid for care of a dependent under age 13.
- Expenses paid for care of a dependent who is physically or mentally incapable of caring for herself or himself.

Non-Qualifying Expenses

Federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA:

- Care while you are not working or looking for work.
- Care for child for whom you have 50% or less physical custody.
- Care for child aged 13 or older who is not disabled.
- Overnight care or camps.
- Instructional or sport specific camps, e.g., ballet camp, soccer camp, summer school.

Establishing & Using the Dependent Care FSA

Estimate your Total Dependent Care Expenses for the Plan Year

Include predictable expenses only.

Enroll in the Dependent Care FSA

Enter your estimated dependent care expenses. Divide your estimate by the number of deductions you will have taken during the Plan Year. (Deductions are generally taken out of the second check of the month.) Contact your agency representative if you need assistance.

Receive Dependent Care Services

Dependent care expenses are incurred when the day care is provided. You must receive the dependent care services before you file a claim for those services.

File Claims

You may include only those child/dependent care expenses that you incur for you and your spouse to be gainfully employed. Only expenses incurred for care and well-being qualify for this tax break (education related sports camps, summer school and private school expenses, food and transportation do not qualify). Child support payments are not allowable. Day camp fees incurred for you to work are allowable but overnight camps are not. Please refer to [IRS Publication 503](#) for further details on qualifying expenses. You may access this publication at <https://www.irs.gov/publications/index.html>.

Expenses are eligible for payment from the Plan based on when incurred not when paid. Expenses are incurred when your dependent is provided with the care that gives rise to the expenses, and not when you are billed, charged for, or pay for the care.

After you have received the dependent care services, you may submit a claim for those expenses to the TPA.

Receive Reimbursements

The TPA will review your claim, and if approved will reimburse you. Claim reimbursements are issued within one business day of the receipt of your claim up to the amount that you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from your payroll contributions.

Some important points you should remember regarding a Dependent Care FSA are:

This category is an alternative to taking a “tax credit” allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the “Tax Credit” or the “FSA.” The IRS will not allow you to receive two tax breaks on the same expenses.

For Plan Year **2024~~5~~** **(July 1, 2023 — June 30, 2024)**, the DCFSa is limited to **\$5,000** for single taxpayers and **\$2,500** for married individuals filing separately. You will experience “tax savings” throughout the year with every paycheck you receive.

Generally, those employees with a combined taxable income over \$69,000 or single parents with taxable income over \$37,000 will save more through the DCFSa.

Please contact your tax advisor if you have questions about which is best for you. You must choose whether to use the tax credit or the DCFSa.

1. You and your spouse together may include up to \$5,000 per calendar year (\$2,500 in the case of a married individual filing a separate tax return for the calendar year) or the lesser of (after subtracting FSA deductions) you or your spouse’s earned income for the calendar

year. In no event shall a married individual filing a separate tax return for the calendar year exceeding \$2,500. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income of \$250 per month if you have one dependent and \$500 per month if you have two or more dependents.

2. Your Plan Year election cannot be changed unless you experience a qualifying life status event.
3. If your participation in the Plan terminates, you may continue to file claims for qualifying expenses incurred prior to your termination during the same Plan Year until you have been reimbursed the balance of your account. In addition, please refer to the continuation of coverage section titled *Continuation of Coverage under COBRA*.
4. You must submit a completed claim form along with copies of invoices or statements from the provider to serve as proof that you have incurred an allowable expense to receive payment. Statements are required to include the provider's name, the date(s) of service, a description of the services, and the expense amount. Copies of personal checks and paid receipts, without the above information, are not acceptable. Documentation and/or copies will not be returned. You will be provided with a supply of claim forms with your enrollment confirmation. Extra claim forms are available from the TPA web site at [or by calling 1-888-763-8232](#). In lieu of providing the above documentation, you may have the provider complete the dependent care section of the claim form and sign on the line provided. The dependent care services must have been provided before you file a claim for those services.
5. Claim reimbursements may be made by direct deposit into the bank account of your choice. By using direct deposit, you will not need to wait for a check to arrive or get it deposited. A notice that a payment was made will be sent to you. This direct deposit notice is available by U.S. Mail or by e-mail. If you prefer, a check can be mailed to you instead of payment by direct deposit.
6. The tax identification (ID) number or Social Security number of the child/dependent care provider must be listed on each of your claim forms and your federal income tax return. Please check with your childcare provider (before enrolling in this category) to be sure that you can obtain their tax ID number or their Social Security number.
7. Participants on leave (paid or unpaid) under FMLA or USERRA leave are entitled to terminate coverage during the leave and reinstate coverage immediately on return to work. Such reinstatement must be made within 60 days of returning to work.

Termination of Participation

Your participation in the Plan will terminate when:

- You are no longer an eligible employee; or,
- You no longer satisfy the conditions for participation in the plan; or,
- You revoke elections under the plan; or,
- The Plan terminates.

You may continue to claim reimbursement from an FSA for up to three months after your date of termination for any eligible expenses incurred on or before the date your participation terminated.

You will not be able to receive reimbursement for expenses that are incurred after your participation terminates.

Continuation of Coverage under COBRA

Health Reimbursement Only

If your health benefits and FSA coverage terminates because of a qualified event i.e., termination of employment (does not include retirement), you may continue your FSA coverage if you elect COBRA. Information regarding continuation of your FSA is included in the COBRA notification form that you receive from PEBP. Please note that continuation of FSA coverage only applies if you have a positive HCFSA account balance (including the remaining monthly administrative fee and the 2% COBRA administrative fee). COBRA FSA benefits will end on the earlier of:

- You cease paying the monthly administration fee;
- Your remaining FSA balance is depleted; or,
- At the end of the applicable Plan Year.

If COBRA is elected, it will be available only for the remainder of the applicable Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Employees who have incurred a COBRA qualifying event because of no longer being actively employed will be responsible for the monthly administration fee. The monthly administration fee will be paid on an after-tax basis.

FSA Rights and Responsibilities

Participant Responsibilities

For dependent care, you are required to file Schedule 2 with your IRS Form 1040 or Form 2441 with your IRS Form 1040 to support the amount redirected (pre-taxed) for the calendar year. Please note that this is for informational purposes. You will not pay taxes on the redirected amount. Claim reimbursements made to you under this category are not taxable, but the amount redirected will appear on your W-2 form. This will inform the IRS that you have received a tax break on that expense through the FSA.

Employer Responsibilities

The employer shall perform the following responsibilities:

- Maintaining Plan records;
- Filing tax returns and reports required under federal and state law and complying with other governmental reporting and disclosure requirements;
- Authorizing payments and resolving questions concerning the Plan and interpreting, in its discretion, the Plan's provisions related to benefits and eligibility;
- Hiring outside professionals to assist with Plan administration and to render advice concerning the responsibility they have under the Plan, including but not limited to hiring a claims administrator, actuaries, attorneys, accountants, brokers, and consultants;
- Establishing policies, interpretations, practices, and procedures of the Plan;
- Receiving disclosures required of fiduciaries and other service providers under any federal or state law;
- Acting as the Plan's agent for service of legal process;
- Administering the Plan, including but not limited to the Plan's claims procedures as set forth in the Summary Plan Description and the Plan Administrator's Plan document;
- For those Participants participating in the HCFSA and/or DCFSA, establishing a separate bookkeeping account for each in order to manage the participant's funds; and,
- Performing other responsibilities allocated to the Plan Administrator by the administrative committee.

Delegation of Responsibilities

The employer may delegate their responsibilities hereunder to other persons or entities. Such delegation shall be effective only if the proposed delegate executes an instrument acknowledging acceptance of the delegated responsibilities, and only if the board of directors, if applicable, specifically authorizes such delegation. The board of directors, if applicable, may also delegate their responsibilities to officers or employees of the employer.

Claims Administrator Responsibilities

Under the Plan, the TPA has agreed to provide certain administrative services on behalf of the Plan Sponsor according to the terms and limitations of the Plan. Claims for benefits under the Plan shall be filed, processed, reviewed, and, if denied, appealed in accordance with the procedures set forth in this Summary Plan Description and the Plan Administrator's Plan document.

Except as otherwise provided by law, the appeal procedures set forth in this Summary Plan Description and the Plan Administrator's Plan document shall be the sole and exclusive remedy.

the TPA will not act nor assume the responsibility to act as the Plan Administrator or Plan Fiduciary on behalf of the Plan Sponsor. the TPA administers the plan by adjudicating claims in accordance with the terms of the plan.

FSA Frequently Asked Questions (FAQs)

Health Care FSA (HCFSAs)

Whose expenses qualify under my HCFSAs?

Qualifying expenses are those for medical care for yourself (the participant), your spouse, your qualified child or qualified relative.

Where can I see a list of qualifying expenses for the HCFSAs?

UMR has an exhaustive eligible expense list; the list can be found in your online UMR portal.

Do prescription medications (drugs available only by prescription from a physician) qualify for the HCFSAs?

Generally, yes, as long as they are prescription drugs and are legal under Federal and State law. However, prescriptions that are purchased solely for cosmetic purposes which are not treating an existing medical condition do not qualify for reimbursement.

Additionally, Federal law does not allow reimbursement through your flexible spending for importation of drugs from foreign countries.

What are the requirements for reimbursements for over-the counter (OTC) medicines and drugs?

OTC drugs and medicines purchased on or after January 1, 2020, do not require a prescription and are eligible for reimbursement. Just submit a claim with a copy of the merchant itemized store receipt showing the store name, date of purchase, a description of each item, and dollar amount. Note: If OTC drug and medicines were purchased prior to January 1, 2020, a physician prescription is required.

Items such as vitamins, herbs or nutritional supplements are typically not eligible for reimbursement. In order to claim these items, you must have:

- an existing or imminent medical condition;
- a pre-printed receipt from the provider documenting the purchase; and
- a physician's diagnosis and prescription for the specific item(s).

How much does it cost me?

You pay a small administration fee of **\$3.15** per month to participate in either one or both (HCFSAs and/or DCFSAs) flexible spending accounts.

What if I do not use all the money in my Flexible Spending Account?

If you have funds remaining in your DCFSAs account at the end of the year, that amount will be forfeited by you as required by federal regulations. If you have funds remaining in your HCFSAs or LFSAs at the end of the year, you will be permitted to carry over up to **\$6410** to the following Plan Year. Funds in excess of **\$6410** will be forfeited.

Are there any negatives that I should know about?

If you do not use all the money in your DCFSFA, you will forfeit it. You will only be able to carry over up to **\$6,410** of your HCFSFA or Limited Purpose FSA. Any remaining amount you will forfeit.

Will the Medical Health Care FSA carryover affect my enrollment in the PEBP Health Savings Account?

Yes. The FSA carryover will make you ineligible for the PEBP health savings account. To be eligible for the PEBP health savings account you may either elect to decline the carryover prior to the next Plan Year or switch your enrollment to the Limited Purpose FSA and carry over the unused funds to your new account.

What if I am already in the FSA?

Participation in both accounts terminates at the end of each Plan Year. You must submit a new election to the TPA each year during Open Enrollment to reenroll.

If I enroll in the Health Savings Account (HSA), can I still enroll in the regular Health Care FSA?

No. Federal rules prevent an individual who is enrolled in a high deductible health plan with an HSA to enroll in the HCFSFA. However, you may sign up for the Limited Purpose FSA which allows you to set aside pre-tax money for vision and certain dental expenses.

Are there any restrictions if my spouse also contributes through his/her employer's FSA plan?

The reimbursement limit for a HCFSFA plan is established by *each* employer, so you may each contribute an amount up to *each respective* employer's plan limit. However, you may only claim reimbursement of each expense from one plan (not the same expense under both plans). PEBP's limit for Plan Year 2024⁵ is **\$6,053,200** for the HCFSFA or the LPFSA. The **maximum plan election** does not include any potential carryover remaining in your HCFSFA or LPFSA from one year to another.

NOTE: This is a per participant deduction limitation, not a household limitation, so if an employee and his or her spouse each have a HCFSFA, they could each establish a HCFSFA with a **\$3,200⁵⁰** deduction.

- For Plan Year 202⁵⁴, the DCFSFA pretax contribution limit is \$5,000 for single taxpayers and married couples filing jointly, and \$2,500 for married individuals filing separately.

When can I make changes?

You can change benefits during open enrollment (prior to the start of each Plan Year). Generally, you will not be able to change your election during the Plan Year. Refer to the *Health Care & Limited Purpose FSA's & dependent care FSA Qualifying Life Status Event Table* in this document.

To make an eligible change during the Plan Year, contact the TPA within 60 days of a qualifying life status event. the TPA may request proof of a qualifying life status event.

Qualifying change in life status events are defined as any one of the following four (4) changes in status.

1. Your legal marital status changes through marriage, divorce, death, or annulment.
2. Your number of dependents changes by reason of birth, adoption (or placement for adoption), or death. If your child no longer qualifies for day care because he or she turned 13, then that is a loss of a dependent under the DCFS, but not under the HCFS.
3. You have a change in employment status that affects eligibility under this plan, including a change from full time to part time or vice versa.
 - a. If you terminate or take a leave of absence, you must be gone at least 31 days for the termination or leave of absence to qualify as a change in status. If your spouse or any of your dependents have an employment status change that affects eligibility under a plan maintained by your spouse's or any dependent's employer, then you may increase or add coverage under this Plan if coverage is lost under the other employer's plan.
 - b. If a participant terminates and then returns to employment within 60 days in the same Plan Year, then your election will be reinstated as it was immediately prior to the termination of employment. If you return to employment after 60 days in the same Plan Year, then you may make a new election for the remainder of the Plan Year. You will not be able to be reimbursed for medical or dependent care expenses incurred during the termination period.
4. One of your dependents satisfies or ceases to satisfy the requirements for coverage under the HCFS for unmarried dependents due to attainment of age, student status, or any similar circumstances.

In addition, the change in status event must result in a gain or loss of eligibility for coverage under this Plan or a plan maintained by your spouse's employer or one of your dependent's employers and your election modification must correspond with that gain or loss of coverage.

Examples of Allowable changes Due Resulting from Qualifying Life Status Changes

1. Adoption of a two-year-old child during the plan year.
 - As a result of the adoption, there is a change to the number of dependents in the household.
 - The child is now eligible for coverage under the HCFS and the DCFS.
 - Employee may increase the HCFS and/or DCFS election(s) or enroll in one or both of those plans if not already enrolled.
 - However, the employee would not be able to decrease or disenroll from the HCFS or the DCFS as the life event resulted in a gain of eligibility and not a loss of eligibility.

2. A judgment, decree, or court order resulting from a divorce, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for an employee's child would be considered an allowable change to the HCFSA, to:
 - Provide coverage for the child, if the order requires coverage under an employee's plan; or,
 - Cancel coverage for the child if the order requires the former spouse to provide coverage.
 - Changes to dependent care providers allow an employee to make an election change to reflect the cost of the new provider. Election decreases are allowed when the child is no longer in childcare or is only in after school care due to entering kindergarten or first grade. (This is considered a provider change.)
3. Employee who takes an unpaid leave under the Family Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) for more than 31 days may revoke an existing election under the HCFSA. However, employee must revoke any DCFSA since employee is not working. Upon returning from FMLA or USERRA leave, employee may choose to be reinstated in either benefit if such coverage was terminated during the FMLA or USERRA leave. Such reinstatement will be on the same terms as prior to taking FMLA or USERRA leave. An employee shall have no greater right to benefits for the remainder of the Plan Year than an employee who has been continuously working during the Plan Year.

If an employee's coverage under the HCFSA or DCFSA terminates while on FMLA or USERRA leave, employee will not be entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If employee elects to be reinstated in a benefit upon return from FMLA or USERRA leave, the coverage for the remainder of the Plan Year is equal to the election for the 12-month period of coverage, prorated for the period during the FMLA or USERRA leave for which no premiums were paid. (See additional information on FMLA or USERRA leave on page 18.)

[Heroes Earnings Assistance & Relief Tax Act of 2008](#)

Under the Heroes Earnings Assistance & Relief Tax Act of 2008, employees called to active military duty for a period of at least six months can receive a taxable distribution of the HCFSA funds to avoid forfeiture.

[What are my rights on claims appeals?](#)

You will receive written notice of any denied claims. You will have 30 days to file a written appeal of that specific claim denial with the TPA claims office. The TPA claims office will provide you with a written notice of the resolution of this appeal within 60 days of the appeal.

General Provisions

Effective Date of the Plan

The Effective Date of the modifications herein is **July 1, 2023**.

Type of Administration

The Plan is administered through the Plan Administrator. PEBP is the Plan Administrator. The Plan Administrator shall have full charge of the operation and management of the plan.

Each Flexible Spending Account (FSA) is administered by the Plan Administrator in accordance with federal regulations. Any forfeited funds may be used by the employer, at its discretion, to pay for administration of the Plan, to offset distributions from flexible spending accounts that exceed contribution, or for redistribution to contributors.

Plan Administrator

PEBP has contracted with UMR to process claims for the Flexible Spending Account program. Contact UMR. if you have questions regarding claims or eligible expenses.

Address: P O Box 30541, Salt Lake City, UT 84130-0541, EDI #39026
Phone: 1-888-7NEVADA (1-888-763-8232)
Web: www.UMR.com

Plan Sponsor and Plan Administration

The Plan is administered by PEBP and has been established and shall be maintained for the exclusive benefit of the employees of the employer. PEBP is the Plan Sponsor and functions as the Plan Administrator, unless another individual or entity is appointed by the Plan Sponsor. The Plan Administrator shall have full charge of the operation and management of the plan. The Plan Sponsor has retained the services of UMR to administer the benefits described in this Summary Plan Description.

Plan Fiduciary

PEBP is the Plan Fiduciary under the plan. The Plan Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the plan, to review denied claims for benefits under the Plan with respect to which it has been designated named Fiduciary, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a participant's rights, and to decide questions of Plan interpretation and those of fact relating to the plan. The decisions of the Plan Fiduciary will be final and binding on interested parties. Every Fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

Plan Changes

The employer reserves the right to amend the Plan at its sole discretion. The employer will communicate to the participant in writing regarding any such changes that affect you.

Any amendments to the Plan will be incorporated in writing into the master copy of the Plan on file with the employer, or a written copy will be kept with the master copy of the plan.

Plan Compliance

The Plan will make any necessary amendments to the Plan that are required to maintain compliance with federal regulations.

The participant may be required to make changes in his or her benefit elections as a result of this action, such as reducing or discontinuing his or her contribution to an FSA. In such event, the Plan Administrator will make the necessary adjustments to the participant's salary reduction amounts for the remainder of the Plan Year.

Plan is not an Employment Contract

The Plan is not a contract between the employer and the participant or an inducement or condition of employment. Nothing in the Plan gives any employee the right to retain the employee status or to interfere with the right of the employer to terminate the employment of any employee at any time.

Plan Right to Recovery

Whenever FSA reimbursement payments have been made from the Plan in excess of the maximum amount of payment necessary, according to the terms of the plan, the Plan will have the right to recover these excess payments. Whenever reimbursements have been made from the Plan that should not have been made according to the terms of the plan, the Plan will have the right to recover these incorrect or improper payments. The Plan has the right to recover any such overpayment, improper or incorrect payment from the person or entity to whom payment was made, or from any other appropriate party, whether such payment was made due to the Plan Administrator's own error.

The Plan reserves the right to follow certain correction procedures to recover improper payments. First, upon identifying an improper payment, the employer shall require the participant to pay back to the Plan an amount equal to the improper payment. Second, if the participant fails to pay back the improper payment, the employer has the right to withhold the amount of the improper payment from the participant's wages or other compensation to the extent consistent with applicable law. Third, if the improper payment amount remains outstanding, the employer has the right to utilize a claim substitution or offset approach to resolve improper claims. This process allows the employer to substitute, or apply, the improper payment amount for a future substantiated claim incurred during the same coverage period. No reimbursement shall be made on any such future claims until the improper payment amount is fully recouped by the plan. In addition, the employer may take other actions to ensure that further violations of the terms of reimbursement do not occur, whether through the participant's use of a reimbursement claim form, or use of a debit card, including temporary or permanent denial of access to the debit card.

Plan Termination

The employer reserves the right to terminate the Plan at any time and will communicate this action to the participant.

In the event the Plan is terminated, the employee may continue to submit timely requests for reimbursement from his or her FSA to recover any remaining balance as provided in the section entitled *Claims Processing and Reimbursement*.

Benefits Not Transferrable

Except as otherwise stated herein, no person other than the enrolled employee is entitled to receive benefits under this plan. Such right to benefits is not transferable.

Clerical Error

No clerical error on the part of the employer or Plan Administrator shall operate to defeat any of the rights, privileges, services, or benefits of any employee hereunder, nor create or continue participation which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or reimbursements will be made when the error or delay is discovered. However, if more than 90 days have elapsed after the end of a Plan Year prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

Conformity with Statute(s)

Any provision of the Plan that conflicts with statutes that are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

Death

Any benefit payments or FSA reimbursements payable to the participant under the Plan after his or her death will be paid to his or her surviving spouse. Eligible requests may be submitted after the participant's death. In the case of no surviving spouse, any payments will be paid to the participant's estate or designated beneficiary.

Incapacitation

The Plan Administrator may direct any reimbursement to the participant's legal representative, relative or friend, or in any other manner that the Plan Administrator considers appropriate on the participant's behalf if the participant is under a legal disability or, in the opinion of the Plan Administrator, the participant is incapacitated so as to be unable to submit a proper reimbursement request from his or her FSA or otherwise manage his or her financial affairs.

Incontestability

All statements made by the employer or by the participant shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the employer or by the participant. A statement made shall not be used in any legal contest unless such statement is made in writing and signed by such person and a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

Legal Actions

No action at law or in equity shall be brought to recover on the FSA reimbursements from the Plan after the expiration of 90 days following the end of the Plan Year, unless otherwise provided by applicable law.

Limits on Liability

Liability hereunder is limited to the services and benefits specified, and the employer shall not be liable for any obligation of the participant incurred in excess thereof. The employer shall not be liable for the negligence, wrongful act, or omission of any medical (health) care or dependent care provider, institution or their employees, or any other person. The liability of the Plan shall be limited to the cost of FSA reimbursements under the provisions stated herein and shall not include any liability for suffering or general damages.

Lost Distributees

Any reimbursement payable hereunder shall be deemed forfeited if the Plan Administrator is unable to locate the participant to whom payment is due. However, if the participant submits a request for reimbursement for the forfeited funds within the time prescribed in the sections entitled *"Health Care Reimbursement"* and *"Dependent Care Reimbursement,"* such funds shall be reinstated.

Misrepresentation

If the participant or anyone acting on behalf of a participant makes false statement on the application for enrollment or on a reimbursement request form and any attachments, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the participant, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided.

Any material misrepresentation on the part of the participant in making application for coverage, or any application for reclassification thereof, or for service thereunder, or; establishing an FSA or seeking FSA reimbursement, shall render the benefits under this Plan invalid.

Pronouns

Any personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

Section 125

This booklet constitutes a Plan document under Section 125 of the Internal Revenue Code ("Code"). The portions of this document related to reimbursement of health expenses constitute a medical expense reimbursement plan under Section 105 of the Code. The portions of this document related to reimbursement of dependent care expenses constitute a separate written plan under Section 129 of the Code. The benefits payable hereunder are intended to be excludable from the participant's gross income under Sections 105, 106 and 129 of the Code, and this Plan document shall be interpreted to the maximum extent to provide this intended effect.

Tax Benefits

The employer bears no responsibility for and makes no warranties regarding any personal income tax filings, such as eligibility of any personal expenses for credits or deductions. It is his or her responsibility to determine what expenditures are eligible under federal, state, or local income tax regulations.

Useful Links

[IRS Publication 502: Medical and Dental Expenses](#)

[IRS Publication 503: Child and Dependent Care Expenses](#)

[IRS Publication 504: Special rules for children of divorced parents](#)

[IRS Publication 969 Health Savings Accounts and other Tax-Favored Health Plans](#)



Access.
Quality.
Affordability.



ENROLLMENT AND ELIGIBILITY MASTER PLAN DOCUMENT

Plan Year 2024~~3~~5

(Effective July 1, 2024~~3~~ – June 30, 2025~~4~~)

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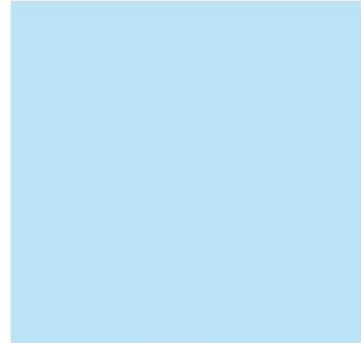
NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

775-684-7000

702-486-3100

or 1-800-326-5496

<https://pebp.nv.gov>





Public Employees' Benefits Program

3427 Goni Road, Suite 109
Carson City, Nevada 89706

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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

~~PEBP and Medicare~~

~~Update Medicare Part B Medicare eligibility to “as determined by the Social Security Administration...”~~

~~Enrollment & Eligibility Events Quick Reference Table~~

~~Under Employer of Spouse/Domestic Partner Offers and Open Enrollment Period: Add “Initial Benefit Enrollment Period” to the section per Qualifying Events section.~~

~~Qualifying Events~~

~~Update to Declining Active Employee Coverage: Removed “and long term disability insurance or any voluntary products.”~~

~~Updates for compliance with IRS Section 125~~

~~Enrollment and Eligibility Events Quick Reference Table~~

~~Updates to “When Coverage Begins or Ends.”~~

~~Change language pertaining to “notice” and “receipt of notice” to “notification.”~~

~~Key Terms and Definitions~~

~~Add definition to clarify plan rules: “**Notification:** When a member initiates a change to their benefits with PEBP (Open Enrollment, Qualifying Life Event, or HIPAA Special Enrollment) through their online PEBP account. The date a notification is received may control the effective date of benefit changes. A notification may be subject to requirements for supporting documentation (see the definition of “completed notification” for more information).”~~

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP offers medical, dental, life insurance, flexible spending accounts, and other voluntary insurance benefits to eligible State and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may select whichever benefit plan offered in your geographical area which best meets your needs, subject to specific eligibility and Plan enrollment requirements. These plans include the Consumer Driven Health Plan, Exclusive Provider Organization (EPO) Plan, Low Deductible PPO Plan, Health Plan of Nevada HMO, and individual Medicare Advantage or Supplement plans through Via Benefits. You are also encouraged to research Plan provider access and quality of care in your service area.

PEBP participants should examine this document, the Consumer Driven Health Plan, PPO Dental Plan, EPO Plan, and the Low Deductible PPO Plan MPD. Important information is also available in the Active Employee Health and Welfare Wrap Plan Document, Retiree Health and Welfare Wrap Plan Document, Section 125 Document, Health Reimbursement Summary Plan Description for Medicare retirees, Health Reimbursement Arrangement Summary Plan Document, and the Summary of Benefits and Coverage (SBC) for applicable plans. These documents are available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

The Master Plan Documents, Summary Plan Descriptions, and Summary of Benefits and Coverage provide a comprehensive description of the benefits, eligibility, and plan provisions. Relevant statutes and regulations are detailed in the Active Employee and Retiree Health and Welfare Wrap Plan Document. The *Participant Contact Guide* section contains telephone numbers, website addresses and other important vendor information associated with each plan.

As a PEBP participant, it is important that you stay informed and keep abreast of your plan benefits. You are encouraged to read the various publications such as benefit guides, newsletters, plan documents, summary plan descriptions, and other materials. You are also encouraged to contact the PEBP office and any of the vendors listed in the *Participant Contact Guide* when you have questions about your benefits.

Sincerely,

Public Employees' Benefits Program

Introduction

This Master Plan Document describes the enrollment and eligibility provisions for state and non-state employees and retirees. It also includes information regarding initial enrollment requirements, qualifying life status events and applicable notification timeframes, COBRA, military, FMLA and other types of leave.

PEBP plans are governed by the State of Nevada.

The Plan and this document are intended to comply with Chapter 287 of the Nevada Revised Statutes (NRS) ~~Chapter 287~~, and Chapter 287 of the Nevada Administrative Code (NAC) ~~287~~, and all other applicable provisions of Nevada law as amended and certain provisions of NRS 695G and NRS 689B. Additionally, PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA).

The provisions and information described in this document are effective **July 1, 2023**.

This document will help you understand eligibility and enrollment requirements. You should review it and show it to members of your family who are or will be covered by the Plan.

It describes the process and timeframes for submitting new hire or retiree enrollment elections, qualifying life status changes, and supporting document requirements. Be sure to read the *Key Terms and Definitions* sections.

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, please contact PEBP at the number listed in the *Participant Contact Guide*. The *Participant Contact Guide* provides you with contact information for the various components of the Public Employees' Benefits Program.

PEBP intends to maintain this program of benefits indefinitely, but reserves the right to terminate, suspend, discontinue, or amend its Plan offerings and benefits at any time and for any reason. As PEBP amends its Plan(s), you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Per NRS 287.0485 no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.

Suggestions for Using this Document:

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The Table of Contents provides you with an outline of the sections.

- The *Participant Contact Guide* helps you become familiar with PEBP vendors and services they provide.
- The Participant Rights section describes your rights and responsibilities as a participant of the Plan.
- The *Key Terms and Definitions* explains many technical, medical, and legal terms that appear in the text.
- The *Summary of Benefit Options* provides a summary of the benefit options depending on the eligibility and status of the participant.
- *Enrollment Processes* provides information for enrollment in benefit options.
- *Eligibility for Coverage* provides information regarding program eligibility depending on status of the participant.
- The *Summary of Supporting Eligibility Documents* provides information regarding what documents are required for enrollment purposes.
- *Qualifying Events* for enrollment and disenrollment information depending on the event type of the participant and their family.
- *COBRA Continuation of Medical Coverage* provides information on continuing health insurance coverage if PEBP coverage is terminated.

Accessing Other Benefit Information:

You will also want to access the following documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA and Privacy and Security and mandatory notices. These documents are available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

- ~~State of Nevada PEBP Active Employee Health and Welfare Wrap Plan~~[State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document](#)
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- ~~Consumer Driven Health Plan (CDHP) Master Plan Document~~[Consumer Driven Health Plan \(CDHP\) Master Plan Document](#)
- ~~CDHP Summary of Benefits and Coverage for Individual and Family~~[CDHP Summary of Benefits and Coverage for Individual and Family](#)
- PEBP Low Deductible PPO (LD-PPO) Master Plan Document
- ~~PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document~~[PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document](#)
- EPO Plan Master Plan Document (EPO)
- EPO Plan Summary of Benefits and Coverage for Individual and Family
- Health Reimbursement Arrangement Summary Plan Document
- ~~Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage~~[Health Plan of Nevada Evidence of Coverage \(EOC\) and Summary of Benefits and Coverage](#)
- ~~Flexible Spending Accounts (FSA) Summary Plan Description~~[Flexible Spending Accounts \(FSA\) Summary Plan Description](#)

- ~~Section 125 Health and Welfare Benefits Plan Document~~Section 125 Health and Welfare Benefits Plan Document
- ~~Medicare Retiree Health Reimbursement Arrangement Summary Plan Description~~Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

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Participant Rights

You have the right to:

- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with State and Federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and providers and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's participants' rights.
- Express, respectfully and professionally, any concerns you may have about PEBP or any benefit or coverage decisions the Plan (or the Plan's designated administrator) makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing benefits for future treatment, and be informed by your physician(s) of the medical consequences.

Rescission of Coverage

The Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a covered person under a benefit option that is a group health plan that is not excepted or exempt under Section 2712 of the [Public Health Service Act](#), unless 30 days' advance written notice is provided and such covered person commits an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; provided however, that the foregoing prohibition shall not prohibit retroactive termination in the event: (i) a Participant fails to timely pay premiums towards the cost of coverage; or (ii) any other circumstance under which retroactive termination would not violate the [Patient Protection and Affordable Care Act](#). The covered person may appeal against the rescission of coverage as a denial of a post-service claim under Article 7 in the Health and Welfare Wrap Document available at ~~www.pebp.state.nv.us~~<https://pebp.nv.gov/>. In the event the Plan Administrator rescinds a Covered Person's coverage on account of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent, such rescission shall not cause the individual to incur a "qualifying event" as provided under COBRA.

Summary of Benefit Options

	Full-Time Employees			Active Legislator	Retirees (non-Medicare)			Survivors of Retirees (non-Medicare)	
	State	Non- State	NSHE		State	Non- State	Reinstated (State or Non-State)	Spouse	Dependent Child
Medical Options									
Consumer Driven Health Plan (CDHP)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exclusive Provider Organization Plan (EPO)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Low Deductible PPO Plan (LD PPO)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Plan of Nevada (HPN) HMO	✓	✓	✓	✓	✓	✓	✓	✓	✓
Other Options									
Self-funded PPO Dental	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basic Life	✓	✓	✓	✓	✓	✓			
					Retirees eligible for Medicare Parts A and B			Survivors of Retirees	
Medicare Exchange for Medicare eligible retirees and their covered Medicare eligible dependents					✓	✓	✓	✓	

Summary of Voluntary Product Options

	Full-Time Employees			Active Legislator	Retirees			Survivors of Retirees	
	State	Non- State	NSHE		State	Non- State	Reinstated (State or Non-State)	Spouse	Dependent Child
Summary of Voluntary Product Options									
VSP Voluntary Vision	X	X	X	X	X	X	X		
The Standard Employee Critical Illness	X	X	X	X					
The Standard Spouse Critical Illness	X	X	X	X					
The Standard Hospital Indemnity	X	X	X	X					
The Standard Accident Insurance	X	X	X	X					
The Standard Employee Voluntary Life and AD&D	X	X	X	X					
The Standard Spouse Voluntary Life	X	X	X	X					
The Standard Child Voluntary Life	X	X	X	X					
LegalEASE – Legal Services	X	X	X	X	X	X	X		
ID Theft Protection – ID Watchdog	X	X	X	X	X	X	X		
The Standard Retiree Voluntary Life				X	X	X	X		

Summary of Voluntary Product Options

The Standard Retiree Critical Illness				X	X	X	X		
The Standard Retiree Accident Insurance				X	X	X	X		
Auto, Home, Renters' Insurance (Liberty Mutual)	X	X	X	X	X	X	X		
Pet Insurance (Nationwide Pet Health)	X	X	X	X	X	X	X		
The Standard Short-Term and Long-Term Disability Insurance	X	X	X	X					

Enrollment Processes

Enrollment

Log on to your E-PEBP portal account at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) and click on the orange “Login” button, then follow the instructions to access your account.

Most enrollment events may be completed online and will eliminate having to complete a paper enrollment form. If you are enrolling in the Consumer Driven Health Plan (CDHP) you may also establish your Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) online.

Enrollment must include without limitation:

- The name, address and social security number of the participant who is enrolling in the Plan; and
- The name, and social security number of any dependent the participant chooses to cover under the Plan and any required supporting documents.

A participant who desires to enroll or add a dependent to the Plan must agree to the authorization section of the enrollment form by signing (submittal of the online enrollment is considered a digital signature) and dating the enrollment.

Initial Enrollment

Initial Enrollment for Active Employees

Benefit eligibility is reported to PEBP by the employer. As a new benefits-eligible employee you must enroll or decline coverage online at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) and upload any required supporting documents (if adding dependents) to your E-PEBP portal no later than the last day of the month your coverage is scheduled to become effective. This is the initial enrollment that is also considered a “new hire” event.

Enrollment Requirement Example:

Date of Hire/Contract Date	Coverage Effective Date	Date Enrollment Must Be Completed	Date Supporting Documents Must be Submitted (if any)	Default Coverage Date
June 1 st	June 1 st	June 30 th	June 30 th	June 30 th Coverage Effective June 1 st
June 2 nd	July 1 st	July 31 st	July 31 st	July 31 st

				Coverage Effective July 1 st

If a member's initial enrollment occurs during Open Enrollment, the initial enrollment must be completed before Open Enrollment elections.

Default Coverage – Failure to Enroll When Eligible

PEBP requires eligible employees to enroll in a medical Plan or decline benefits no later than the last day of the month coverage is scheduled to become effective. If an employee fails to enroll or decline coverage as specified above, the employee will be automatically enrolled in the Consumer Driven Health Plan (CDHP) with a Health Reimbursement Arrangement (HRA), in the "employee-only" tier without coverage for dependents.

Initial Enrollment for Retirees

Retirees who wish to enroll in retiree coverage must complete the required paper enrollment documents and submit to the PEBP office within 60 days of the date of retirement. Required forms include the Retiree Benefit Enrollment and Change Form (RBECE) and the Years of Service Certification Form (YOSCF) and are available upon request by contacting the PEBP office. Eligible dependents must be enrolled at the same time as the retiree.

Initial Enrollment for Survivors

Eligible surviving dependent(s) who wish to be covered under PEBP must complete an enrollment election within 60 days of the date of death of the employee or retiree.

Initial Enrollment for COBRA

Qualified beneficiaries who wish to elect COBRA continuation coverage must submit their COBRA enrollment election within 60 days of the qualifying event date. Coverage will not be processed until payment is received.

Open Enrollment

Open enrollment is typically held May 1 - May 31 and any changes made during open enrollment become effective on July 1st, immediately following the open enrollment period.

During this time active employees and retirees may:

- Enroll in a medical Plan or change Plan options; or
- Add or delete eligible dependents to/from medical coverage; or
- Decline coverage.
- Retirees covered under the Medicare Exchange may:
 - Opt-in/out of PEBP dental coverage (must be covered under a PEBP sponsored medical Plan)
 - Add or delete eligible dependents

During a positive enrollment period or if a medical Plan option is discontinued, the covered participant must submit a new plan election within the required timeframe as determined by PEBP. Failure to make a new enrollment election will cause the Participant and any covered dependents to be defaulted to the CDHP Plan (default Plan).

Retiree Late Enrollment

Per NRS 287.0475, a retired public officer or employee of the State, NSHE, a participating local government, or the surviving spouse thereof, may reinstate insurance during the open enrollment period if the retired public officer or employee did not have more than one period during which he or she was not covered under the PEBP Plan on or after October 1, 2011, or on or after the date of his or her retirement, whichever is later. Meaning, the above individuals will only have one opportunity to rejoin a PEBP Plan following retirement.

In accordance with NRS 287.0475, a retired public officer or employee or the surviving spouse thereof, may reinstate insurance through the Medicare Exchange, except life insurance, under the Public Employees' Benefits Program, if the retired public officer or employee (1) did not have more than one period during which he or she was not covered by insurance under the Program on or after October 1, 2011; (2) retired from a nonparticipating local governmental agency; (3) was enrolled in the Program as a retiree on November 30, 2008; and (4) is enrolled in Medicare Parts A and B at the time of the request for reinstatement.

To enroll as a late enrollee, contact PEBP between April 15th and May 15th to request the retiree late enrollment form. Approved enrollment for reinstated retirees will become effective July 1st. Reinstated retirees are not eligible for basic life insurance coverage through the PEBP. Requests for reinstatement must be completed through the submission of the required forms to the PEBP office not later than 31 days before the commencement of the plan year.

HIPAA Special Enrollment Notice

If you are declining medical benefits for yourself or your eligible dependents (including your eligible spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in medical benefits provided under a PEBP-sponsored plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

If you request a change due to a special enrollment event within the 60-day timeframe, coverage will be effective the date of birth, adoption, or placement for adoption. For other events, coverage may be effective the first day of the month following the receipt of a completed request for enrollment. A completed request for enrollment means required supporting documentation

such as a marriage certificate, birth certificate, proof of coverages, etc. For a list of supporting documents, see “Summary of Supporting Eligibility Documents,” below.

HIPAA Special Enrollment Rights [26 CFR §1.125-4(b)] allow a “special enrollee” to change his or her existing enrollment after:

- A loss of eligibility for group health coverage, health insurance coverage, Medicare Part A, CHIP, or Medicaid.
- Becoming eligible for state premium assistance, Medicaid, or CHIP subsidies; and
- Obtaining a new spouse or dependent by marriage, domestic partnership, legal guardianship, birth, adoption, or placement for adoption.

Change in Status applies to marital status (marriage, divorce), number of dependents (includes birth, adoption, placement for adoption, registration/termination of domestic partnership, and death, employment status, dependent satisfies or ceases to satisfy eligibility requirements, change in residence [26 CFR §1.125-4(c)(1)(i)]).

Special enrollment rights are subject to certain circumstances. If you are a State or non-State retiree, special enrollment does not apply to you, but it does apply to your dependents if you and the dependent are covered under the Plan. If you are a surviving spouse or surviving domestic partner not covered under a plan, special enrollment does not apply to you or your dependents.

To request special enrollment or to obtain more information, contact PEBP at our information in the Participant guide, below, or email member services by selecting the contact us feature in your E-PEBP portal member account.

Retroactive Premiums

Deductions for elections and/or tier changes may take several pay cycles to be applied. This may result in “catch-up” for retroactive premiums. Some members may see larger than anticipated pay deductions.

Eligibility for Coverage

Summary of PEBP Eligibility and Enrollment Requirements

This chapter outlines the enrollment processes and eligibility requirements for individuals eligible for coverage under the Public Employees' Benefits Program (PEBP). Information regarding the enrollment process, coverage termination procedures, timeframes for completing enrollment and submitting supporting documents and premium payments are detailed in this document.

- Any spouse or domestic partner that is eligible for coverage as both a primary participant and a dependent shall be enrolled as a primary participant.
- A child that is eligible as both a primary participant and a dependent may enroll as a primary participant or continue coverage as a dependent of a PEBP participant until age 26 years.

Eligibility Determinations

Eligibility for PEBP coverage is determined in accordance with the [NRS Chapter 287](#), [NAC Chapter 287](#), and the provisions outlined in this document. Individuals have the right to appeal an eligibility decision and request information as to why a determination was made; however, unless evidence supports that an eligibility determination fails to comply with the eligibility terms in this document, the original determination will not be reversed.

Note: A retroactive rescission of coverage may be appealed except when the coverage termination is due to non-payment of premium.

Eligibility for Active Employees

The following full-time employees are eligible to participate in PEBP after satisfying their respective waiting period:

- Employees of a State and participating non-State agency.
- Employees of the Nevada Senate or Assembly.
- NSHE employees under a letter of appointment with benefits.
- NSHE classified employees.
- NSHE professional employees under annual contract.

Eligibility for Member of the Senate and/or Assembly

Members of the Nevada Senate or Assembly are eligible to enroll for coverage as provided in ~~in conjunction with NRS 287.045, a member of the Senate or Assembly is not an employee; however, eligible to enroll for coverage.~~

Pursuant to NRS 287.045-(4), a member of the Senate or Assembly is eligible on a) the first day of the initial term of office of the member, if that date is the first day of the month; or b) ~~the~~ the first day of the month immediately following the first day of the initial term of office of the member.

When ~~if~~ a member of the Senate or Assembly becomes an employee of the state, or vice versa, the basis for the member's ~~distinct~~ eligibility will correspond to the member's current status, that

is, the basis for eligibility will change accordingly~~changes from a member of the Senate or Assembly to a state employee. Upon such a~~Should this change occur, or vice versa, the member is entitled to the initial enrollment benefits.

Eligibility for Retirees

Pursuant to NAC 287.135, retirees with 5 or more years of service credit (8 or more years of service credit for retired legislators; NRS 287.047) are eligible for PEBP coverage if the retiree's last employer is a participating public agency and the retiree is receiving retirement benefit distributions from one or more of the following:

- Public Employees' Retirement System (PERS)
- Legislators' Retirement System (LRS)
- Judges' Retirement System (JRS)
- Retirement Plan Alternative (RPA) for professional employees of the Nevada System of Higher Education
- A long-term disability plan of the public employer

Eligibility for Dependents

Your Spouse

For the purposes of this Plan, the participant's lawful spouse is eligible for coverage under the PEBP Plan. Spouses that are eligible for health coverage through their current employer group health plan are typically not eligible for coverage under the PEBP Plan. If your spouse's employer group health plan satisfies PEBP's definition of "Significantly Inferior Coverage" and you comply with the items listed in the Exception paragraph below, you may be able to enroll or continue your spouse's coverage under PEBP. The definition of "Significantly Inferior Coverage" is provided in the *definition section* of this document.

The Plan requires proof of the legal marital relationship and completion of the enrollment online declaring that the spouse is not eligible for an employer group health plan. A spouse is not an eligible dependent after divorce.

Your Domestic Partner

The participant's domestic partner, as recognized by the laws of the State of Nevada, is eligible for coverage under the PEBP Plan. Domestic partners that are eligible for group health insurance through their current employer are typically not eligible for coverage under the PEBP Plan. If your domestic partner's employer sponsored health coverage satisfies PEBP's definition of "Significantly Inferior Coverage" and you comply with the items listed in the Exception paragraph listed below, you may be able to enroll or continue your domestic partners coverage under PEBP. The definition of "Significantly Inferior Coverage" is provided in the *definition section* of this document.

The Plan requires a copy of the domestic partnership certification, and completion of the online enrollment or through the submission of a paper enrollment form declaring that the domestic partner is not eligible for an employer group health plan. By completing an enrollment election, the participant acknowledges their responsibility for any federal income tax consequences

resulting from the enrollment of the domestic partner in the Plan. A domestic partner is not an eligible dependent after dissolution of the domestic partnership. Participants who have a legal union or domestic partnership validly formed in another jurisdiction which is substantially equivalent to a domestic partnership in Nevada, are not required to file with, or provide a certification from the Nevada Secretary of State.

PEBP requires the participant to provide an official summary of the coverage details from the employer of their spouse/domestic partner outlining all health insurance coverage plans available to their employees. PEBP has the authority to determine if the spouse's/domestic partner's employer sponsored health plan meets the definition of "Significantly Inferior Coverage."

Your Children/Stepchildren

A participant's children, stepchildren, or children of their domestic partner, under age 26 years, are eligible for coverage on:

- The day the participant becomes eligible for coverage, or
- The day the participant acquires the eligible dependent by birth, adoption, or placement for adoption, or
- The first day of the month concurrent with or following the date of the participant's marriage or certification of domestic partnership, or
- The first day of the month concurrent with or following the loss of coverage through an employer group health plan.

A dependent of two PEBP participants cannot be covered under more than one PEBP medical Plan at the same time.

To enroll a dependent child(ren), the participant must submit an enrollment election online or paper form.

In the case of a stepchild or domestic partner's child, a certified marriage certificate or certification of domestic partnership will also be required. Participants who have a legal union or domestic partnership validly formed in another jurisdiction which is substantially equivalent to a domestic partnership in Nevada, are not required to file with, or provide a certification from the Nevada Secretary of State.

Dependent children are terminated from coverage on:

- The date of termination of the participant's coverage.
- The end of the month in which a dependent child under permanent legal guardianship turns age 19 years.
- The end of the month in which the dependent child reaches age 26 unless proof of disabled dependent child status has been provided to and approved by PEBP.
- For stepchildren, the end of the month for the date of dissolution of marriage or domestic partnership.

A dependent child under the age of 26 years who is covered as a dependent on his or her parent's PEBP Plan, and who later becomes eligible for their own PEBP coverage as a primary PEBP participant, may decline primary coverage as an active employee and retain coverage as a dependent on his or her parent's plan; or the newly eligible employee (dependent) may enroll in their own coverage as a primary PEBP participant.

A child who enrolls as a primary participant or who is defaulted as a primary participant will be removed as a dependent from their parent's PEBP coverage.

For more information, refer to the applicable sections in this document.

Your Newborn Child(ren)

The newborn dependent child(ren) of a PEBP participant will automatically be covered under a PEBP medical Plan option from the date of birth to 31 days following the date of birth (referred to as the initial coverage period) per NRS 689B.033. If the newborn is covered under more than one health insurance plan, the PEBP Plan reserves the right to coordinate benefits as stated in the Coordination of Benefits section of the PEBP Consumer Driven Health Plan, Low Deductible PPO Plan, and EPO Plan Master Plan Documents or HMO Evidence of Coverage Certificate (as applicable).

When the member has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days ([NRS 689B.033](#)). Individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.

To continue coverage beyond the initial coverage period, enrollment must be completed within 60 days of the newborn's date of birth. A copy of the child's hospital birth confirmation will be required within the first 60 days to add the child, followed by a copy of the child's certified birth certificate and social security number within 120 days following the date of birth. A newborn dependent child may not be enrolled for coverage unless the participant is also enrolled for coverage. If newborn enrollment is not completed within 60 days of the date of birth, coverage of the newborn will end 31 days after the child's date of birth. If all supporting documentation for the newborn is not received within the required timeframe(s) the dependent newborn coverage will terminate at the end of the month the documents were due. Under no circumstances shall a newborn child have dual coverage under two PEBP plans. If the mother and father of the newborn are both primary participants under PEBP, the participant who elects to continue coverage for the newborn after the initial 31-day period shall be deemed to have covered the newborn since the date of birth.

Your Adopted Dependent Children

[Pursuant to NRS 689B.033, PEBP includes coverage for members' adopted children and children placed with a member for purpose of adoption.](#)

A newborn child who is adopted or placed for adoption may be covered ~~from the effective the~~ date of 1) adoption, or 2) placement for adoption~~birth~~, if the employee ~~is enroll~~sed in coverage and enrolls the newborn within 60 days of the date of the adoption or placement for adoption

and submits any required supporting documents, (e.g., legal adoption or placement for adoption papers as certified by the public/private adoption agency, copy of the certified birth certificate, and the child's social security number). PEBP will also require a copy of the court order for adoption, signed by a judge within 6 months of the adoption date.

A dependent child who is adopted or placed for adoption more than 60 days after the child's date of birth will be covered from the 1st day of the same month that the child is adopted or placed for adoption, whichever is earlier. To add the dependent, PEBP will require the enrollment request within 60 days of the adoption or placement for adoption and any required supporting documents (e.g., legal adoption or placement for adoption papers as certified by the public/private adoption agency, copy of the certified birth certificate, and the child's social security number).

A child is placed for adoption on the date the participant first becomes legally obligated to provide full or partial support of the child. However, if a child is placed for adoption and the adoption does not become final, coverage of that child will terminate on the last day of the month that the participant no longer has a legal obligation to support the child. PEBP must be notified of the ineligibility for dependent coverage.

Legal Guardianship

Unmarried children under age 19 who are under a legal permanent guardianship may be enrolled as dependents. To continue coverage after age 19 (to age 26), the child must be unmarried and either reside with the participant or be enrolled as a full-time student at an accredited institution and satisfy the following conditions:

- Is eligible to be claimed as a dependent on the federal income tax return of the participant or his spouse/domestic partner for the preceding calendar year; and
- Dependent is a grandchild, brother, sister, stepbrother, step-sister, or descendent of such relative.
- Children covered under legal guardianship are not eligible to continue benefits under the provision of a disabled dependent.

The IRS allows the premiums for coverage of a person under age 19 (24 if a full-time student) to be paid on a pre-tax basis (excluded from gross income) if certain criteria are met. If the criteria are met, the coverage will be provided on a pre-tax basis. If they are not met, or the dependent is over age 24 as of the end of the calendar year, the subsidies associated with the coverage of the dependent are taxable and the payroll deductions must be done after income tax is calculated. If the subsidies are deemed taxable, they will be included as income on an employees' Form W-2.

Children under a temporary guardianship are **not** eligible for coverage as a dependent under the PEBP Plan.

Disabled Dependent Child

To cover a dependent child with a disability and who is 26 years old or older requires that the dependent has maintained continuous medical coverage with no break in service and the completion of the *Certification of Disabled Dependent Child Form* by the participant and the child's physician. To be eligible for coverage, the physician must diagnose the child as having a mental or physical impairment causing incapability of self-sustaining employment and depending chiefly on the participant and/or participant's spouse for support and maintenance. Evidence of disability must be provided within 30 days after the child reaches age 26 years (NAC 287.312(1)(d)). The Plan will require proof of support and maintenance through the submission of a copy of the preceding year's income tax return showing the child was or could have been claimed as a tax dependent in compliance with the IRS Code 152 (a) without regard to the gross income test.

If the dependent is not deemed permanently disabled, PEBP will require proof of continuing disability once each year. PEBP reserves the right to have the child examined by a physician of PEBP's choice and at the Plan's expense to determine that the child meets the definition of a dependent child with a disability.

Children covered under legal guardianship are not eligible to continue benefits under this provision.

Grandchildren

Grandchildren are not eligible for coverage unless they are adopted or qualify under permanent legal guardianship. Please refer to the *Guardianship* section of this document for more information.

Foster children

Foster children are not eligible for dependent coverage.

Survivors

Surviving dependents include a participant's spouse or domestic partner and dependent children to age 26 years (or to age 19 years for child(ren) under permanent legal guardianship) who are covered under the participant's medical Plan on the date of the participant's death.

Coverage for a surviving dependent(s) will end on the last day of the month of the participant's death. Surviving dependent(s) who meet the eligibility provisions to re-enroll as a surviving dependent(s) have the option to continue coverage as a surviving dependent(s). To re-enroll as an eligible surviving dependent(s), the surviving dependent(s) must re-enroll by submitting an enrollment election within 60 days of the date of death of the employee or retiree.

Surviving dependents are not eligible for a years of service premium subsidy or years of service Medicare Exchange HRA contribution or basic life insurance coverage.

Survivors of Active Employees

If an active employee dies with 10 or more years of service credit, the employee's covered dependent(s) are eligible to continue current PEBP Plan coverage as surviving dependent(s). Any dependent not enrolled for coverage on the date of the participant's death, is not eligible to enroll for coverage as a survivor. A surviving spouse may not enroll dependent children who were not covered on the date of the participant's death. Surviving dependents include an employee's covered spouse or domestic partner and child(ren) to age 26 years (or to age 19 years for a child under permanent legal guardianship) on the date of the employee's death. If an active employee dies with less than 10 years of service credit, any covered dependents will be offered 36 months of COBRA coverage.

A surviving dependent child shall pay the surviving/unsubsidized spouse rate if there is no surviving spouse or the surviving spouse declines coverage.

Survivors of Retirees

Survivor dependent(s) of retirees who were covered on the date of the retiree's death have the option either to continue or cancel PEBP coverage. Any dependent that is not enrolled at the time of the retiree's death will not be eligible to enroll as a survivor. A surviving spouse may not enroll dependent children who were not covered on the date of the retiree's death.

Survivors of Police Officer or Firefighter Killed in the Line of Duty

Pursuant to [NRS 287.0477](#), the surviving spouse and any surviving child of a police officer or firefighter who was employed by a participating public agency and who was killed in the line of duty may join or continue coverage under PEBP if the police officer or firefighter was eligible to participate on the date of the death of the police officer or firefighter. If the surviving dependent elects to join or discontinue coverage under the PEBP pursuant to this section, the dependent or legal guardian of the dependent must notify the participating public agency that employed the police officer or firefighter in writing within 60 days after the date of death of the police officer or firefighter.

The participating public agency that employed the police officer or firefighter shall pay the entire cost of the premiums or contributions to the Public Employees' Benefits Program for the surviving dependent who meets the requirements. The State will pay the entire cost of the premiums or contributions to the PEBP for the surviving dependent(s) of a police officer or firefighter.

A surviving spouse is eligible to receive coverage pursuant to this section for the duration of the life of the surviving spouse. A surviving child is eligible to receive coverage pursuant to this section until the child reaches age 26 years. (A surviving child under permanent guardianship of deceased police officer or firefighter killed in the line of duty is eligible for coverage to age 19 years.)

Unsubsidized Dependents Covered under a PEBP Plan

An unsubsidized dependent is an otherwise eligible spouse/domestic partner or dependent child who remains covered under PEBP while the primary Plan participant transitions medical coverage to the Medicare Exchange.

Termination of a retiree's coverage through the Medicare Exchange will result in the termination of any unsubsidized dependents. See *Survivors of Retirees* for exceptions to this provision.

Unsubsidized dependents enrolled in the CDHP, EPO Plan, LD PPO, or HMO Plan can decline their coverage at any time (coverage ends the last day of the month of notification).

Unsubsidized Dependents Covered under the Medicare Exchange

An unsubsidized dependent is an otherwise eligible spouse/domestic partner who transitions to the Medicare Exchange and elects PEBP dental coverage, while the primary Plan participant remains covered under a PEBP Plan. See *Survivors of Retirees* for exceptions to this provision.

Termination of a primary participant's coverage will result in termination of the unsubsidized dependent.

Unsubsidized dependents enrolled in the Medicare Exchange with PEBP dental coverage can decline their coverage at any time (coverage ends the last day of the month of notification).

Retirees with Tricare for Life and Medicare Parts A and B

Retirees who are otherwise eligible for the Health Reimbursement Arrangement (HRA) and who have Tricare for Life and Medicare Parts A and B are not required to enroll in a medical plan through the Medicare Exchange. To receive the monthly HRA contribution, PEBP will require a copy of the Tricare for Life military ID card (front and back) and a copy of the retiree's Medicare Parts A and B card. The required documents must be submitted to PEBP within 60 days of the Medicare Parts A and B effective date, or within 60 days of the retirement date of the employee, whichever date is later. Retirees enrolled in Tricare for Life and Medicare Parts A and B and a medical plan through the Medicare Exchange may disenroll from the Medicare Exchange without experiencing a qualifying life status change or waiting for the Open Enrollment period.

If Tricare and Medicare cards are not received within this timeframe, the only other time to apply for Tricare coverage is during the open enrollment period with an effective date of July 1.

Dental Eligibility

When an eligible retiree is covered through Medicare, dependent children are not eligible for PEBP Dental coverage. Only primary retiree, spouse, domestic partners, surviving spouse or domestic partners, and unsubsidized spouse or domestic partners are eligible for PEBP Dental coverage.

PEBP Open Enrollment is the only opportunity (besides initial enrollment) to enroll or decline PEBP's retiree dental-only coverage. If you would like to enroll or change your PEBP dental coverage, complete the Retiree Benefit and Enrollment Change Form and mail to PEBP or use the secure document upload form on our Contact Us page.

When Coverage Begins

Active Employees

New Hire, Reinstated, and Rehired Employees

New Hire, Reinstated, and Rehired employees are eligible for coverage on the first day of the month concurrent with or following the date of hire.

Elected Officials

Pursuant to NRS 287.045-(4), a member of the Senate or Assembly is eligible on a) the first day of the initial term of office of the member, if that date is the first day of the month; or b)–the first day of the month immediately following the first day of the initial term of office of the member.

Retirees

A retiree must enroll in a PEBP-sponsored medical Plan within 60 days of their retirement date as determined by the Public Employees' Retirement System (PERS) or NSHE.

Retiree Premium Subsidy or Exchange HRA Contribution for certain employees initially hired on or after January 1, 2010

Employees working for a PEBP participating agency with an "initial date of hire" on or after January 1, 2010, but prior to January 1, 2012, and who subsequently retire with less than 15 years of service are eligible to elect retiree coverage but will not qualify for a subsidy or Exchange HRA contribution unless the retirement occurs under a long-term disability plan.

Except for persons to whom NRS 287.043 applies, the initial date of hire is defined by NAC 287.059 as the first date on which service credit is earned by a participant during the participant's last period of continuous employment with a public employer, as determined by PERS or NSHE.

Continuous employment as defined by NAC 287.021 includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more.

Retiree Years of Service Premium Subsidy or Exchange HRA Contribution for Employees Initially Hired with a PEBP Participating Agency on or after January 1, 2012

- Employees of a State agency, judges, professional (contracted) employees of the Nevada System for Higher Education, legislators, and employees of participating local government entities with an initial date of hire on or after January 1, 2012, may participate in the program, but will not be eligible for a years of service premium subsidy or Medicare Exchange HRA contribution upon retirement.
- Eligibility for a subsidy at retirement is based on the initial date of hire as defined by NAC 287.059 as the first date on which service credit is earned by a participant during the participant's last period of continuous employment with a public employer (as determined by PERS or NSHE). Continuous employment (defined by

NAC 287.021) includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more.

- Pursuant to NRS 287.046 (8), this section does not apply to a person who was employed by the State on or before January 1, 2012, who has a break in service and returns to work for the State at the same or another participating State agency after that date, regardless of the length of the break in service, so long as the person did not withdraw their retirement from PERS and was eligible to participate in the Public Employees' Retirement System (PERS) or the retirement plan alternative for the Nevada System of Higher Education (NSHE) before or during the break in service.

State Retirees

Retirees whose last employer is a State agency, NSHE, PERS, the Legislature, Legislative Counsel Bureau or a State Board or Commission are considered State retirees.

Non-State Retirees

Retirees whose last employer is a non-State public entity are considered non-State retirees. Non-State retirees are eligible to join PEBP only if their last employer is a participating local government entity (a local government that is contracted with PEBP to provide coverage to their active employees pursuant to NRS 287.025). If the participating local government entity leaves the PEBP Plan, the entity's retirees will also be dis-enrolled unless the retiree was covered under PEBP as a retiree continually since November 30, 2008. Retirees who were covered under PEBP as a retiree on November 30, 2008, and continually since then may remain covered under PEBP if they continue to pay their premiums.

Retiree Coverage Information

EXAMPLE	<u>Termination Date</u>	<u>Retirement Date</u>	<u>Retiree Health Benefit Start Date</u>	<u>Benefit Impact</u>
	<u>May 30th</u>	<u>May 31st</u>	<u>June 1st</u>	<u>NO BREAK IN COVERAGE</u>
	<u>May 31st</u>	<u>June 1st</u>	<u>June 1st</u>	
	<u>Because the retirement occurred immediately after the termination date, with no gap, there is no break in coverage.</u>			
	<u>May 30th</u>	<u>June 3rd</u>	<u>July 1st</u>	<u>BREAK IN COVERAGE</u>
	<u>Generally, when a termination/separation date and retirement date occur in different months with a gap, you 1) will be offered COBRA coverage or 2) will have a break in coverage & loss of PEBP benefits.</u>			

Dependents

Benefit Coverage for any Eligible Dependent is effective on:

- The day an employee or retiree becomes eligible and enrolled for medical coverage,
- The day an employee or retiree acquires and enrolls eligible dependent by birth, adoption, placement for adoption, or
- The first day of the month following a request for enrollment due to a qualifying event.

Eligible Dependents may be Enrolled if:

- Benefit coverage is in effect for the active employee or retiree on that day;
- Any required supporting documents are received in the PEBP office:
 - within 60 days of the qualifying event date (for example: certified birth certificate, certified marriage certificate, etc.); or
 - Within 30 days following the last day of open enrollment; or

Covered dependents must be enrolled in the same medical plan option as the employee or retiree except as described in the *Coverage Options for Individuals with Medicare* section. Eligible dependents include a spouse, domestic partner, and/or dependent child(ren) (as defined in the *Definitions* section of this document). Anyone who does not qualify as a covered dependent has no right to any benefits or services under this Plan. Any retiree covered through the Medicare Exchange will have the option to enroll in the CDHP, Low Deductible, or EPO Plan, or HMO Plan when a non-Medicare eligible dependent is enrolled, subject to the rules described in the *Coverage Options for Individuals with Medicare* section and the rules of the Plan chosen through the Medicare Exchange.

When Coverage Ends

In Case of Death

In cases of death, coverage ends on the date of death of the employee, retiree, surviving spouse, or dependent. Dependent coverage ends on the last day of the month of the primary insured death.

Active Employees

For an active employee, coverage ends on the last day of the month in which:

- Employment ends.
- Employment contract ends.
- Employee is no longer eligible to participate in the Plan.
- The last day of the Plan Year if the employee declines coverage during open enrollment.
- Premium payment was last received (see *Termination for Non-Payment*); or
- The Plan is discontinued.

Elected Officials

Elected officials coverage ends on the last day of the month in which :

- They are no longer eligible to participate in the Plan.
- The last day of the Plan Year if they decline coverage during open enrollment.
- Premium payment was last received (see *Termination for Non-Payment*); or
- The Plan is discontinued.

Retirees

Retiree coverage ends on the last day of the month in which:

- The retiree no longer meets the definition of a retiree.
- PEBP received notification, generally in writing, of voluntary declination of coverage.
- Premium payment was last received (see *Termination for Non-Payment*).
- If a retiree is covered under a medical plan through the Medicare Exchange, coverage ends on the last day of the month preceding coverage through the Medicare Exchange; or
- The Plan is discontinued.

Dependents

Dependent coverage ends on the last day of the month in which:

- The active employee or retiree coverage ends.
- The covered spouse, domestic partner, or dependent child(ren) no longer meet the definition of spouse, domestic partner, or dependent child(ren) as provided in the *Definitions section* of this document.

- Premium payment was last received (see *Termination for Non-Payment*);
- Dependent is covered under a medical plan through the Medicare Exchange; or
- The Plan is discontinued.

Surviving Spouse/Domestic Partner of a Retiree

Coverage for a surviving spouse/domestic partner of a retiree ends on the last day of the month in which:

- PEBP received notification of voluntary declination of coverage;
- Premium payment was last received (see *Termination for Non-Payment*);
- If the surviving spouse/domestic partner is covered under a medical plan through the Medicare Exchange, coverage ends on the last day of the month preceding coverage through the Medicare Exchange; or
- The Plan is discontinued.

Unsubsidized Dependent

Coverage for an unsubsidized dependent will end on the last day of the month in which:

- The covered dependent no longer meets the definition of dependent as provided in the *Definitions section* of this document.
- Premium payment for the primary plan participant or the covered dependent was last received;
- PEBP received notification; or
- The Plan is discontinued.

Dependent Children of a Surviving Spouse or Domestic Partner of a Retiree

Coverage for dependent children of a surviving spouse or domestic partner of a retiree ends on the last day of the month in which:

- The covered dependent child(ren) no longer meets the definition of dependent child(ren) as provided in the *Definitions section* of this document.
- Premium payment was last received (see *Termination for Non-Payment*); or
- The Plan is discontinued.

Notice to the Plan When a Dependent Ceases to be Eligible for Coverage

An employee, spouse/domestic partner, or any dependent child(ren) must notify the Plan no later than 60 days after the date:

- Of a divorce or dissolution of a domestic partnership.
- On which a dependent child ceases to meet the definition of dependent as defined in the *Definitions section* of this document; or
- On which a dependent child over age 26 years ceases to have a physical or mental impairment where the child no longer has a disability.

Failure to give such a notification within 60 days will cause the spouse/domestic partner, and/or dependent child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a dependent child with a disability to end when it otherwise might continue. For information regarding other notices that must be furnished to the Plan, see *Qualifying Events*.

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Qualified Medical Child Support Orders (QMCSO), or National Medical Support Notice (NMSN),
or Court Orders

Qualified Medical Child Support Orders (QMCSO), ~~or~~ National Medical Support Notice (NMSN), or Court Orders

PEBP follows the U.S. Department of Labor, Employee Benefits Security Administration publication on Qualified Medical Child Support Orders or its most current revision: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/qualified-medical-child-support-orders.pdf>.

The Plan Administrator shall enroll for immediate coverage under this Plan any child who is the subject of a ~~QMCSO~~ QMCSO, NMSN, or court order if such child is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) shall mean a notice that contains the following information:

- Name of the issuing authority.
- Name and mailing address (if any) of an individual who is eligible for coverage as a primary participant under the Plan, whether they are enrolled or in declined coverage status.
- Name and mailing address of one or more alternate recipients (i.e., the child or children of the participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipient(s)); and
- Identity of an underlying child support order.

According to federal law, a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) is a child support order of a court or state administrative agency that:

- Designates one parent to pay for a child's health plan coverage.
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO/NMSN.
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the way such type of coverage is to be determined; and
- States the period for which the QMCSO/NMSN applies.

An order is not a QMCSO/NMSN if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not eligible for coverage by the Plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO/NMSN, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

Upon receiving a QMCSO/NMSN, the Plan Administrator shall:

- Notify the issuing authority with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
 - Whether the child is covered under the Plan; and
 - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

If the employee is a Plan participant, the QMCSO/NMSN may require the Plan to provide coverage for the employee's dependent child(ren). If the employee is covered by a medical plan option that will not cover the dependent child(ren) specified in the QMCSO/NMSN (for example, the child lives outside an EPO Plan or HMO coverage area), the participant will be enrolled in the base plan option that allows compliance with the QMCSO/NMSN. Coverage under the new medical plan option begins on the first day of the month following receipt of the QMCSO/NMSN in the PEBP office and may not be reverted until the next open enrollment period.

If the QMCSO/NMSN orders a covered employee to provide coverage for the dependent child(ren) named in the QMCSO/NMSN, PEBP will enroll the dependent child(ren) specified in the QMCSO/NMSN. If the employee is in declined coverage status, but is otherwise eligible for coverage, PEBP will enroll the employee and the dependent child(ren) specified in the QMCSO/NMSN in an appropriate medical plan option to cover the employee and the dependent child(ren). Coverage will become effective on the first day of the month concurrent with or following the date the QMCSO/NMSN is received by PEBP.

Coverage of the dependent child(ren) named in the QMCSO/NMSN will be subject to all terms and provisions of the Plan, including limits on selection of provider and requirements for authorization of services, as permitted by applicable law. No coverage will be provided for any dependent child under a QMCSO/NMSN unless the employee (as applicable) and dependent contributions are paid, and all the Plan's requirements for coverage of that dependent child have been satisfied. Coverage of a dependent child under a QMCSO/NMSN will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any required contributions, subject to the dependent child's right to elect COBRA continuation coverage if that right applies. Refer to the *COBRA section* for information on the dependent's right to elect COBRA, if applicable.

If the dependent listed on the QMCSO/NMSN is covered under another PEBP Plan participant, the dependent will be dropped from the non-QMCSO/NMSN participant's Plan and added to the QMCSO/NMSN participant's Plan.

Qualified Medical Child Support Orders (QMCSO), or National Medical Support Notice (NMSN),
or Court Orders

If a QMCSO/NMSN is rescinded the participant has the option to continue coverage for the dependent(s) or remove the dependent(s). If the participant would like to remove the dependent(s), coverage will end at the end of the month of receipt of the order. The primary participant must continue coverage under the same medical Plan until the next open enrollment period.

Any dispute over terms of a QMCSO/NMSN must be appealed directly to the issuing child support enforcement agency.

Court Orders

If a court or state administrative agency has issued an order with respect to health care coverage for any dependent child of an employee, PEBP will determine if that order is a QMCSO/NMSN as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. PEBP will notify the parents and each child if an order is determined to be a QMCSO/NMSN and if the employee is covered by the Plan and advise them of the procedures to be followed to provide coverage of the dependent child(ren).

Restoration of Benefits by a Hearing Officer

Restoration of health care coverage when included in the decision of a hearing officer will be implemented as follows:

1. If health care coverage was provided to the employee and their eligible dependents under the CDHP, LD PPO Plan or EPO Plan coverage will be restored retroactively to the date specified by the hearing officer. Any retroactive health insurance subsidy due from the agency will be paid to PEBP. Any retroactive health insurance premiums due from the employee will be paid by the employee to PEBP within 60 days of the hearing officer's decision. The amount due to PEBP will be determined by PEBP.
 - a. Restoration of coverage will comply with NRS 287, NAC 287 and this Master Plan Document.
 - b. Upon restoration of coverage, PEBP will notify its third-party administrator, pharmacy benefits manager, life insurance vendor and any other applicable vendors of the restoration of coverage.
 - c. If the employee and/or their eligible covered dependents incurred medical, dental, vision or prescription drug expenses, PEBP will assist the employee with obtaining reimbursement for the eligible health care expenses.
2. If health care coverage was provided to the employee and their eligible dependents under the PEBP-sponsored Health Maintenance Organization (HMO), coverage will be restored retroactive to a date not to exceed six (6) months prior to PEBP's receipt of the notice from the hearing officer. Any retroactive health insurance subsidy amounts due to PEBP by the employee's agency will be paid to PEBP by the agency. Any retroactive health insurance premiums due to PEBP by the employee will be paid by the employee to PEBP within 60 days of the hearing officer's decision. The amount due to PEBP will be determined by PEBP.
3. If an employee chooses not to proceed with a retroactive effective date for health insurance coverage, coverage shall be reinstated on the first day of the month following the hearing officer's decision.
4. Coverage will be restored to the same coverage that was in place before the suspension of benefits. If a new Plan Year intervenes, the employee will be allowed to indicate the desired coverage retroactive to the beginning of the new Plan Year.
5. Any premiums associated with voluntary insurance products are the employee's responsibility.

PEBP and Medicare

Premium Free Medicare Part A

Retirees and their covered dependents who are eligible for premium free Medicare Part A are required to enroll in premium free Medicare Part A coverage.

Most people aged 65 years or older who are citizens or permanent residents of the United States are eligible for premium free Medicare hospital insurance (Part A).

You are eligible for premium-free Medicare Part A if:

- You receive or are eligible to receive Social Security benefits; or
- You receive or are eligible to receive railroad retirement benefits; or
- You or your spouse (living or deceased, including divorced spouses to whom you were married at least 10 years) worked long enough in a job where Medicare taxes were paid.

To determine your eligibility for premium-free Medicare Part A, contact the Social Security Administration (SSA) approximately three months before your 65th birthday.

Premium Free Medicare Part A Enrollment Timeframe

Retirees and/or their covered dependents who are eligible for premium free Medicare Part A are required to enroll in Part A coverage three months prior to their 65th birthday.

Disabled retirees and/or their covered dependents who are eligible for Social Security disability insurance must enroll in premium free Medicare Part A and purchase Medicare Part B coverage.

You must submit a copy of your Medicare card indicating your effective date with Part A and Part B to the PEBP office as follows:

- For birthdays occurring on the first day of the month, your Medicare card must be received no later than the last day of the month the individual turns 65.
- For birthdays NOT occurring on the first day of the month, your Medicare card must be received no later than the last day of the month, following the 65th birthday month.
- For newly retiring employees, your Medicare card must be received within 60 days of the retirement coverage effective date.
- Disabled retirees and/or their covered dependents who are entitled to Social Security disability benefits must enroll in premium-free Medicare Part A and purchase Medicare Part B coverage and submit a copy of their Medicare card to PEBP within 60 days of their Medicare effective date.

If you are not eligible for Premium Free Medicare Part A

If you are not eligible for premium free Medicare Part A, PEBP will require a copy of the Medicare benefit verification letter, sometimes referred to as a Medicare Award letter from Social Security. This letter will indicate that you are not eligible for premium free Medicare Part A. Retirees who

are not eligible for premium free Medicare Part A may remain on the PEBP CDHP, LD PPO, EPO Plan or HMO Plan.

You must submit a copy of the Medicare benefit verification letter/Medicare Award letter to the PEBP office as follows:

- For birthdays occurring on the first day of the month, a copy of the benefit verification letter/Medicare Award letter must be received no later than the last day of the month the individual turns 65.
- For birthdays NOT occurring on the first day of the month, a copy of the benefit verification letter/Medicare Award letter must be received no later than the last day of the month, following the 65th birthday month.
- For newly retiring employees, a copy of the benefit verification letter/Medicare Award letter must be received within 60 days of the retirement coverage effective date.

NOTE: Failure to provide PEBP with the required documentation will result in termination of coverage for the retiree and any covered dependents. This will result in a break in coverage and may impact your retiree benefits.

Medicare Part B

Retirees and dependents of retirees who are eligible for Medicare Part B are required to purchase and maintain Medicare Part B. Eligibility is determined by the Social Security Administration. Contact the Social Security Administration to inquire about purchasing Medicare Part B. Failure to provide proof of Medicare Part B enrollment (through the submission of the individual's Medicare card) will result in termination of coverage.

If you are a retiring active employee (or a dependent of a retiring active employee) eligible for Medicare, you will be required to purchase and maintain Medicare Part B.

If you are a retiree or dependent of a retiree under age 65 years and are eligible for ~~Medicare~~ Medicare, as determined by the Social Security Administration, this Plan requires you to purchase Medicare Part B and provide a copy of your Medicare card to PEBP indicating that you have both Medicare Parts A and B.

When a retiree or a retiree's covered spouse is eligible for Medicare Part B, this Plan will always be secondary to Medicare Part B. If a retiree or spouse of a retiree is eligible for but not enrolled in Medicare Part B, this Plan will estimate Medicare's Part B benefit. The Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. The Plan will only consider the remaining 20% of Medicare Part B expenses.

A copy of the Part B card must be submitted to the PEBP office as follows:

- For birthdays occurring on the first day of the month, the Part B card must be received no later than the last day of the month when the individual turns 65 years of age.

- For birthdays NOT occurring on the first day of the month, the Part B card must be received no later than the last day of the month, following the 65th birthday month.
- For retirees and covered dependents under age 65 who become eligible for Medicare as determined by the Social Security Administration, proof of Medicare Part B enrollment must be received within 60 days of the effective date.
- For newly retiring employees eligible for Medicare at retirement, the Part B card must be received within 60 days of the retirement coverage effective date.
- Disabled retirees and/or their covered dependents who are entitled to Social Security disability benefits must enroll in premium-free Medicare Part A and purchase Medicare Part B coverage and submit a copy within 60 days of Medicare effective date.

NOTE: For retirees, failure to provide proof of Medicare Part B coverage within 60 days of the coverage effective date or retirement date will result in termination of PEBP coverage.

Retirees eligible for premium free Medicare Part A are required to purchase Medicare Part B, enroll in a medical plan, and maintain medical coverage through the Medicare Exchange to receive a years of service Health Reimbursement Arrangement (HRA) contribution (if applicable).

Exceptions:

- Retirees who are eligible for premium-free Medicare Part A and who have purchased Medicare Part B coverage and who cover a non-Medicare dependent(s) may enroll in a:
 - PEBP Plan with the non-Medicare dependent(s) until covered dependents become Medicare eligible.
- Retirees who permanently reside outside the United States may remain on a PEBP Plan.

Medicare Retirees Covered through the Medicare Exchange

Retirees who are eligible for premium-free Medicare Part A must enroll in a medical plan through the Medicare Exchange no later than the last day of the month, following the Medicare Part A and B effective date, or no later than the end of the month following the date of retirement, whichever occurs later.

Contributions to a retiree's Health Reimbursement Arrangement through the Medicare Exchange will become effective concurrent with the retiree's medical plan effective date through the Medicare Exchange.

Dependents are not eligible for a Health Reimbursement Arrangement contribution through the Medicare Exchange.

Medicare Retirees Covered under the Medicare Exchange who have break in coverage

Retirees who experience a break in medical coverage or who terminate medical coverage through the PEBP-sponsored Medicare Exchange will also terminate the years of service HRA

contribution, PEBP dental coverage, basic life insurance, and voluntary life insurance (if applicable). See the *Retiree Late Enrollment* section for re-enrollment rights.

Retirees that elect PEBP dental and fail to pay dental premiums will be subject to forfeiture of PEBP dental benefits and retroactive termination of PEBP dental to the last day of the month the dental premium was received.

Medicare Retirees Not Eligible for Premium Free Medicare Part A

Retirees who are not eligible for premium-free Medicare Part A and who purchase Medicare Part B and/or cover one or more non-Medicare eligible dependents may remain on the PEBP CDHP, LD PPO, EPO Plan, or HMO Plan.

A retiree/survivor covered under the PEBP CDHP, LD PPO, EPO Plan, or HMO that experiences a qualifying event that changes their eligibility status to participant only, must enroll in a medical plan through the Medicare Exchange.

Medicare Part B Premium Credit

Retirees who are covered under the PEBP CDHP, LD PPO, EPO Plan, or HMO and who have Medicare Part B will receive a premium credit in an amount determined by PEBP. Dependents are not eligible for the Part B premium credit.

The premium credit will apply concurrent with the Medicare Part B effective date or the first of the month concurrent with or following PEBP's receipt of the retiree's Medicare Part B card, whichever is later.

[Eligibility for the Medicare Part B Premium credit is subject to NRS 287.046.](#)

Retiree Years of Service Benefit

Years of Service Eligibility

Retirees eligible for a subsidy ([NAC 287.485](#)) must submit a Years of Service Certification Form with the appropriate enrollment documents.

Retirees who retired prior to January 1, 1994, receive a premium subsidy or HRA contribution equal to the base amount or 15 years of service.

Retirees who retired on or after January 1, 1994, receive a premium subsidy or HRA contribution based on the sum of the total years and months of service credit earned from all Nevada public employers, excluding purchased service (minimum 5 years; maximum 20 years).

Employees with an initial date of hire on or after January 1, 2010, but prior to January 1, 2012, and who retire with less than 15 years of service are eligible for PEBP retiree coverage. These retirees will not qualify for a subsidy or a retiree HRA contribution unless they retire under a long-term disability plan.

Initial date of hire is defined by [NAC 287.059](#) as “the first date on which service credit is earned by a participant during the participant’s last period of continuous employment with a public employer, as determined by the appropriate certifying agency.” Continuous employment, as defined by [NAC 287.021](#), includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more.

Employees with an initial date of hire on or after January 1, 2012, may continue to participate in the program but will not be eligible for any subsidy or Exchange HRA contribution upon retirement. The retiree will have to pay the entire premium or contribution for the coverage selected.

Years of Service Premium Subsidy

Retired public employees enrolled in the CDHP, LD PPO, EPO Plan, or HMO Plan may qualify for a premium subsidy based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employee. For more information on retiree years of service premium subsidy, refer to the Retiree Enrollment Guide available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Years of Service HRA Contribution for Medicare Retirees Enrolled in a Medical Plan through the Medicare Exchange

Retired public employees enrolled in a medical plan through Medicare Exchange may qualify for an HRA contribution based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employer. For more information on retiree years of service HRA contribution, please refer to the years of service contribution table located on the PEBP website at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/).

Health Reimbursement Arrangement for Retirees Covered Through the Medicare Exchange

The Medicare Exchange HRA accounts are employee-owned accounts established on behalf of eligible retirees covered in a medical plan through the Medicare Exchange.

The Medicare Exchange HRA funds can be used to pay for qualified medical expenses as defined by the IRS including medical plan premiums. Funds placed in the Medicare Exchange HRA for a retiree's use are based on the years of service of the retiree. Dependents and surviving dependents are not eligible to have an Exchange HRA. For more information see Publication 502 at www.irs.gov.

For more information regarding uses, contribution amounts, and other rules, see the Medicare Exchange HRA Summary Plan Document available on the PEBP website.

Medicare Exchange HRA Contribution Eligibility

To receive the PEBP HRA contribution, an eligible retiree must enroll in and maintain coverage through the PEBP-sponsored Medicare Exchange. If the eligible retiree does not enroll and maintain medical coverage as described above, the eligible retiree will NOT receive the PEBP HRA contribution amount and will lose their PEBP sponsored benefits entirely. For re-enrollment eligibility and information, please see the *Retiree Late Enrollment* section for re-enrollment rights.

NOTE: *This policy does not apply to eligible retirees who have health coverage under TRICARE for Life and Medicare. These individuals must submit a copy of their military ID card(s) to PEBP. PEBP will coordinate their enrollment with the HRA administrator.*

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Summary of Supporting Eligibility Documents

Dependent Type	Social Security Number	Marriage Certificate	Birth Certificate	Hospital Birth Confirmation	Adoption Decree Signed by a Judge	Certificate of Registered Domestic Partner	Legal Permanent Guardianship signed by a judge	Disabled Dependent Child aged 26 Years or Older
Newborn Child	✓		✓	✓				
Child Under Age 26	✓		✓					
Adoption	✓		✓		✓			
Permanent Legal Guardianship (child)	✓		✓				✓	
Stepchild	✓	✓	✓					
Domestic Partner's Child	✓		✓			✓		
Domestic Partner's Adopted Child	✓		✓		✓	✓		
Disabled Child	✓		✓					✓
Disabled Stepchild	✓	✓	✓					✓
Domestic Partner's Disabled Child	✓		✓			✓		✓
Spouse	✓	✓						
Domestic Partner	✓					✓		

- A complete notification also means a completed event when the member submits a request for changes. To complete an event/notification the required supporting documentation must be provided to PEBP within the specified timeframe.

- Failure to provide the required documentation within the specified timeframe will result in an incomplete event/notification that will void the change request.
- When adding a dependent, other dependents cannot be dropped for the same qualifying event.
- Enrollment of a newly acquired spouse, domestic partner, and/or dependent child(ren) must occur no later than 60 days after the date of the qualifying event.
- Employees in declined coverage status and who experience a change in number of dependents may opt to enroll in coverage mid-year if adding a newly acquired dependent.
- All foreign documents must be translated to English.

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Enrollment and Eligibility Events Quick Reference Table

<u>Enrollment and Eligibility Events Quick Reference Table</u>			
<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
<u>New Hire</u>	<u>No later than the last day of the month in which coverage is scheduled to become effective</u>	<u>Full-time employees are eligible for coverage on the first day of the month concurrent with or following the date of hire.</u>	<u>May add eligible dependent(s) in the family unit</u>
<u>Required Supporting Documents</u> <u>Spouse/domestic partner</u> ☐ <u>Social Security number of spouse or domestic partner</u> ☐ <u>Copy of the certified marriage certificate or domestic partnership certificate</u> <u>Dependent child(ren):</u> ☐ <u>Social Security number of child(ren)</u> ☐ <u>Copy of child(ren)'s certified birth certificate(s)</u> <u>Child(ren) under legal guardianship to age 19 years:</u> ☐ <u>Copy of legal guardianship papers (signed by a judge)</u> ☐ <u>Copy of certified birth certificate(s)</u> ☐ <u>Social Security number of child(ren)</u> ☐ <u>If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate recognized under Nevada law</u> <u>Stepchild(ren) and child(ren) of a domestic partnership:</u> ☐ <u>Copy of certified birth certificate(s)</u>			

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
☐ Social Security number of child(ren) ☐ A copy of the certified marriage certificate or domestic partnership			
<u>Newborn Child</u>	<u>Within 60 days of the event date</u>	<u>Newborn coverage is effective on the date of birth for the first 31 days, also known as the initial coverage period.</u> <u>Coverage for other dependent(s) is effective on the first day of the month concurrent with or following notification.</u>	<u>Participant shall enroll in coverage to cover the newborn.</u> <u>May add the newborn child and other eligible dependent(s) in the family unit.</u>
<u>Required Supporting Documents</u> ☐ Copy of the hospital's birth confirmation for the child (within 60 days of the date of birth) ☐ If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate (within 60 days of the date of birth) ☐ Child's Social Security number (within 120 days of the date of birth) ☐ Copy of child's certified birth certificate (within 120 days of the date of birth)			
<u>Adoption of a Child or Placement for Adoption of a Child</u>	<u>Within 60 days of the event date</u>	<u>Coverage effective on the date of adoption or placement for adoption for the first 31 days, also</u>	<u>Participant shall enroll in coverage to cover the adopted child.</u> <u>May add the designated adopted child(ren) and</u>

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
		<u>known as the initial coverage period.</u> <u>Coverage for a child adopted within 60 days of the child's date of birth becomes effective on 1) the date of adoption, or 2) placement for adoption.</u> <u>Coverage for other dependent(s) is effective on the first day of the month concurrent with or following notification</u>	<u>other eligible dependent(s) in the family unit.</u>
<u>Required Supporting Documents</u> ☐ <u>Within 2 months (60 days) of the adoption date:</u> <u>o Copy of initial legal adoption papers or placement for adoption (signed by a judge)</u> ☐ <u>Within 6 months (180 days) of the adoption date:</u> <u>o Final adoption papers (signed by a judge)</u> <u>o Child's Social Security number</u> <u>o A copy of the child's certified birth certificate</u>			

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
<u>Permanent Guardianship of a Child to Age 19</u>	<u>Within 60 days of the event date</u>	<u>Coverage effective on the first day of the month concurrent with or following notification.</u> <u>Coverage is provided only up to age 19 years</u> <u>Coverage for other dependent(s) is effective on the first day of the month concurrent with or following notification</u>	<u>May add the child(ren) to age 19 years and other eligible dependent(s) in the family unit</u>
<u>Required Supporting Documents</u> ☐ <u>Copy of legal guardianship papers (signed by a judge)</u> ☐ <u>Child's Social Security number</u> ☐ <u>Copy of certified birth certificate</u> ☐ <u>If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate</u>			
<u>Permanent Guardianship of Unmarried Child Aged 19 to Age 26 Currently Enrolled in a PEBP Plan</u>	<u>Within 60 days of the event date</u>	<u>Coverage continues to age 26 assuming child continues to meet eligibility requirements as set forth in Legal Guardianship Form</u>	<u>Not applicable</u>

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
		<u>Coverage ends the last day of the month child turns age 19 or last day of the month PEBP determines the child is no longer eligible</u>	
<u>Required Supporting Documents</u> ☐ <u>Completion of the Legal Guardianship Certification Form; and</u> ☐ <u>Any required supporting documents listed in the certification</u>			
<u>Disabled Child (Age 26 or Older)</u>	<u>Within 31 days of dependent child turning age 26 years</u>	<u>If already covered under PEBP, coverage will continue</u> <u>If the disabled child is new to PEBP Plan, coverage becomes effective on the first day of the month concurrent with or following the notification.</u>	<u>Not applicable</u>
<u>Required Supporting Documents</u> • <u>Certification of Disabled Dependent Child Form (completed by primary participant and child's physician)</u> • <u>Child's Social Security number</u> • <u>If not the participant's child, copy of the certified marriage certificate or domestic partnership certificate</u>			

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
• <u>Verification that the child has had continuous health insurance since the age of 26 years; and proof of support and maintenance through the submission of a copy of the participant's preceding year's income tax returns showing the child may be claimed as a tax dependent. The Plan will thereafter require proof of the child's continuing incapacity and dependency not more than once a year beginning 2 years after the child attains age 26 per NRS 689B.035.</u>			
<u>Qualified Medical Child Support Order (QMCSO), National Medical Support Notice (NMSN), or Court Order</u>	<u>Within 60 days of issuance of order or Release of order</u>	<u>Begins: First of the month concurrent with or following a determination that an order is qualified.</u> <u>Ends: Coverage terminates on the last day of the month concurrent with or following the date of determination that the release of order is qualified.</u>	<u>Participant shall enroll in coverage to comply with the order.</u> <u>Must add dependent(s) as stated in the order</u>
<u>Required Supporting Documents</u>			
☐ <u>Copy of QMCSO, NMSN, or court order appropriately signed by issuing agency/county.</u>			
<u>Declination of coverage for an employee, retiree, spouse, domestic partner, or dependent who becomes eligible for and enrolls in Medicare Part A or B</u>	<u>Within 60 days of Medicare effective date</u>	<u>Coverage terminates on the last day of the month preceding the Medicare coverage effective date, or the last day of the month of notification, whichever is later.</u>	<u>Employee/Retiree may decline coverage</u> <u>May delete spouse/domestic partner or dependent who enrolls in Medicare Part A or B.</u>

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
<u>Required Supporting Documents</u> ☐ <u>Copy of the Medicare card confirming the Medicare effective date.</u>			
<u>Declination of Coverage for employee, retiree, or dependent who becomes eligible for and enrolled in CHIP, Medicaid, or Nevada Check Up</u>	<u>Within 60 days of the event date.</u>	<u>PEBP coverage terminates on the last day of the month before gaining new coverage or the last day of the month of notification, whichever is later.</u>	<u>Employee, retiree, or dependent may decline coverage due to enrollment in CHIP, Medicaid, or Nevada Check Up</u>
<u>Required Supporting Documents</u> ☐ <u>Documentation from Medicaid, CHIP or Nevada Check Up showing that the eligibility was approved and the coverage effective date</u>			
<u>Special enrollment opportunity due to the loss of Medicare Part A, CHIP, Medicaid, or Nevada Check UP (applies to employees and their eligible dependents, does not apply to retirees)</u>	<u>Within 60 days of the event date.</u>	<u>Coverage effective on the first day of the month following loss of coverage or the notification of loss of coverage, whichever is later</u>	<u>Eligible employee and/or applicable dependents may enroll for coverage.</u>
<u>Required Supporting Documents</u> ☐ <u>Documentation from Medicaid, CHIP or Nevada Check Up showing that eligibility was 1) denied, 2) the date it was denied or that 3) Medicaid, CHIP or Nevada Check Up coverage ended or will end,</u> ☐ <u>Copy of a marriage certificate, domestic partnership certification, or</u> ☐ <u>certified birth certificate(s) for each dependent child(ren) being added to the Plan.</u>			

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
<u>Dependent Gains Coverage</u> <u>Eligible dependent experiences a change of status resulting in a gain of eligibility and enrolls in another employer group health plan.</u>	<u>Within 60 days of the event date.</u>	<u>PEBP coverage terminates on the last day of the month before gaining new coverage or the last day of the month of notification, whichever is later.</u>	<u>Must remove spouse or domestic partner if coverage is employer based; and may delete any dependent(s) that are being added to the spouse/domestic partner's employer group health plan</u>
<u>Required Supporting Documents</u> ☐ <u>Documentation from the spouse's/domestic partner's or dependent's employer or from the other health plan listing the first and last name(s) of the individuals to be deleted from PEBP coverage, including their new plan's coverage effective date.</u>			
<u>Dependent Loses Coverage</u> <u>Eligible dependents experiences a change of status resulting in a loss of eligibility from another employer group health plan.</u>	<u>Within 60 days of the event date</u>	<u>PEBP coverage is effective on the first day of the month following loss of coverage or the first day of the month following notification, whichever is later.</u>	<u>May add eligible dependent(s) in the family unit who experienced a loss of coverage</u>
<u>Required Supporting Documents</u> ☐ <u>Documentation from the spouse/domestic partner or dependent's employer or from the other health plan listing the first and last name(s) of the individuals being added to your plan and the coverage termination date of that other plan.</u>			

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
☐ <u>Social Security number for all dependent(s) being added.</u> ☐ <u>Copy of a certified marriage certificate or domestic partnership certificate recognized under Nevada law.</u> ☐ <u>If adding dependent child(ren), a copy of the child(ren)'s certified birth certificates.</u>			
<u>Marriage or the establishment of Domestic Partnership</u>	<u>Enrollment election must be submitted within 60 days of the event date</u>	<u>Coverage effective on the first day of the month following the date of marriage or domestic partnership registration, or the first day of the month following notification, whichever is later.</u>	<u>Participant shall enroll in coverage to add dependents.</u> <u>May add eligible dependent(s) in the family unit</u>
<u>Required Supporting Documents</u> ☐ <u>Copy of marriage certificate or registered domestic partnership certificate</u> ☐ <u>Social Security Number for spouse or domestic partner and/or covered child(ren)</u> ☐ <u>If adding dependent child(ren), copy of the child(ren)'s certified birth certificates; and a copy of the marriage or domestic partnership registration if not adding the spouse or domestic partner.</u>			
<u>Declination of Coverage due to Marriage or Establishment of Domestic Partnership (DP) and enrollment in spouse's/DP's Employer Group Health Plan</u>	<u>Within 60 days of the event date.</u>	<u>Coverage for the primary participant and any covered dependents will terminate on the last day of the month of marriage or establishment of domestic partnership or the first day of the month following the</u>	<u>Primary participant may decline coverage</u>

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
		<u>date of notification, whichever is later.</u>	
<u>Required Supporting Documents</u> ☐ <u>Copy of certified marriage certificate or copy of domestic partnership certificate recognized under Nevada law; and</u> ☐ <u>Documentation from the other employer or group health plan stating the effective date of the new coverage and the first and last name(s) of the newly covered individual(s).</u>			
<u>Employer of Spouse/ Domestic Partner Offers an Open Enrollment Period</u> <u>OR</u> <u>Initial Benefit Enrollment Period</u>	<u>Within 60 days of the event date</u>	<u>Enrolling in PEBP coverage: PEBP coverage becomes effective on the first day of the month following the end date of coverage under the other employer's health plan, or the first day of the month following notification to PEBP, whichever is later.</u> <u>Declining PEBP coverage: PEBP coverage terminates on the last day of the month prior to the effective date of coverage under the other group health plan; or,</u>	<u>Participant and any covered dependents may decline PEBP coverage to newly enroll in the other employer's coverage; or</u> <u>Participant and eligible dependent in declined status with PEBP may re-enroll in PEBP coverage if the other employer coverage is terminated</u>

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
		<u>the last day of the month following notification to PEBP coverage, whichever is later.</u>	
<u>Required Supporting Documents</u> ☐ <u>Proof of open enrollment from the employer</u> ☐ <u>Documentation from the other employer or group health plan stating the effective date of the new coverage and the first and last name(s) of the newly covered individual(s)</u>			
<u>Medicare Part B Premium Credit (Retirees covered under the CDHP, LD PPO, EPO plan, or HMO plan only.)</u>	<u>No later than the end of the month in which your Medicare Part B is effective</u>	<u>The Part B premium credit will apply concurrent with the Medicare Part B effective date or the first day of the month concurrent with or following PEBP's receipt of the retiree's Medicare Part B card, whichever is later.</u>	<u>Premium credit will only apply to primary retirees covered under the CDHP, LD PPO, EPO plan, or HMO plan</u>
<u>Required Supporting Documents</u> ☐ <u>Copy of Medicare Part B card; or</u> ☐ <u>Copy of the Medicare Part B award letter</u>			

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
<u>Initial Retirement Coverage for Eligible Retiring Employees</u>	<u>Within 60 days of the employee's date of retirement</u>	<u>Retiree coverage is effective on the first day of the month concurrent with or following the date of retirement</u>	<u>May add or remove eligible dependent(s).</u> <u>May select a new health plan option.</u> <u>If retiree is eligible for free Medicare Part A, must purchase Part B, and may be required to enroll for coverage through the Medicare Exchange as shown in the Initial Enrollment Section</u>
<u>Required Supporting Documents</u> ☐ <u>Enrollment election completed via paper form.</u> ☐ <u>Years of Service Certificate Form</u> ☐ <u>If age 65 or older, copy of Medicare Parts A and/or B card</u> ☐ <u>If age 65 or older and ineligible for premium-free Medicare Part A, a copy of the Medicare Benefits Verification Letter and a copy of the Medicare B card</u>			
<u>Retiree/ Dependent or Survivor's entitlement to Medicare Parts A and/or B</u>	<u>End of the month following the date the individual becomes eligible for Medicare</u>	<u>Coverage under Medicare Exchange becomes effective within 60 days of Medicare effective date or</u>	<u>Must enroll in a Medicare Exchange plan if retiree and covered dependents (if any) are eligible for free Part A;</u>

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
		<u>retirement date, whichever is later</u>	<u>otherwise, coverage is terminated.</u> <u>If one family member is not eligible for free Part A, the participant may remain on the CDHP, LD PPO, EPO Plan, or HMO, or the individual with Part A may choose coverage through the Medicare Exchange.</u>
<u>Required Supporting Documents</u> ☐ <u>Copy of Medicare Parts A and B card, if eligible for free Part A, or</u> ☐ <u>Copay of Part B card (if ineligible for free Medicare Part A); and a copy of the Medicare Benefit Verification Letter from the Social Security Administration (Medicare); or</u> ☐ <u>If covered under Tricare for Life, a copy of the military ID card and a copy of the Medicare A and B card</u> ☐ <u>Enrollment election completed via online/paper form (only if Medicare entitlement includes Parts A and B and participant is changing health plans to the Medicare Exchange).</u>			
<u>Divorce, Annulment, or Termination of Domestic Partnership*</u>	<u>Within 60 days of the event date</u>	<u>Coverage terminates on the last day of the month from 1) notification or 2) the divorce decree is signed by the judge or termination of domestic partnership is official, whichever is later.</u>	<u>Must remove ex-spouse or ex-domestic partner and all other ineligible dependent(s)</u>

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
		<u>If the divorce decree/ termination of domestic partnership is received more than 60 days after the divorce, coverage ends at the end of the first of the month following receipt of the divorce decree/termination of domestic partnership</u>	
<u>Required Supporting Documents</u> ☐ <u>Copy of the divorce/annulment decree signed by the judge (all pages)</u> ☐ <u>Copy of the termination of domestic partnership filed with appropriate issuing agency</u>			
<u>PEBP's Open Enrollment Period</u>	<u>Typically, May 1- May 31 of each year</u>	<u>Coverage effective date is July 1 immediately following open enrollment period</u>	<u>May add or delete dependents, change plan options, or decline coverage</u>
<u>Required Supporting Documents</u> ☐ <u>If adding a dependent, refer to the Summary of Supporting Eligibility Documents provided in this document</u> ☐ <u>Required supporting documents are due by June 15</u>			

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
<u>Primary Participant Moves Outside the EPO Plan or HMO Plan Coverage Area</u>	<u>Within 30 days after moving outside EPO Plan or HMO coverage area</u>	<u>Coverage under the CDHP, LD PPO, EPO Plan, or HMO plan will begin on the first day of the month concurrent with or following notification.</u>	<u>Participants who move outside an EPO Plan or HMO coverage area must select another coverage option.</u> <i><u>Note: Moving outside the EPO Plan or HMO coverage area is not a qualifying event to add or delete dependents.</u></i>
<u>Required Supporting Documents</u> ☐ <u>Copy Provide proof of address change, including, but not limited to, an updated driver's license, USPS change of address, etc.</u> ☐ <u>Call PEBP to update address; or</u> ☐ <u>Send a secure message through you ePEBP portal</u>			
<u>Termination of Retiree Benefits</u>	<u>Upon request from participant</u>	<u>Written request by the retiree to decline all PEBP benefits effective on the first day of the month concurrent with or following notification.</u>	<u>Coverage terminates for retiree and any covered dependents on the last day of the month request is received</u>
<u>Required Supporting Documents</u> ☐ <u>Must provide a written request to decline PEBP benefits.</u>			

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
<u>Survivor's Coverage</u> <u>Surviving dependent must covered on as dependent on the primary participant's plan on the date of death</u>	<u>Within 60 days of the primary participant's date of death</u>	<u>Coverage for eligible survivor(s) is effective on the first day of the month following the primary participant's date of death</u>	<u>May qualify for survivor's coverage if the dependent meets the survivor's eligibility requirements as shown in the <i>Initial Enrollment Section</i></u>
<u>Required Supporting Documents</u> ☐ <u>Copy of certified death certificate</u> ☐ <u>Submission of a completed Retiree Benefit Enrollment and Change Form</u>			
<u>Employee or Retiree Death*</u> <u>AND/OR</u> <u>Dependent Death*</u>	<u>Within 60 days of the event date</u>	<u>Participant coverage terminates on the date of death; and</u> <u>Coverage for any covered dependent terminates on the last day of the month concurrent with the participant's date of death</u> <u>Coverage for the deceased dependent terminates on the date of death.</u>	<u>Covered dependents may qualify for re-enrollment in survivor's coverage if he/she meets the eligibility requirements as stated in this document</u> <u>Must remove the deceased dependent from coverage and any ineligible dependent(s) (e.g., children of domestic partner or stepchildren)</u>
<u>Required Supporting Documents</u> ☐ <u>Copy of certified death certificate</u>			

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
<u>*Late Notification of Death: Adjustments in premiums resulting from the death of a covered participant or dependent will be refunded if notification of death is received within 60 days of the participant's or dependent's date of death. Notification of death beyond the 60-day period will not be refunded.</u>			
<u>Survivor of Police/ Firefighter killed in the line of Duty (NRS 287.0477)</u>	<u>Within 60 days of the police officer's or firefighter's date of death</u>	<u>Coverage for eligible survivor(s) is effective on the first of the month following the police officer's or firefighter's date of death, or after notification, whichever is later.</u>	<u>May qualify for survivor's coverage if the dependent meets the survivor's eligibility requirements as stated in this document</u> <u>Eligible dependents may join the plan.</u>
<u>Required Supporting Documents</u> ☐ <u>Submission of a completed Retiree Benefit Enrollment and Change Form (RBECE).</u> ☐ <u>Copy of death certificate.</u> ☐ <u>SSN and copy of the certified marriage certificate</u>			
<u>Settlement Agreement</u>	<u>Within 60 days of Settlement Agreement</u>	<u>Retroactive to date established by the hearing officer decision, but not more than 12 months under the CDHP, LD PPO, or EPO Plan; or not more than 6 months prior to PEBP's receipt of the hearing</u>	<u>Employee may re-enroll in coverage; or</u> <u>Decline coverage</u>

Enrollment and Eligibility Events Quick Reference Table

<u>Event Type</u>	<u>Notification Period</u>	<u>When Coverage Begins or Ends</u>	<u>Allowable Changes Based on Event</u>
		<u>officer's decision for the HMO; or</u> <u>If the employee chooses not to pay back premiums, the first month after notification.</u>	
<u>Required Supporting Documents</u> ☐ <u>Copy of the hearing officer's decision.</u>			

Examples of Timelines

This is intended to be an example of Qualifying Life Events timeframes and impact on participants.

<u>Event Date</u>	<u>Complete Notification Deadline (60-days)</u>	<u>Notification Date</u>	<u>Effective Date of Change</u>	<u>Benefit Impact</u>
<u>April 21st</u>	<u>June 20th</u>	<u>April 28th</u>	<u>May 1st</u>	<u>Because the notification was timely, benefit changes may take effect. Subject to providing supporting documents.</u>
<u>April 21st</u>	<u>June 20th</u>	<u>May 21st</u>	<u>June 1st</u>	
<u>April 21st</u>	<u>June 20th</u>	<u>June 15th</u>	<u>July 1st</u>	
<u>April 21st</u>	<u>June 20th</u>	<u>June 25th</u>	<u>NONE</u>	 <u>Because the notification was not timely, benefit changes will not take effect.</u>
<u>The Complete Notification Deadline means the date a notification must be wholly completed. This may include required supporting documents such as certified certificates, proof of coverage, etc.</u>				
<u>The Notification Date is an example when a member notifies PEBP, subject to required supporting document.</u>				

Retiree Coverage Examples

<u>Termination Date</u>	<u>Retirement Date</u>	<u>Retiree Health Benefit Start Date</u>	<u>Benefit Impact</u>
<u>May 30th</u>	<u>May 31st</u>	<u>June 1st</u>	<u>NO BREAK IN COVERAGE</u>
<u>May 31st</u>	<u>June 1st</u>	<u>June 1st</u>	
<u>Because the retirement occurred immediately after the termination date, with no gap, there is no break in coverage.</u>			
<u>May 30th</u>	<u>June 3rd</u>	<u>July 1st</u>	<u>BREAK IN COVERAGE</u>
	<u>Generally, when a termination/separation date and retirement date occur in different months with a gap, you 1) will be offered COBRA coverage or 2) will have a break in coverage & loss of PEBP benefits.</u>		

Enrollment and Eligibility Events Quick Reference Table

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
New Hire	No later than the last day of the month in which coverage is scheduled to become effective	Full-time employees are eligible for coverage on the first day of the month concurrent with or following the date of hire	May add eligible dependent(s) in the family unit

Required Supporting Documents

Spouse/domestic partner

- ☐ Social Security number of spouse or domestic partner
- ☐ Copy of the certified marriage certificate or domestic partnership certificate

Dependent child(ren):

- ☐ Social Security number of child(ren)
- ☐ Copy of child(ren)'s certified birth certificate(s)

Child(ren) under legal guardianship to age 19 years:

- ☐ Copy of legal guardianship papers (signed by a judge)
- ☐ Copy of certified birth certificate(s)
- ☐ Social Security number of child(ren)
- ☐ If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate recognized under Nevada law

Stepchild(ren) and child(ren) of a domestic partnership:

- ☐ Copy of certified birth certificate(s)
- ☐ Social Security number of child(ren)

Enrollment and Eligibility Events Quick Reference Table

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
A copy of the certified marriage certificate or domestic partnership			
Newborn Child	Within 60 days of the event date	Newborn coverage is effective on the date of birth for the first 31 days, also known as the initial coverage period. Coverage for other dependent(s) is effective on the first day of the month concurrent with or following notification.	May add the newborn child and other eligible dependent(s) in the family unit
<u>Required Supporting Documents</u> Copy of the hospital's birth confirmation for the child (within 60 days of the date of birth) If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate (within 60 days of the date of birth) Child's Social Security number (within 120 days of the date of birth) Copy of child's certified birth certificate (within 120 days of the date of birth)			

Enrollment and Eligibility Events Quick Reference Table

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Adoption of a Child or Placement for Adoption of a Child	Within 60 days of the event date	Coverage effective on the date of adoption or placement for adoption for the first 31 days, also known as the initial coverage period. Coverage for a child adopted within 60 days of the child's date of birth becomes effective on 1) the date of adoption, or 2) placement for adoption. Coverage for other dependent(s) is effective on the first day of the month concurrent with or following notification	May add the designated adopted child(ren) and other eligible dependent(s) in the family unit

Required Supporting Documents

- ☐ ~~Copy of legal adoption papers or placement for adoption (signed by a judge)~~
- ☐ ~~Adoption papers (signed by a judge) within 60 days of issuance~~
- ☐ ~~Child's Social Security number (within 120 days of the adoption)~~
- ☐ ~~A copy of the child's certified birth certificate (within 120 days of the adoption)~~
- ☐ ~~If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate recognized under Nevada law~~

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
~~Permanent Guardianship of a Child to Age 19~~	~~Within 60 days of the event date~~	~~Coverage effective on the first day of the month concurrent with or following notification.~~ ~~Coverage is provided only up to age 19 years~~	~~May add the child(ren) to age 19 years and other eligible dependent(s) in the family unit~~
<u>Required Supporting Documents</u> ~~☐ Copy of legal guardianship papers (signed by a judge)~~ ~~☐ Child's Social Security number~~ ~~☐ Copy of certified birth certificate~~ ~~☐ If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate~~			
Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
~~Permanent Guardianship of Unmarried Child Aged 19 to Age 26 Currently Enrolled in a PEBP Plan~~	~~Within 60 days of the event date~~	~~Coverage continues to age 26 assuming child continues to meet eligibility requirements as set forth in Legal Guardianship Form~~ ~~Coverage ends the last day of the month child turns age 19 or last day of the month PEBP determines the child is no longer eligible~~	~~Not applicable~~

Required Supporting Documents

- ☐ ~~Completion of the Legal Guardianship Certification Form; and~~
- ☐ ~~Any required supporting documents listed in the certification~~

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Disabled Child (Age 26 or Older)	Within 31 days of dependent child turning age 26 years	• ~~If already covered under PEBP, coverage will continue~~ • ~~If new to PEBP Plan, coverage becomes effective on the first day of the month concurrent with or following the notification.~~	Not applicable

Required Supporting Documents

- ☐ ~~Certification of Disabled Dependent Child Form (completed by primary participant and child's physician)~~
- ☐ ~~Child's Social Security number~~
- ☐ ~~If not the participant's child, copy of the certified marriage certificate or domestic partnership certificate~~
- ☐ ~~Verification that the child has had continuous health insurance since the age of 26 years; and proof of support and maintenance through the submission of a copy of the participant's preceding year's income tax returns showing the child may be claimed as a tax dependent. The Plan will thereafter require proof of the child's continuing incapacity and dependency not more than once a year beginning 2 years after the child attains age 26 per NRS 689B.035.~~

Qualified Medical Child Support Order (QMCSO) or	~~Within 60 days of issuance of QMCSO or Release of QMCSO~~	• ~~QMCSO: First of the month concurrent with or following~~	• ~~Must add dependent(s) as stated in the QMCSO~~

~~National Medical Support Notice (NMSN)~~		~~a determination that a QMCSO is qualified.~~ ~~• Release of QMCSO: Coverage terminates on the last day of the month concurrent with or following the date of determination that the release is qualified.~~	~~• May add other eligible dependent(s) in the family unit~~

Required Supporting Documents

- ~~☐ Copy of QMCSO appropriately signed by issuing agency/county~~

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
~~Declination of coverage for an employee, retiree, spouse, or dependent who becomes eligible for and enrolls in Medicare Part A or B~~	~~Within 60 days of Medicare effective date~~	~~Coverage terminates on the last day of the month preceding the Medicare coverage effective date, or the last day of the month of notification, whichever is later.~~	~~Employee/Retiree may decline coverage~~ ~~May delete spouse/domestic partner or dependent who enrolls in Medicare Part A or B.~~

Required Supporting Documents

- ~~☐ Copy of the Medicare card confirming the Medicare effective date.~~

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
~~Declination of Coverage for employee, retiree spouse, or dependent who becomes eligible for and enrolled in CHIP~~ ~~Medicaid or Nevada Check Up~~	~~Within 60 days of Medicaid effective date~~	~~PEBP coverage terminates on the last day of the month preceding the first day of the month the participant or participant's dependent gains eligibility or the last day of the month of notification, whichever is later.~~	~~Employee, retiree, spouse/domestic partner or dependent may decline coverage due to enrollment in CHIP/Medicaid~~
<u>Required Supporting Documents</u> ~~☐ Documentation from Medicaid, CHIP or Nevada Check Up showing that the dependent's eligibility for Medicaid or CHIP was approved and the coverage effective date~~			
Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
~~Special enrollment opportunity due to the loss of Medicare Part A, CHIP, Medicaid, or Nevada Check Up (applies to employees and their eligible dependents), does not apply to retirees)~~	~~Within 60 days of Medicare Part A, Medicaid, CHIP, or Nevada Check Up termination date~~	~~Coverage effective on the first day of the month following notification for loss of coverage from Medicaid and/or Nevada Check Up.~~	~~Eligible employee and/or applicable dependents may enroll for coverage.~~
<u>Required Supporting Documents</u> ~~☐ Documentation from Medicaid, CHIP or Nevada Check Up showing that eligibility for Medicaid or CHIP was denied, the date it was denied or that Medicaid, CHIP or Nevada Check Up coverage ended or will end, and a copy of a marriage certificate, domestic partnership certification, or certified birth certificate(s) for each dependent child(ren) being added to the Plan.~~			

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
~~Dependent Gains Coverage~~ ~~Spouse/domestic partner or eligible dependent experiences a change of status resulting in a gain of eligibility and enrolls in another employer group health plan~~	~~Within 60 days of the event date~~	~~PEBP coverage terminates on the last day of the month preceding the first day of the month the participant or participant's dependent gains eligibility or the last day of the month of notification, whichever is later.~~	~~Must remove spouse or domestic partner if coverage is employer based; and may delete any dependent(s) that are being added to the spouse/domestic partner's employer group health plan~~
<u>Required Supporting Documents</u> ~~☐ Documentation from the spouse's/domestic partner's or dependent's employer or from the other health plan listing the first and last name(s) of the individuals to be deleted from PEBP coverage, including their new plan's coverage effective date.~~			
Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
~~Dependent Loses Coverage~~ ~~Spouse/domestic partner or eligible dependents experience a change of status resulting in a loss of eligibility~~	~~Within 60 days of the event date~~	~~Coverage effective on the first day of the month following notification.~~	~~May add the spouse or domestic partner and all other eligible dependent(s) in the family unit who experienced a loss of coverage~~

~~from another employer group health plan~~			

Required Supporting Documents

- ~~☐ Documentation from the spouse/domestic partner or dependent's employer or from the other health plan listing the first and last name(s) of the individuals being added to your plan and the coverage termination date of that other plan.~~
- ~~☐ Social Security number for all dependent(s) being added.~~
- ~~☐ Copy of a certified marriage certificate or domestic partnership certificate recognized under Nevada law.~~
- ~~☐ If adding dependent child(ren), a copy of the child(ren)'s certified birth certificates.~~

~~Enrollment and Eligibility Events Quick Reference Tables~~

~~Event Type~~	~~Notification Period~~	~~When Coverage Begins or Ends~~	~~Allowable Changes Based on Event~~
~~Marriage or the establishment of Domestic Partnership~~	~~Enrollment election must be submitted within 60 days of the event date~~	~~Coverage effective on the first day of the month following the date of marriage or domestic partnership registration, or the first day of the month following notification, whichever is later.~~	~~May add spouse/domestic partner and/or other eligible dependent(s) in the family unit~~

Required Supporting Documents

- ~~☐ Copy of marriage certificate or registered domestic partnership certificate~~
- ~~☐ Social Security Number for spouse or domestic partner and/or covered child(ren)~~
- ~~☐ If adding dependent child(ren), copy of the child(ren)'s certified birth certificates; and a copy of the marriage or domestic partnership registration if not adding the spouse or domestic partner~~

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
~~Declination of Coverage due to Marriage or Establishment of Domestic Partnership (DP) and enrollment in spouse's/DP's Employer Group Health Plan~~	~~Within 60 days of the date of marriage or establishment of domestic partnership~~	~~Coverage for the primary participant and any covered dependents will terminate on the last day of the month of marriage or establishment of domestic partnership or the first day of the month following the date of notification, whichever is later.~~	~~Primary participant may decline coverage~~
<u>Required Supporting Documents</u> ~~☐ Copy of certified marriage certificate or copy of domestic partnership certificate recognized under Nevada law; and~~ ~~☐ Documentation from the other employer or group health plan stating the effective date of the new coverage and the first and last name(s) of the newly covered individual(s).~~			

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Employer of Spouse/ Domestic Partner Offers an Open Enrollment Period OR Initial Benefit Enrollment Period	Within 60 days of the event date	- Enrolling in PEBP coverage: PEBP coverage becomes effective on the first day of the month following the end date of coverage under the other employer's health plan, or the first day of the month following notification to PEBP, whichever is later. - Declining PEBP coverage: PEBP coverage terminates on the last day of the month prior to the effective date of coverage under the other group health plan; or, the last day of the month following notification to PEBP coverage, whichever is later.	- Participant and any covered dependents may decline PEBP coverage to newly enroll in the other employer's coverage; or - Participant and eligible dependent in declined status with PEBP may re-enroll in PEBP coverage if the other employer coverage is terminated
<u>Required Supporting Documents</u> ☐ Proof of open enrollment from the employer			

☐ Documentation from the other employer or group health plan stating the effective date of the new coverage and the first and last name(s) of the newly covered individual(s)			
Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Medicare Part B Premium Credit (Retirees covered under the CDHP, LD PPO, EPO plan, or HMO plan only.)	No later than the end of the month in which your Medicare Part B is effective	The Part B premium credit will apply concurrent with the Medicare Part B effective date or the first day of the month concurrent with or following PEBP's receipt of the retiree's Medicare Part B card, whichever is later.	Premium credit will only apply to primary retirees covered under the CDHP, LD PPO, EPO plan, or HMO plan
<u>Required Supporting Documents</u> ☐ Copy of Medicare Part B card; or ☐ Copy of the Medicare Part B award letter			

Enrollment and Eligibility Events Quick Reference Tables			
Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Initial Retirement Coverage for Eligible Retiring Employees	Within 60 days of the employee's date of retirement	Retiree coverage is effective on the first day of the month concurrent with or following the date of retirement	• May add dependent(s) • May select a new health plan option

			If retiree is eligible for free Medicare Part A, must purchase Part B, and may be required to enroll for coverage through the Medicare Exchange as shown in the <i>Initial Enrollment Section</i>
<u>Required Supporting Documents</u> ☐ Enrollment election completed via paper form. ☐ Years of Service Certificate Form ☐ If age 65 or older, copy of Medicare Parts A and/or B card ☐ If age 65 or older and ineligible for premium free Medicare Part A, a copy of the Medicare Benefits Verification Letter and a copy of the Medicare B card.			
Retiree/ Dependent or Survivor's entitlement to Medicare Parts A and/or B	End of the month following the date the individual becomes eligible for Medicare	Coverage under Medicare Exchange becomes effective within 60 days of Medicare effective date or retirement date, whichever is later	• Must enroll in a Medicare Exchange plan if retiree and all covered dependents (if any) are eligible for free Part A; otherwise, coverage is terminated • If one family member is not eligible for free Part A, the family may remain on the CDHP, LD PPO, EPO Plan, or HMO, or the individual with Part A may choose coverage through the Medicare Exchange

Required Supporting Documents

- ☐ ~~Copy of Medicare Parts A and B card, if eligible for free Part A, or~~
- ☐ ~~Copay of Part B card (if ineligible for free Medicare Part A); and a copy of the Medicare Benefit Verification Letter from the Social Security Administration (SSA); or~~
- ☐ ~~If covered under Tricare for Life, a copy of the military ID card and a copy of the Medicare A and B card~~
- ☐ ~~Enrollment election completed via online/paper form (only if Medicare entitlement includes Parts A and B and participant is changing health plans to the Medicare Exchange).~~

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Divorce, Annulment or Termination of Domestic Partnership*	Within 60 days of the event date	• ~~Coverage terminates on the last day of the month from 1) notification or 2) the divorce decree is signed by the judge or termination of domestic partnership is official, whichever is later.~~ • ~~If the divorce decree/ termination of domestic partnership is received more than 60 days after the divorce, coverage ends at the end of the first of the month following receipt of the divorce decree/termination of domestic partnership~~	~~Must remove ex-spouse or ex-domestic partner and all other ineligible dependent(s)~~

Required Supporting Documents

- ☐ ~~Copy of the divorce/annulment decree signed by the judge (all pages)~~
- ☐ ~~Copy of the termination of domestic partnership filed with appropriate issuing agency~~

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
PEBP's Open Enrollment Period	Typically, May 1–May 31 of each year	Coverage effective date is July 1 immediately following open enrollment period	May add or delete dependents, change plan options, or decline coverage

Required Supporting Documents

- ☐ ~~If adding a dependent, refer to the Summary of Supporting Eligibility Documents provided in this document~~
- ☐ ~~Required supporting documents are due by June 15~~

Primary Participant Moves Outside the EPO Plan or HMO Plan Coverage Area	Within 30 days after moving outside EPO Plan or HMO coverage area	Coverage under the CDHP, LD PPO, EPO Plan, or HMO plan will begin on the first day of the month concurrent with or following notification.	Participants who move outside an EPO Plan or HMO coverage area must select another coverage option. <i>Note: Moving outside the EPO Plan or HMO coverage area is not a qualifying event to add or delete dependents.</i>

Required Supporting Documents

- ☐ ~~Provide proof of address change, including, but not limited to, an updated driver's license, USPS change of address, etc.~~
- ☐ ~~Call PEBP to update address; or~~

☐ ~~Send a secure message through you ePEBP portal~~

~~Event Type~~	~~Notification Period~~	~~When Coverage Begins or Ends~~	~~Allowable Changes Based on Event~~
~~Termination of Retiree Benefits~~	~~Upon request from participant~~	~~Written request by the retiree to decline all PEBP benefits effective on the first day of the month concurrent with or following notification.~~	~~Coverage terminates for retiree and any covered dependents on the last day of the month request is received~~
<u>Required Supporting Documents</u> ☐ ~~Must provide a written request to decline PEBP benefits.~~			

~~Enrollment and Eligibility Events Quick Reference Tables~~

~~Event Type~~	~~Notification Period~~	~~When Coverage Begins or Ends~~	~~Allowable Changes Based on Event~~
~~Survivor's Coverage Surviving dependent must covered on as dependent on the primary participant's plan on the date of death~~	~~Within 60 days of the primary participant's date of death~~	~~Coverage for eligible survivor(s) is effective on the first day of the month following the primary participant's date of death~~	~~May qualify for survivor's coverage if the dependent meets the survivor's eligibility requirements as shown in the Initial Enrollment Section~~
<u>Required Supporting Documents</u> ☐ ~~Copy of certified death certificate~~			

~~☐ Submission of a completed Retiree Benefit Enrollment and Change Form.~~

~~Employee or Retiree Death*~~	~~Within 60 days of the event date~~	~~Participant coverage terminates on the date of death; and~~ ~~Coverage for any covered dependent terminates on the last day of the month concurrent with the participant's date of death~~	~~Covered dependents may qualify for re-enrollment in survivor's coverage if he/she meets the eligibility requirements as stated in this document~~
~~Dependent Death*~~	~~Within 60 days of the event date~~	~~Coverage for the deceased dependent terminates on the date of death.~~	~~Must remove the deceased dependent from coverage and any ineligible dependent(s) (e.g., children of domestic partner or stepchildren)~~

Required Supporting Documents

~~☐ Copy of certified death certificate~~

~~*Late Notification of Death: Adjustments in premiums resulting from the death of a covered participant or dependent will be refunded if notification of death is received within 60 days of the participant's or dependent's date of death. Notification of death beyond the 60-day period will not be refunded.~~

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Survivor of Police/ Firefighter killed in the line of Duty	Within 60 days of the police officer's or firefighter's date of death	Coverage for eligible survivor(s) is effective on the first of the month following the police officer's or firefighter's date of death, or after notification, whichever is later.	May qualify for survivor's coverage if the dependent meets the survivor's eligibility requirements as stated in this document
<u>Required Supporting Documents</u> ☐ Submission of a completed Retiree Benefit Enrollment and Change Form (RBECE). ☐ Copy of death certificate. ☐ SSN and copy of the certified marriage certificate			
Settlement Agreement	Within 60 days of Settlement Agreement	• Retroactive to date established by the hearing officer decision, but not more than 12 months under the CDHP, LD PPO, or EPO Plan; or not more than 6 months prior to PEBP's receipt of the hearing officer's decision for the HMO; or • if the employee chooses not to pay back premiums, the first month after notification.	• Employee may re-enroll in coverage; or • Decline coverage
<u>Required Supporting Documents</u> ☐ Copy of hearing officer's decision.			

Qualifying Events

IRS Code Section 125

IRS Code Section 125 states that Qualifying Life Events, or HIPAA Special Enrollments, are generally prospective from the notification date when subject to “cafeteria plan” rules. In the event there is a conflict, IRS Code Section 125 controls.

See Section 125 Health and Welfare Benefits Master Plan Document, specifically section 3.5 and 5.1, regarding changes on a prospective basis.

Dependent Loses Other Employer Group Health Care Coverage

An eligible spouse, domestic partner or dependent that ceases to be covered by another employer group health plan may be added to the participant’s coverage if enrollment and proof of loss of coverage is provided within 60 days after the termination of coverage under that other employer group health insurance policy or plan if that other coverage terminated because:

- Loss of eligibility because of divorce, dissolution of a domestic partnership, cessation of dependent status (such as attaining the limiting age for a dependent child), death, termination of employment, reduction in hours; or
- An HMO or other arrangement in the employer group market that does not provide benefits to individuals who no longer reside or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; or
- A plan no longer offers any benefits to a class of similarly situated individuals; or
- The termination of COBRA Continuation Coverage for any of the following reasons:
 - When the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
 - When the individual no longer resides or works in a service area of an EPO, HMO, or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
 - The 18-month, 24-month, 29-month or 36-month period of COBRA Continuation Coverage has expired.

However, if an employee or dependent lost other health care coverage as a result of the individual’s voluntary cancellation of coverage, termination of coverage through the state health exchange (Affordable Care Act (ACA)), failure to pay premiums, reduction, or elimination of employer financial payment of premiums, or for cause, such as making a fraudulent claim, that individual does not have enrollment rights.

Gain of Other Employer Group Health Care Coverage

If an otherwise eligible spouse/domestic partner gains health care coverage through their employer, they are no longer eligible to maintain PEBP coverage. For additional information, see the section on *Significantly Inferior Coverage*.

The primary participant and any covered dependents may opt to accept the other employer's coverage and decline PEBP coverage during the spouse's/domestic partner's initial benefit enrollment period. The participant will be required to submit an enrollment election along with proof of the new hire date, effective date of coverage, including the names of covered dependents within 60 days of the new coverage effective date.

PEBP must be notified within 60 days of the effective date of the spouse's or domestic partner's coverage under the spouse's or domestic partner's employer group health plan. Notification after 60 days will result in coverage terminating at the end of the month PEBP receives proof of the other employer's coverage. Premium refunds will not be given for late notification.

If a dependent child gains coverage through their employer, the dependent child can be removed from coverage by the participant or the child can remain on the PEBP Plan. The order of benefit determination rules is described in the Coordination of Benefits section in the PEBP EPO Plan, Low Deductible PPO or Consumer Driven Health Plan for Medical, Vision and Prescription Drug Benefits Master Plan Document or the HMO Evidence of Coverage Certificate to establish which plan is the primary plan (pays first) and which is secondary (pays second).

Open Enrollment for Employer of Spouse or Domestic Partner

If the employer of an eligible spouse or domestic partner offers an open enrollment period for their employees, the primary participant and any covered dependents may opt to accept the other employer's coverage and decline PEBP coverage during the spouse's/domestic partner's open enrollment period. This option only applies when the participant's coverage is new under the spouse's/domestic partner's plan.

The participant will be required to submit an enrollment election along with proof of the open enrollment period, effective date of coverage, including the names of covered dependents within 60 days of the new coverage effective date.

Change of Residence

A qualifying event may be initiated by a participant's change in place of residence, if that change impairs the ability of a participant to access the services of in-network health care providers. Participants who move outside of the EPO Plan or HMO coverage area must select another coverage option by updating their information with PEBP within 30 days after moving out of the previous service area. If a participant does not select a coverage option that is available at the new address within 30 days, the participant will be defaulted into the CDHP with an HRA. If the enrollment update is not received within 30 days, the change will be made for the first of the month following submission of the change of address. Any overpayments due to lack of notification within 30 days will not be refunded.

Retirees covered through Medicare exchange who move out of the United States may select coverage under an eligible PEBP Plan. Retirees who are eligible for premium-free Medicare Part A and who move back into the United States must select coverage through the Exchange.

Declining Active Employee Coverage

An employee may decline coverage ~~at~~for these events:

- -initial enrollment,
- during PEBP's open enrollment, ~~or~~
- ~~dd~~during the spouse's/domestic partner's employer's
 - initial enrollment period,
 - open enrollment period, ~~or~~
 - Qualifying Life Event

contingent on the employee furnishing proof of coverage under the spouse/DP's plan.

~~or marriage (see open enrollment for employer of spouse or domestic partner~~open enrollment for employer of spouse or domestic partner section).

An employee will not receive a financial incentive or compensation when in declined coverage status and will not be eligible for ~~basic life insurance~~other PEBP benefits, including but not limited to, basic life insurance.

Declining Retiree or Survivor's Coverage

Retirees and survivors may decline coverage at any time during the year. Coverage will terminate on the last day of the month PEBP receives notification, generally written, request to decline coverage. Declining coverage will terminate medical, dental, vision, prescription drug coverage, basic life insurance, voluntary life insurance, years of service premium subsidy and HRA contribution (if applicable). See the *Retiree Late Enrollment* section for re-enrollment rights.

Declining Unsubsidized Dependent Coverage

Unsubsidized dependents enrolled in a PEBP-sponsored medical plan may decline coverage at any time during the year. Coverage will terminate on the last day of the month PEBP receives notification, generally written, to decline coverage.

Significantly Inferior Coverage

If PEBP determines the coverage available to the spouse/domestic partner by their employer meets the definition of “Significantly Inferior Coverage,” the spouse/domestic partner is required to decline such coverage from their employer prior to being enrolled as a dependent on the participant’s PEBP plan.

The PEBP Board has defined significantly inferior coverage as either:

- A mini-med or other limited benefit plan (see definitions, below); or
- A catastrophic coverage plan which includes a Deductible equal to or greater than \$5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement

In order for PEBP to make the determination to allow a spouse/domestic partner with “Significantly Inferior Coverage” to enroll as a dependent in the PEBP Plan, an official summary of the coverage details from spouse/domestic partner’s employer outlining the health insurance coverage plans available to their employees must be provided to PEBP.

If your spouse/domestic partner cannot decline coverage from their employer until the open enrollment period, the decline of coverage at that time will be considered a qualifying event to add the spouse/domestic partner to the participant’s PEBP Plan.

Leaves of Absence

Family and Medical Leave Act (FMLA)

The FMLA entitles an eligible employee to up to 12 weeks of unpaid, job-protected leave during a rolling 12-month period measured backward from the date an eligible employee uses any qualifying FMLA leave. The FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period, measured forward from the first day of usage.

During FMLA leave, the employer must maintain the employee's health coverage under any employer group health plan on the same terms as if the employee had continued to work, regardless of whether the employee is on paid or unpaid leave. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Employees are eligible for FMLA leave if they have worked for 12 months and for 1,250 hours over the previous 12 months. For an overview of FMLA provided by the Department of Administration, Human Resource Management visit <https://www.dol.gov/general/topic/benefits-leave/fmla>.

Employees who return to work promptly at the end of that leave, regardless of whether they kept their coverage while on leave, may continue or reinstate the same plan option and coverage tier without any additional limits or restrictions imposed on account of the leave. If an employee declines coverage while on family or medical leave, coverage will be reinstated to the same plan option and coverage tier on the first of the month in which the employee is in paid status 80 hours using a combination of FMLA and/or paid time.

The National Defense Authorization Act of 2008 (NDAA) expanded provisions of the FMLA. The NDAA extends family medical leave entitlements to the relatives of members of the armed services (including the National Guard and Reserves). NDAA makes two significant changes to FMLA: (i) an eligible employee who is a spouse or domestic partner, son, daughter, parent or "next of kin" of a covered service member is now entitled to a total of 26 weeks of FMLA during a 12 month period to care for the serious injury or illness of the wounded/disabled service member; and (ii) an employee will be entitled to FMLA on account of a "qualifying exigency" that occurs because the spouse or domestic partner, son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

Any changes in the Plan's terms, rules or practices that went into effect while an employee is away on leave will apply to the employee and any dependents in the same way they apply to all other employees and their dependents. Employees should contact their agency representative to find out more about their entitlement to family or medical leave as required by federal and/or state law, and the terms on which it may be entitled.

Leave Without Pay (LWOP)

NAC 287.450

A State agency that employs an individual who is on LWOP (other than FMLA leave) shall NOT pay any amount of the cost of premium or contributions for group insurance for that employee, unless the employee receives a minimum compensation of 80 hours in the month .

An employee who is on approved LWOP may pay the full cost of premiums for their coverage and insurance to PEBP. An employee on LWOP is not eligible for coverage as a dependent of another PEBP covered participant

At the initial start of leave, it is the employee's responsibility to inform PEBP of their coverage preference while on leave. If the employee fails to inform PEBP of his or her coverage preference while on leave, PEBP will continue the same medical plan and coverage tier that the employee had in effect prior to taking that leave. When the employee returns from leave, their coverage will revert to their original plan selection prior to going on leave.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

Employees who go into active military service for up to 31 days can continue their health care coverage during that leave period if they continue to pay their contributions for that coverage during the period of that leave.

State employees who go into active military service for 31 days or more are eligible to enroll in health care coverage provided by the military the day the employee is activated for military duty. This coverage is also available to dependents. The employee is also eligible to purchase continued health care coverage through PEBP for up to 24 months in a manner like the provisions of COBRA. When the employee returns from military leave within the required reemployment period, there will be an immediate reinstatement of PEBP-sponsored medical coverage with no waiting period. Questions regarding entitlement to this leave and to the continuation of health care coverage should be referred to PEBP. Questions regarding reemployment rights should be addressed with the employer.

Worker's Compensation Leave

Employee and dependent health care coverage during the period of Worker's Compensation leave will automatically be continued for a period of up to 9 months. To continue coverage, employees must pay their contribution for that coverage during the period of that leave directly to PEBP by the date on the bill. Late payment will result in termination of coverage. Coverage terminated for non-payment may not be reinstated until the employee returns to work. Employees may elect to discontinue dependent coverage while on Workers' Compensation leave.

Following the 9-month period during which the employee has been on Worker's Compensation leave, the employee will be required to make the full, unsubsidized payment for health care coverage for themselves and their dependents. Once the employee returns to work, insurance coverage will be reinstated exactly the way it was before the employee was placed on Workers'

Compensation leave, unless the employee selected different coverage during an open enrollment period or experienced a qualifying event.

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Premium Assistance

Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022.
Contact your State for more information on eligibility**

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIP.PPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102

TTY: Maine relay 711	
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human
Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB

under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See . U.S.C. U.S.C.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Payment for Coverage

Most eligible State employees are provided a subsidy toward the cost of plan coverage. To obtain information about subsidy amounts, service calculations, and premium information, please visit the PEBP website (~~www.pebp.state.nv.us~~<https://pebp.nv.gov/>) or call PEBP Member Services. Employees on leave without pay (other than FMLA), dependents, legislators and survivors are not eligible for a subsidy. The option of electing additional voluntary products at cost may be available to an employee or retiree.

Retirees eligible for a subsidy must submit the required Years of Service Certification Form to the PEBP office by the last day of the month preceding the retirement effective date to receive the first month's subsidy.

To receive a Medicare Part B premium credit, eligible retirees must send a copy of their Medicare Card to PEBP. The Medicare Part B premium credit will be applied to the retiree account the first day of the month following the receipt of the Medicare Card, but no earlier than the effective date of the Medicare Part B coverage. The Medicare Part B premium credit is for retirees on the CDHP, HMO or EPO Plan only.

Premiums for CDHP, LD PPO Plan, HMO or EPO Plan coverage are automatically deducted from the participant's paycheck or pension. Each monthly premium applies to coverage for that same month. In the following circumstances, premiums shall be paid directly to PEBP monthly:

- The employee is on unpaid leave.
- The retiree's pension is not large enough to cover the premium amount, or if PERS payroll deductions rules cause the PEBP contribution to not be taken.
- The participant is a retiree of the Nevada System of Higher Education who participates in an alternative retirement plan.
- The participant is an active legislator.
- The participant is on COBRA coverage.
- The individual is an unsubsidized dependent; or
- For survivors who do not receive a PERS pension benefit.

If COBRA coverage is terminated due to non-payment, that individual will not be able to re-enroll in the Plan under COBRA. If employee coverage is terminated due to non-payment, that employee will not be able to re-enroll in the Plan until the next open enrollment, he or she experiences a special enrollment or mid-year change event, or until the employee returns from leave and the account has been paid in full. If coverage of a retiree, survivor or unsubsidized dependent is terminated for non-payment that individual will not be able to re-enroll in the Plan until the next open enrollment period (if eligible) and until the account is paid in full.

Participants will be billed via premium invoice and will be required to pay the following directly to PEBP:

- Contributions resulting from retroactive coverage changes; or
- Claims incurred by the participant or their dependents who access the Plan during a period when they are ineligible for coverage.

Premium overpayments due to lack of proper notification by the participant will not be refunded. Participants who fail to pay their premiums or ineligible claims may be reported to the State Controller's office or to a private collection agency for collection of past due amounts. Collection costs may also be assessed to the participant.

PERS Deduction for the Medicare Exchange Plan

Federal rules for the Medicare Exchange require the individual to pay medical insurance premiums directly to the carrier. PEBP will not take automatic deductions from retirement distributions to pay for coverage provided through the Medicare Exchange except dental coverage provided by PEBP if the retiree elects to enroll in the PEBP Self-funded PPO dental plan.

Late Notification of Death

Adjustments in premiums resulting from the death of a covered participant or dependent will be refunded if notification of death is received within 60 days of the participant's or dependent's date of death. Notification of death beyond the 60-day period will not be refunded.

Billing Errors

It is the participant's responsibility to ensure the premiums paid by the participant are accurate. Refunds for premiums billed in error and paid by the participant more than six months old are at the sole discretion of PEBP.

Termination for Non-Payment

Payment for the current month's coverage is due on the 20th of each month. Acceptance and deposit of a payment does not in itself guarantee coverage. If the participant fails to meet eligibility and enrollment requirements, coverage may be terminated, and the payment refunded to the participant.

Any account 30 days past due, including Retirees enrolled in the Medicare Exchange with PEBP Dental, is subject to termination retroactive to the last day of the month for which premium payment was received in full. Participants will be billed for any claims incurred and paid for by the Plan after the effective date of termination.

Change to Years of Service Re-Audit Results for Retirees

Years of service premium subsidy and years of service Exchange HRA contribution are effective upon the date of retirement, based on the audit from either the Public Employees' Retirement System (PERS) or the Nevada System of Higher Education (NSHE). Changes to the years of service premium subsidy and years of service Exchange HRA contribution resulting from a future audit will occur on the first (1st) day of the month concurrent with or following the date PEBP receives the audit results from the PERS or NSHE. (NAC 287.485)

COBRA

COBRA – the Consolidated Omnibus Budget Reconciliation Act – requires group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain events. Those events include:

- A covered employee's or retiree's death,
- A covered employee's job loss or reduction in hours for reasons other than gross misconduct,
- A COBRA beneficiary becoming entitled to Medicare,
- A covered employee's divorce or legal separation, and
- A child's loss of dependent status (and therefore coverage) under the plan.

COBRA sets rules for how and when plan sponsors must offer and provide continuation coverage, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage.

Employers may require individuals to pay for COBRA continuation coverage.

Life insurance and disability benefits are not considered "medical care." COBRA does not cover plans that provide only life insurance or disability benefits.

Alternatives to COBRA Continuation Coverage

Those entitled to elect COBRA continuation coverage may have more affordable or generous alternatives for coverage. One option may be "special enrollment" in other group health coverage. Under the Health Insurance Portability and Accountability Act (HIPAA), upon certain events, group health plans and health insurance issuers are required to provide a special enrollment period. During that period, individuals who previously declined coverage for themselves and their dependents, and who are otherwise eligible, may enroll without waiting until the next open season for enrollment. One event that triggers special enrollment is an employee or dependent losing eligibility for other health coverage. For example, an employee who loses group health coverage may be able to special enroll in a spouse's health plan. The employee or dependent must request special enrollment within 30 days of losing other coverage.

Who Is Entitled to Continuation Coverage

A group health plan must offer COBRA continuation coverage only to qualified beneficiaries and only after a qualifying event has occurred.

Qualified Beneficiaries

A qualified beneficiary is an employee who was covered by a group health plan on the day before a qualifying event occurred, or that employee's or retiree's spouse, former spouse, or dependent child. In certain cases, involving employer bankruptcy, a retired employee and their spouse, former spouse, or dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is

automatically considered a qualified beneficiary. An employer's agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Qualifying Events

"Qualifying events" are events that cause an individual to lose group health coverage. The type of qualifying event determines who the qualified beneficiaries are and the period of time that a plan must offer continuation coverage. COBRA establishes only the minimum requirements for continuation coverage. A plan may always choose to provide longer periods of continuation coverage and/or to contribute toward the cost.

The following are qualifying events for a covered employee if they cause the covered employee to lose coverage:

- Termination of the covered employee's employment for any reason other than "gross misconduct," or
- Reduction in the covered employee's hours of employment.

The following are qualifying events for a spouse and dependent child of a covered employee or retiree if they cause the spouse or dependent child to lose coverage:

- Termination of the covered employee's employment for any reason other than "gross misconduct,"
- Reduction in hours worked by the covered employee,
- Covered employee becomes entitled to Medicare,
- Divorce or legal separation from the covered employee or retiree, or
- Death of the covered employee or retiree.

In addition to the above, the following is a qualifying event for a dependent child of a covered employee or retiree if it causes the child to lose coverage: Loss of "dependent child" status under the plan rules. Under the Affordable Care Act, plans that offer coverage to children on their parents' plan must make coverage available until the child reaches the age of 26.

COBRA Continuation of Medical Coverage Notice

You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to PEBP, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

[When is COBRA continuation coverage available?](#)

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment.
- Death of the employee.
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to PEBP.

[How is COBRA continuation coverage provided?](#)

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA continuation coverage is generally either 18 months or 36 months, depending on which qualifying event occurred, measured from the time the qualifying event occurs. The 18-month period of COBRA continuation coverage may be extended for up to 11 months under certain circumstances (described in another area of this section on extending COBRA in cases of disability). That period may also be cut short for the reasons set forth in the section "When COBRA Continuation Coverage May Be Cut Short" that appears later in this section.

Who is entitled to COBRA continuation coverage (the qualified beneficiary), when (the qualifying event), and for how long is shown in the following chart:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries		
	Employee	Spouse or Domestic Partner	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making Employee ineligible for the same coverage).	18 months	18 months	18 months
Employee or Retiree dies.	N/A	36 months	36 months
Employee or retiree becomes divorced.	N/A	36 months	36 months
Employee becomes entitled to Medicare.	N/A	36 months	36 months

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries		
	Employee	Spouse or Domestic Partner	Dependent Child(ren)
Dependent child ceases to have dependent status.	N/A	N/A	36 months
Retiree coverage is terminated or substantially eliminated within one year before or after PEBP files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Life	Life plus 36 months after death of retiree	Life plus 36 months after death of retiree

When Cobra Continuation Coverage May be Cut Short

The Plan may terminate continuation coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis.
- The employer ceases to maintain any group health plan.
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage.
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
- A qualified beneficiary engages in fraud or other conduct that would justify terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage.

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. If you decide to terminate your COBRA coverage early, you generally will not be able to enroll in a Marketplace plan outside of the open enrollment period.

If you have questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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Subrogation and Third-Party Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the way they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). All payments made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. Any and all payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury.

The Participant must cooperate fully, at all times, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

- (1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation.
- (2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
- (3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate Health and Welfare Benefits Wrap Plan document available at [www.pebp.state.nv.ushttps://pebp.nv.gov/](https://pebp.nv.gov/) for more information regarding third party liability and subrogation.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) 3427 Goni Road, Ste 109 Carson City, NV 89706 Customer Service: (775) 684-7000, (702) 486-3100, or (800) 326-5496 Fax: (775) 684-7028 www.pebp.state.nv.us https://pebp.nv.gov/	Plan Administrator • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR <u>Claims Submission</u> P O Box 30541 Salt Lake City, UT 84130-0541 EDI #39026 <u>Appeal of Claims</u> P O Box 30546 Salt Lake City, UT 84130-0546 <u>Customer Service</u> (888) 763-8232 www.UMR.com <u>Diabetes Care Management form submission</u> UMR 27 Corporate Hill Drive Little Rock, AR 77205 Fax: 800-458-0701 Email: diabetes@HealthscopeBenefits.com	Third-party Claims Administrator/Third-party Administrator/PPO Network/ Disease Management Administrator • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Disease Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Sierra Health-Care Options, Inc PO BOX 15645 Las Vegas, NV 89144-5648 Customer Service : 888-323-1461 Fax : 800-288-2264	Utilization Management and Case Management Company • Pre-Certification/Prior Authorization • Utilization Management • Case Management • Transplants
Express Scripts Pharmacy <u>Customer Service</u>	Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and EPO Plan • Prescription drug information • Retail network pharmacies

Participant Contact Guide

(855) 889-7708 www.Express-Scripts.com <u>Accredo Patient Customer Service:</u> (800) 803-2523 <u>Accredo Physician Service Line</u> (800) 987-4904 option 5 <u>Express Scripts / Accredo Prior Authorization</u> (800) 753-2851 Electronic option: express-scripts.com/PA <u>Specialty Medication SaveonSP copay assistance</u> (800) 683-1074 www.saveonsp.com/pebp	• Prior authorization • Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies • Accredo Specialty Drug Services • Coverage and Clinical reviews • Appeals • External Review Requests • Copay/Deductible/Coinsurance assistance
HSA Bank HRA Claim Submission PO Box 2744 Fargo, ND 58108-2744 hsaforms@hsabank.com Fax: 855-764-5689 www.hsabank.com Customer Service: 833-228-9364 askus@hsabank.com myaccounts.hsabank.com	HSA and HRA Claims Administrator • HSA/HRA Claims and claim appeals
Diversified Dental Services 5470 Kietzke Lane, Ste 300 Reno, NV 89511 ProviderRelations@ddsppo.com 1-866-270-8326 diversifieddental.com	PPO Dental Network • Statewide PPO Dental Providers • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 www.myhpnstateofnevada.com/	Southern Nevada Health Maintenance Organization (HMO) • Medical claims/provider network

Participant Contact Guide

VIA Benefits 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888)598-7545 https://my.viabenefits.com/pebp Phone: (888) 598-7545; Fax: (402) 231-4310	Medicare Exchange and Medicare HRA administrator • Medigap (Supplemental) plans • Medicare Advantage Plans (HMO and PPO) • Voluntary Vision • Voluntary Dental • HRA claims administrator
United Healthcare Specialty Benefits Group Number: 370074 Customer Service: 1-888-763-8232 UnitedHealthcare Specialty Benefits P.O. Box 7149 Portland, ME 04112-7149	• Basic Life Insurance for eligible active and retirees • Member Assistance Program • Global Travel Assistance
Office for Consumer Health Assistance 3320 W. Sahara Ave, Suite 100 Las Vegas, NV 89102 Customer Service: (702) 486-3587 or (888) 333-1597 https://adssd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/	Consumer Health Assistance • Concerns and problems related to coverage • Provider billing issues • External review information
Corestream PEBP+ Customer Care: (775) 249-0716 E-mail: pebpcustomer@corestream.com www.corestream.com <u>Voluntary Life, Critical Illness, Accident, and Hospital Indemnity Insurance</u> The Standard Insurance Company (888) 288-1270 www.standard.com/mybenefits/nevada General Customer Service for Supplemental Products: (866) 851-2429	PEBP+ Voluntary Benefits Administrator • Accident Insurance • Auto Insurance • Critical Illness • Disability Insurance (Long-term and Short-term) • Home Insurance • Hospital Indemnity • Identity Theft • Legal Services • Life Insurance (Supplemental) • Pet Insurance • Vision Care

Key Terms and Definitions

The following terms or phrases are used throughout the MPD. These terms or phrases have the following meanings. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Base Plan: The Self-Funded Consumer Driven Health Plan (CDHP). The base Plan is also defined as the “default Plan” where applicable in this document and other communication materials produced by PEBP.

Business Day: Refers to all weekdays, except Saturday or Sunday, or a State or Federal holiday.

Child(ren): See the definition of dependent child(ren).

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

COBRA: means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complete Notification: means a completed event when the member submits a request for changes. To complete an event/notification the required supporting documentation must be provided to PEBP within the specified timeframe.

- Failure to provide the required documentation within the specified timeframe will result in an incomplete event/notification that will void the change request.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how plan benefits are payable when a person is covered by two or more health care plans. (See also the Coordination of Benefits section of the Consumer Driven Health Plan, Low Deductible PPO Plan, EPO Plan Master Plan Documents, or the HMO or EPO Plan Evidence of Coverage Certificate).

Coverage Tier: the category of rates and premiums or contributions for coverage that correspond to:

- An eligible participant only.
- An eligible participant and eligible spouse.
- An eligible participant and eligible dependent child(ren).
- An eligible participant, their eligible spouse, and their eligible child(ren).
- An eligible participant and eligible domestic partner.
- An eligible participant and eligible domestic partner’s child(ren); or
- An eligible participant, their eligible domestic partner, and their eligible child(ren).

Covered Individual: Any employee or retiree (as those terms are defined in this Plan), and that person’s eligible spouse/domestic partner or dependent child who has completed all required formalities for enrollment for coverage under the Plan and is covered by the Plan.

Dependent: Any of the following individuals: dependent child(ren), spouse or domestic partner as those terms are defined in this document.

Dependent Child(ren): For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),
- any other person who:
 - (1) Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
 - (2) Is unmarried.
 - (3) Has not attained the age set forth in 45 C.F.R. § 147.120(a).
 - (4) Either resides with the participant or is enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school or accredited trade or business school, on a full-time basis
 - (5) Satisfies one of the following conditions:
 - a. Is currently under a permanent legal guardianship of the participant or his or her spouse or domestic partner pursuant to chapter 159 of NRS; or
 - b. Was eligible to be claimed as a dependent on the federal income tax return of the participant or his or her spouse or domestic partner for the immediately preceding calendar year; and
 - (6) Is in a relationship with the participant or his or her spouse or domestic partner that is like a child-parent relationship. The participant or his or her spouse or domestic partner must complete and submit to the Program an affidavit attesting to the fact of the relationship.

Dependent Coverage Ends: Coverage of a dependent child ends at the end of the month:

- The child reaches his or her 26th birthday.
- The active employee or retiree coverage ends.
- The spouse, domestic partner, or dependent child(ren) no longer meets the definition of spouse, domestic partner, or dependent child(ren) as provided in the Definitions section of this document.
- Premium payment was last received (see Termination for Non-Payment);

- The plan is discontinued

Disability: A determination by the Plan Administrator or its designee (after evaluation by a Physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as mental retardation, cerebral palsy, epilepsy, neurological disorder, or psychosis.

Domestic Partner/Domestic Partnership: As defined by NRS 122A.030. The Plan will require the participant to provide a copy of the domestic partner certification from the Nevada Secretary of State. Participants who have a legal union or domestic partnership validly formed in another jurisdiction which is substantially equivalent to a domestic partnership in Nevada, are not required to file with, or provide a certification from the Nevada Secretary of State. The participant must also provide a statement acknowledging the participant's responsibility for any federal income tax consequences resulting from the enrollment of the domestic partner in the Plan. A domestic partner is not eligible for coverage as a dependent after termination of the domestic partnership.

Eligible Dependent: Your spouse/domestic partner and your dependent child(ren). An eligible dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.

Employer: Unless specifically indicated otherwise when used in this document, employer refers to an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

Employer Group Health Plan: Any employer who sponsors a health plan for their active employees.

Enroll, Enrollment: The process of completing enrollment, either by use of the e-PEBP online enrollment tool or submitting a written form indicating that coverage by the Plan is requested by the employee or retiree. An employee or retiree may request coverage for an eligible dependent only if he or she is or will be covered by the Plan.

Family Unit: The covered employee or retiree and the family members who are covered as dependents under the covered employee's or retiree's plan.

Full-Time Employment: Employees working 80 hours a month (NAC 287.150) or an average of at least 130 hours per month as defined by the IRS ("Identifying Full-time Employees").

Employer Group Health Plan; Group Health Insurance: Group health insurance is any group health policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, dental or surgical services, home health care or health supportive services for members of the family or dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group. Group health insurance is declared to be that form of health insurance covering groups of two or more persons, formed for a purpose other than obtaining insurance (NRS 689B.020).

Health Reimbursement Arrangement: A Health Reimbursement Arrangement (HRA) is an employee-funded spending account that can be used to pay qualified medical expenses. The HRA is 100% funded by the employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted or insurance coverage kicks in. The contribution amount per employee is set by the employer, and the employer determines what the funds can be used to cover and if the dollars can be rolled over to the next year. In most cases, if the employee leaves the employer, they cannot take remaining HRA funds with them.

Health Care Provider: A health care practitioner, hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility.

Health Savings Account: An account that allows qualified employees to pay for current health expenses and save for future qualified medical and Retiree health expenses on a tax-free basis.

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights for certain employees and dependents who experience a loss of other employer group coverage and when there is an adoption, placement for adoption, birth, marriage, or a domestic partnership certification from the office of the Nevada Secretary of State or a domestic partnership validly formed in another jurisdiction which is substantially equivalent in Nevada.

Ineligible Dependents: Individuals who are not eligible as defined above are not eligible dependents under this Plan.

Medicare: The health insurance for the aged and disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Part A: Hospital insurance provided by the federal government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the federal government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the federal government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.

Mini-med or other limited benefit plan: Mini-med health plans or other limited benefit plans feature limited benefits. There is a maximum amount that the plan will pay. Once that limit is hit, remaining medical expenses have to be covered “out-of-pocket” by the enrollee.

National Medical Support Notice (NMSN)/Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a dependent child and requiring that benefits payable on account of that dependent child be paid directly to the health care provider who rendered the services.

Notification: When a member initiates a change to their benefits with PEBP (Open Enrollment, Qualifying Life Event, or HIPAA Special Enrollment) through their online PEBP account. The date a notification is received may control the effective date of benefit changes. A notification may be subject to requirements for supporting documentation (see the definition of “completed notification” for more information).

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage. The Plan’s open enrollment period is described in the *Eligibility* section of this document.

Over age Child with a Disability or Disabled Dependent Child over the age of 26 years: As determined by the Plan Administrator or its designee, is an unmarried child who has reached his or her 26th birthday who, as evaluated by a physician, has a permanent or continuing mental or physical impairment and is incapable of self-sustaining employment or self-sufficiency as a result of having that impairment; depending chiefly on the participant or the participant’s spouse/domestic partner for support and maintenance and whom the participant claims as a dependent on IRS tax forms under the IRS Code 152(1) (without regard to the gross income test). This Plan will require proof of having a disability at reasonable intervals during the two years following the date the dependent reaches the limiting age of 26 years and after this two-year period the Plan Administrator may require proof not more than once each year. The Plan Administrator reserves the right to have the dependent examined by a physician of the Plan Administrator’s choice (and at the Plan’s expense) to determine that the dependent meets the definition of a disabled dependent child over the age of 26 years. Children covered under legal guardianship are not included in this definition.

Placed for Adoption: For the definition of placed for adoption as it relates to coverage of adopted dependent children, see the definition in the section on adopted dependent children in the *Eligibility* section.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Participant: The employee or retiree or their enrolled spouse/domestic partner or dependent child(ren) or a surviving spouse/domestic partner of a retiree.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, all Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

Positive Open Enrollment: This process requires that each participant affirmatively make their benefit elections during the PEBP open enrollment period. Even if they do not want to make any coverage changes, they must affirmatively make their elections, or they will be defaulted to self-coverage only under the PEBP Base Plan.

Program: Means the Public Employees' Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

Provider: See the definition of Health Care Provider.

Qualified Medical Child Support Order (QMCSO)/National Medical Support Notice (NMSN): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a dependent child and requiring that benefits payable on account of that dependent child be paid directly to the health care provider who rendered the services.

Rescission: A cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.

Retiree: Unless specifically indicated otherwise, when used in this document, retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Significantly Inferior Coverage: A "mini med" or other limited benefit plan; or a catastrophic coverage plan with a Deductible equal to or greater than \$5,000 with no employer contributions to Health Savings Accounts or Health Reimbursement Arrangements or any other coverage. PEBP will determine if an employer sponsored group health plan meets the definition of significantly inferior coverage.

Spouse: The employee's or retiree's lawful spouse (opposite sex or same sex) as determined by the laws of the State of Nevada. The Plan will require proof of the legal marital relationship. The former spouse of an employee or retiree is not an eligible spouse under this Plan.

State: When capitalized in this document, the term State means the State of Nevada.

Tier of Coverage: The category of rates and premiums or contributions for coverage that correspond to either an eligible participant only, or an eligible participant and one or more eligible dependents.

Unsubsidized Dependent of a Retiree: An unsubsidized dependent is defined as the eligible spouse/domestic partner and/or eligible dependent(s) of a retiree who remains covered under the Consumer Driven Health Plan (CDHP), Low Deductible PPO (LD PPO), HMO Plan or EPO Plan while the primary participant transitions coverage to the Medicare Exchange.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.



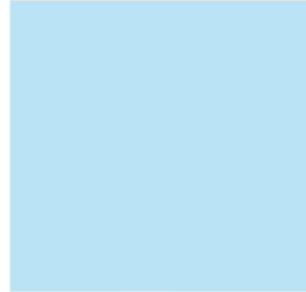
Access.
Quality.
Affordability.



MEDICARE EXCHANGE HEALTH REIMBURSEMENT ARRANGEMENT SUMMARY PLAN DESCRIPTION

Plan Year 2024~~3~~5

(Effective July 1, 2024~~3~~5 – June 30, 2025~~4~~5)





Administered By:



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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Plan Information

Name of Plan (The Plan):	Public Employees' Benefits Program Medicare Exchange Health Reimbursement Arrangement (HRA)
Plan Sponsor:	State of Nevada Public Employees' Benefits Program (PEBP)
Plan Administrator:	State of Nevada Public Employees' Benefits Program (PEBP)
Address:	3427 Goni Road, Suite 109 Carson City, NV 89706
E-mail Address:	Contact member services by logging on to your E-PEBP member portal accessed by clicking on the orange log in icon at https://pebp.nv.gov/ . ~~www.pebp.state.nv.us~~
Telephone Number:	(775) 684-7000, (702) 486-3100, or (800) 326-5496
Tax Identification Number:	88-0378065

Third-Party Administrator

Third-Party Administrator:	Via Benefits formally Towers Watson's One Exchange
Address:	10975 Sterling View Drive, Suite A1 South Jordan, UT 84095
Telephone Number:	(888) 598-7545
Website Address:	https://my.viabenefits.com/PEBP

Third-Party Administrator for the HRA

Third-Party Administrator:	Via Benefits Reimbursement Accounts Administered by Extend Health, LLC
Claims Address:	P.O. Box 891155 El Paso, TX 79998-1155
Telephone Number:	(888) 598-7545 (TTY: 711)
Claims Fax Number:	(855) 321-2604
Plan Number:	Medicare Exchange HRA
Plan Year:	Plan Year 202 ~~4~~ ⁵ ; effective July 1, 202 ~~4~~ ³ – June 30, 202 ~~5~~ ⁴
Plan Origination:	July 1, 2011

Introduction

The Public Employees' Benefits Program provides a health reimbursement arrangement ("HRA") for the purpose of allowing Eligible Retirees to obtain reimbursement of Qualified Medical Expenses incurred by such retirees and their eligible dependents.

The Medicare Exchange HRA is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45 and a medical reimbursement plan under Code sections 105 and 106. The Qualifying Medical Expenses reimbursed under the HRA are intended to be eligible for exclusion from a retiree's gross income under Code section 105(b). PEBP's HRA benefits may also be subject to IRS Publication 969.

The Plan sponsor and its designee(s) will have discretionary authority to determine the applicability of and interpret the provisions within this document.

This Summary Plan Description will help you understand how the Medicare Exchange HRA works. It describes the benefits available, the advantages of a health reimbursement arrangement and the key features of the Medicare Exchange HRA. Please take the time to familiarize yourself with the contents of this document and keep it for your future reference.

Provisions of this document contain important information. If you have questions about the Medicare Exchange HRA or your obligations under the Medicare Exchange HRA Plan, contact the Third-Party Administrators that is listed under "**Plan Information.**"

The following list of documents provides additional related to dental insurance, life insurance, PEBP enrollment and eligibility provisions, HIPAA Privacy and Security, and Mandatory Notices. These documents are available at <https://pebp.nv.gov/> ~~www.pebp.state.nv.us~~ or by request by calling PEBP.

- PPO Dental Plan Master Plan Document (MPD)
- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO (LD PPO)
- PEBP PPO Dental Plan and Summary of Benefits for Life and Long-Term Disability Insurance Master Plan Document
- Exclusive Provider Organization Plan Master Plan Document
- Exclusive Provider Organization Plan Summary of Benefits and Coverage for Individual and Family
- Health Reimbursement Arrangement Summary Plan Document
- Section 125 Health and Welfare Benefits Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description
- PEBP Enrollment and Eligibility Master Plan Document.

These documents are available at <https://pebp.nv.gov/>. ~~www.pebp.state.nv.us.~~

It is important to stay informed of the most up to date information regarding your healthcare benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Medicare Exchange Health Reimbursement Arrangement Plan (HRA)

Purpose of the Medicare Exchange HRA

The HRA or reimbursement account is initially set up on behalf of Eligible Retirees. The HRA is funded based on an amount determined by the Plan Administrator. Eligible Retirees receive a monthly allocation to their individual HRA based upon the monthly funding amount set by the Plan Administrator, the retiree's years of service, and retirement date. The HRA can be used by Eligible Retirees to request reimbursement of HRA-Qualified Medical Expenses incurred by the retiree, retiree's spouse, or the retiree's IRS-qualified tax dependent(s).

The HRA is established on behalf of Eligible Retirees coincident with their coverage effective date in an individual health insurance policy (Medicare Plan) through Via Benefits; or on behalf of Eligible Retirees with Tricare for Life and Medicare Parts A and B. The HRA is funded solely by the Plan Administrator. Reimbursement payments from the Medicare Exchange HRA are not includible in the retiree's gross income and are not taxable to the retiree.

Medicare Exchange HRA Eligibility

Eligible Retiree

To qualify for the Medicare Exchange HRA, an Eligible Retiree must meet the following requirements:

- Enroll in Medicare Parts A and B coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code, and;
- Enroll in an individual health insurance policy (Medicare Plan) through Via Benefits¹; and
- Retain coverage in an individual health insurance policy (Medicare Plan) through Via Benefits; or
- Enroll in TRICARE for Life, Medicare Parts A and B, and submit copies of the Tricare for Life and Medicare Parts A and B cards to the Plan Administrator; and
- Complete any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator.

Termination of the Medicare Exchange HRA

Participation in the Medicare Exchange HRA plan will end:

1. On the date the Eligible Retiree ceases to be an Eligible Retiree for any reason, including but not limited to:
 - a. Enrollment in the CDHP, LD PPO, Exclusive Provider Organization Plan, or Health

¹ Any eligible retiree who does not enroll in and maintain an individual health insurance policy through the Via Benefits WILL LOSE their PEBP sponsored benefits (i.e., Medicare Exchange HRA funding, life insurance, dental insurance, etc.)

- Plan of Nevada (HMO) coverage, if eligible;
 - b. Enrollment in other employer group coverage that may preclude enrollment in an individual Medicare plan through Via Benefits;
 - c. Upon obtaining employment as an active employee of the State of Nevada or a participating local government;
 - d. Ineligibility or declination Medicare Parts A and/or B coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code;
 - e. Failure to pay for Medicare Part B coverage resulting in termination of Medicare Part B coverage;
 - f. Any change to a retiree's Medicare Supplement (Medigap), Medicare Advantage Plan, Medicare Advantage Plan with Prescription Drug Plan, etc., resulting in the removal of Via Benefits as the Agent of Record. For example, if a retiree knowingly or unknowingly enrolls in a medical plan directly with an insurance carrier which results in a change of Via Benefits as the Agent of Record. **Important!** To avoid the loss of HRA funding and other PEBP-sponsored benefits, retirees should always contact Via Benefits for assistance regarding questions related to their Medicare plans. This includes questions about plan options, including changing plans if moving to another city, state or county, premiums, etc.;
 - g. Due to the death of the Eligible Retiree.
2. On the effective date of any Medicare Exchange HRA Plan amendment that renders the Eligible Retiree ineligible to participate.
 3. On the effective date of termination of the Medicare Exchange HRA Plan.
 4. With respect to an eligible dependent, the date he or she ceases to be an eligible dependent for any reason, including but not limited to:
 - a) death of the eligible dependent;
 - b) divorce from the Eligible Retiree;
 - c) if the dependent is otherwise no longer considered a dependent pursuant to IRS Code 152; or
 - d) the cessation of participation of the Eligible Retiree.

Loss of Coverage

When coverage through Via Benefits is terminated by the Eligible Retiree, PEBP (the insurance carrier), due to the Eligible Retiree's death, non-payment of premiums or Via Benefits, is no longer the "Agent of Record," the retiree shall receive no further Medicare Exchange HRA funding, and;

- A. his or her eligible expenses incurred after such date will not be reimbursed even if HRA funding credits remain in the retiree's HRA account; and
- B. the Eligible Retiree may submit claims for reimbursement for HRA-Qualified Medical Expenses incurred prior to his or her loss of coverage (e.g., break in coverage, loss of eligibility, etc.), provided the Eligible Retiree files such claims within one hundred eighty

(180) days of loss of coverage. This means, when an Eligible Retiree's coverage is terminated, he or she will have one hundred eighty days (6 months) from the date coverage ends to file a claim for reimbursement for qualified medical expenses incurred during the eligible coverage period.

COBRA

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event to elect coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). If a proceeding in bankruptcy is filed with respect to the State of Nevada PEBP Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Funding

Medicare Exchange HRA Plan Funding

The benefits described in this document are provided by the Plan Administrator out of its assets, and no assets shall be segregated or earmarked for the purpose of providing benefits, nor shall any person have any right, title or claim to such assets prior to the submission and acceptance of a claim for eligible medical expenses. As such, each Medicare Exchange HRA is established pursuant to the Medicare Exchange HRA Plan as a notional account which reflects a bookkeeping concept and does not represent assets that are set aside for the exclusive purpose of providing reimbursement of qualified expenses to the Eligible Retiree under the terms of the Medicare Exchange HRA Plan. In no event may any benefits under the Medicare Exchange HRA Plan be funded with retiree contributions.

Benefit Credits

The Plan Administrator will credit each Eligible Retiree's Medicare Exchange HRA account with the benefit credits as described under the definition of *HRA Contribution*.

Medicare Exchange HRA Carryover Limit

HRA balances in excess of **\$8,000** will be capped annually on May 31st. This means HRA funds may accumulate throughout the year; however, on May 31st of each year, any HRA balance which exceeds **\$8,000** will be returned to the Plan and will not be available for reimbursement. Once funding for balances over **\$8,000** are removed from the HRA they cannot be reinstated, even by means of an appeal. To avoid having HRA funds returned to the Plan, retirees are encouraged to use their HRA dollars to request reimbursement for monthly insurance premiums such as Medicare Supplement (Medigap), Medicare Advantage, Part D prescription drug plans, Medicare Part B, dental, and vision plans. HRA funds may also be used for eligible out of pocket expenses such as copays, deductibles, and other qualifying out of pocket healthcare expenses. Timely claim submission is also recommended as retirees have one year from when the expense is incurred to have it submitted and processed for reimbursement. Claims submitted and processed for reimbursement more than one year after the incurrence date will automatically be denied.

HRA-Qualified Medical Expenses

Eligible Expenses

The Medicare Exchange HRA Plan is administered by Via Benefits for the purpose of reimbursing Eligible Retirees for HRA-Qualified Medical Expenses incurred by the retiree, the retiree's spouse, and eligible dependent(s) on a tax-free basis. IRS Tax Code 213(d) determines reimbursable expenses. View IRS [Publication 502](https://www.irs.gov/pub/irs-pdf/p502.pdf) (<https://www.irs.gov/pub/irs-pdf/p502.pdf>), Medical and Dental Expenses for detailed information and descriptions of qualified medical expenses.

Examples of HRA-Qualifying Medical Expenses:

- Premiums for Medicare Parts A, B and D coverage,
- Premiums for Medicare Plan coverage purchased through Via Benefits,
- Excess Medicare Part B charges,
- Premiums for medical, dental and vision care plans, which are not paid on a pre-tax basis through a Code section 125 plan ("cafeteria" plan),
- Premiums for coverage under a long-term care plan,
- Deductibles for Medicare Parts A and B, medical, dental and vision care plans,
- Co-payments under Medicare, Medicare Plans, medical, dental and vision care plans,
- Out-of-pocket expenses for prescription drug copayments,
- Charges in excess of reasonable and customary charges as determined under medical, dental and vision care plans,
- Hearing exams and hearing aids,
- Acupuncture fees, and, but not limited to
- Eye exams, prescription eyeglasses and contact lenses.
- Certain Over-the-Counter products in accordance with the CARES Act, passed by Congress on March 27, 2020, repealed a rule from the 2010 Affordable Care Act that disallowed tax-free reimbursement of over-the-counter drugs or medicines (collectively "OTC") without a prescription. With this change, HRAs can cover certain OTC products without prescriptions. Eligible OTC includes any drugs or medications that are primarily for treatment (not cosmetic or for general health), menstrual care products such as tampons, pads, liners, etc., and medical devices and supplies.

In no event shall any benefits under this Medicare Exchange HRA Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for IRS-approved out-of-pocket health care expenses and qualifying health insurance premiums. The Medicare Exchange HRA Plan is considered a retiree only arrangement and is not subject to PPACA group market reforms.

Amount of Reimbursement

Eligible Retirees may request reimbursement of HRA-Qualified Medical Expenses from the HRA at any time during the Plan Year. A retiree will only be reimbursed up to the amount in the HRA.

If the amount of the expense for which a retiree is requesting is more than the unused amount in his or her HRA, then the amount of the expense will be carried forward until the unused amount in the HRA is sufficient to reimburse the expense.

Summary of Reimbursement Options and Requirements

Timely Filing of HRA reimbursement claims

In accordance with NAC 287.610, claims must be submitted to the Via Benefits within one year (12 months) from the date the service(s) were incurred. No HRA reimbursements will be paid for any claim submitted after this period.

Automatic Dental Premium Reimbursement for Retirees Enrolled in PEBP's PPO Dental Plan

Automatic Dental Premium Reimbursement is required for any retiree who enrolls in PEBP's PPO Dental Plan. Any retiree who enrolls in PEBP's PPO Dental Plan will automatically be reimbursed his or her PPO Dental Plan premium up to the amount in the HRA. If the amount of the PPO Dental Plan premium is more than the unused amount in the HRA, then the amount of the premium will be carried forward in his or her HRA until the unused amount in the HRA is sufficient to reimburse for the PPO Dental Plan premium.

Automatic Premium Reimbursement (APR) - Via Benefits Participating Plans

Automatic Premium Reimbursement (APR) is a service offered by Via Benefits that enables retirees to be reimbursed for their monthly insurance plan premiums without manually submitting a reimbursement request. Automatic Premium Reimbursement is available for most, but not all Via Benefits' plans. With Automatic Premium Reimbursement, the retiree pays their premium to the insurance carrier (Automatic Premium Reimbursement does not pay the premium). Once the premium has been paid, the insurance carrier transmits an electronic receipt for the payment to Via Benefits and Via Benefits reimburses the retiree for their premium, up to the available balance in the retiree's HRA. To find out which insurance carriers offer Automatic Premium Reimbursement, login to the Via Benefits portal or contact Via Benefits.

If Automatic Premium Reimbursement is not available, retirees may be able to use Recurring Premium Reimbursement.

Recurring Premium Reimbursement Request

The Recurring Premium Reimbursement Request is available for plans that do not offer automatic reimbursement. Submit the Recurring Premium Reimbursement Request only for recurring plan premiums that are scheduled and reoccur on a monthly basis. The Recurring Premium Reimbursement Request must be submitted once each calendar year to be reimbursed monthly. The request can be made online using the Via Benefits portal, the VIA Benefits Mobile App, or by completing the *Reimbursement Request Form*. You must also submit a copy of your annual policy statement or coupon book that is sent to you by your insurance carrier which shows your premium for the year and includes the following information.

- Name of insured
- Name of insurance company (e.g., AARP)

- Type of coverage (e.g., medical, dental)
- Date of coverage (e.g., 1/01/2018 thru 12/31/2018)
- Monthly premium amount (e.g., \$125)

Medicare Part B Reimbursement

You can be reimbursed for your standard Medicare Part B premium without having to submit a Reimbursement Request Form or supporting documentation if you are enrolled in a “core Medicare Medical plan with Via Benefits. To activate this reimbursement type you can call Via Benefits, access your account online, or access your account via the Via Benefits Mobile App. It is important to note the following:

- If you have a Medicare Part B Premium that is greater or less than the standard premium amount, a claim form and supporting documentation is required.
- If you have a Tricare exception to qualify for the HRA, this reimbursement option is not available and you would have to submit a request manually.

You can be reimbursed for your Medicare Part B premium by submitting the *Reimbursement Request Form*. The recurring reimbursement request must be submitted once each calendar year to be reimbursed monthly. The request may be submitted online by logging into the Via Benefits portal or by using the *Reimbursement Request Form*. In addition to the Reimbursement Request Form, you must also submit a copy of your *Social Security Benefit Award Letter (Proof of Income Letter)*. You can request a copy of this letter by contacting Social Security Administration (SSA) at 1-800-772-1213 (TTY: 1-800-325-0778) or online at SSA.gov and searching for “*Request a Proof of Income Letter*”. If you are not collecting Social Security, you can submit a copy of the monthly or quarterly Medicare Premium Bill for Part B in place of the Awards Letter.

Prescription and/or Office Visit Copayments

Non-premium related expenses such as prescription and office visit copays may be reimbursed by submitting a Reimbursement Request Form. This request can be made by logging into the Via Benefits portal or by using the *Reimbursement Request Form*. You will need to include a receipt or third-party document that includes the following information:

- Provider name,
- Participant name,
- Date of service,
- Description of service or product, and
- Proof you paid for the service, or
- An Explanation of Benefits (EOB) from your insurance company which includes the above information.

Expenses incurred in a foreign country

Qualified expenses incurred in a foreign country may be eligible for reimbursement. If the supporting documentation is in a foreign language, the five required elements (provider name, participant name, date of service, description of service or product, and proof of payment for

the service) must be translated into English. The amount of the expense must be converted from the foreign currency to U.S. dollars using a current currency exchange rate.

Via Benefits will reimburse the Eligible Retiree for expenses that it determines are eligible expenses up to the balance in the retiree's HRA at such intervals as PEBP may deem appropriate (but not less frequently than monthly). Via Benefits reserves the right to verify that claimed health care expenses satisfy the IRS 213D definition of Qualifying Medical Expenses prior to reimbursement.

By submitting the reimbursement request, you certify that the information provided on the Reimbursement Request Form is correct and complete. You also certify that the expenses for which you are requesting reimbursement were incurred for expenses for the covered participant while eligible under the plan on or after its effective date, the expenses have not been reimbursed in any other way from any other source, and the expenses will not be submitted for future reimbursement from any other source.

Expenses eligible for coverage under any medical, HMO, dental, or vision care plans in which the Eligible Retiree or his or her eligible dependent(s) are enrolled must be submitted first to appropriate claims administrators for such plans before submitting the expenses to the Third-Party Administrator for reimbursement under the HRA. An Eligible Retiree who is entitled to payment or reimbursement under a health care reimbursement account in a cafeteria plan under IRS Code Section 125 must receive his or her maximum annual reimbursement under the health care reimbursement account in the cafeteria plan before he or she is entitled to any reimbursement under this HRA.

Claim Review Timing

Claims will be paid in the order in which they are received by Via Benefits and will be charged to the HRA account of the eligible retiree who submits the claim. PEBP may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

Via Benefits shall review received claims and respond within thirty (30) days of receipt. If the Via Benefits determines that an extension is necessary due to matters beyond the control of the HRA, Via Benefits will notify the claimant within the initial thirty (30) day period that they will need up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to Via Benefits. In accordance with NAC 287.610, claims must be submitted to Via Benefits within one year (12 months) from the date the service(s) were incurred. No HRA reimbursements/benefits will be paid for any claim submitted after this period.

Via Benefits Medicare HRA Claim Appeal Process

Notice of Claim Denial

Via Benefits will notify every claimant who is denied a claim for benefits (in whole or in part) the following in written or electronic notice:

- the specific reason or reasons for the denial;
- specific reference pertinent to plan provisions on which denial is based;
- a description of any additional material or information necessary for the claimant to correct the claim and an explanation of why such material or information is necessary;
- upon request, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge; and
- a description of the HRA's appeal procedures and the time limits applicable to such procedures.

Requests for appeal must be made in writing to the office where the claim was originally submitted or online at <https://my.viabenefits.com/pebp> within 180 days after receipt of the notice of denial. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against PEBP (or State of Nevada) in a court proceeding.

The appeal process works as follows:

Level 1 Appeal

If your HRA claim is denied, or if you disagree with the amount paid on a claim, you may request a review from Via Benefits within 180 days of the date you received the explanation of payment (EOP) with the initial claim determination. Failure to request a review in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Medicare Exchange HRA Plan unless the Plan Administrator determines that the failure was acceptable. The written request for appeal must include:

- The name and social security number, or member identification number, of the participant;
- A copy of the EOP and claim; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit your own comments in writing. Via Benefits will review your claim. If any additional information is needed to process your request for appeal, it will be requested promptly.

The decision on your appeal will be given to you in writing. Ordinarily, a decision on your appeal will be reached within twenty (20) days after receipt of your request for appeal. If the appeal results in a denial of benefits in whole or in part, it will explain the reasons for the decision, with reference to the applicable Medicare Exchange HRA provisions on which the denial is based. It will also explain the steps necessary if you wish to proceed to a Level 2 appeal if you are not satisfied with the response at Level 1.

Level 2 Appeal

If, after a Level 1 appeal is completed, you are still dissatisfied with the denial of your HRA claim, rescission of coverage, or amount paid on your claim you may submit your written request to the Executive Officer of PEBP or his designee (see the *Plan Information* section in this document for the address) within 35 days after you receive the decision on the Level 1 appeal, together with any additional information you have in support of your request.

To file a Level 2 claim appeal, PEBP encourages you to complete a claim appeal request form. To obtain a claim appeal request form, contact PEBP customer service. Furthermore, you are welcome to submit Level 2 Claim Appeals online through a form that can be found under the subheading “Filing an Appeal” under PEBP’s contact us web page. Your Level 2 appeal must include a copy of:

- the Level 1 review request;
- a copy of the decision made on review; and
- any other documentation provided to the HRA Third-Party Administrator by the participant.

A decision on a Level 2 appeal will be given to you in writing within 30 days after the Level 2 appeal request is received by the Executive Officer or his designee and will explain the reasons

for the decision. If the appeal review results in a denial of benefits in whole or in part, it will explain the reasons for the decision, with reference to the applicable provisions of the Plan upon which the denial is based. A Level 2 appeal is final.

Definition of Terms

Account Structure: A separate Medicare Exchange HRA account will be established for an eligible retiree within a single family. An otherwise eligible retiree enrolled as a dependent of an eligible retiree will NOT receive a separate Medicare Exchange HRA account.

Agent of Record: An Agent of Record is a company or individual who has the legal authority to represent the insured in maintaining, servicing, and purchasing an insurance policy.

Benefit Credit: The amount credited to an eligible retiree's Medicare Exchange HRA accounts for the provision of benefits under the Medicare Exchange HRA.

Code: The Internal Revenue Code of 1986 (Section 105), as amended from time to time.

Death: Dependents shall NOT continue to receive benefit credits after the month of the eligible retiree's death.

Eligible Dependent²: A dependent who is:

- A spouse or other dependent of an eligible retiree as defined in Internal Revenue Code (IRC) Section 152 (26 USC § 152).
- A spouse or other dependent of an eligible retiree as defined in PEBP's Master Plan Document.
- HRA funds may not be used for a person who does not meet the IRS definition of dependent as defined in IRC section 26 USC § 152, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether PEBP provides coverage for the dependent.

Eligible Expenses: Eligible expenses that do not exceed the balance in your HRA can be reimbursed from your HRA if the expenses are incurred during the time you participate in the HRA. Expenses are eligible only to the extent that they are not paid for by your health care coverage. Eligible expenses are the costs associated with the diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. See also *Qualifying Medical Expenses*.

Eligible Retiree²: An eligible retiree is a retiree who:

- A. is eligible to be covered under PEBP pursuant to:
 - 1) Nevada Revised Statutes Chapter 287;
 - 2) Nevada Administrative Code Chapter 287, and

² For complete eligibility information, please refer to the PEBP Enrollment and Eligibility Master Plan Document.

- 3) The Master Plan Document for the PEBP Enrollment and Eligibility.
- B. is eligible for and enrolled in premium-free Medicare Part A;
- C. is eligible for and enrolled in Medicare Part B; and
- D. elects medical coverage through the Individual Medicare Exchange sponsored by PEBP; or
- E. has TRICARE for Life

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal Regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HRA Contribution: Also referred to as a “benefit credit” is the amount of money determined by your years of service and retirement date that is deposited to your HRA account on a schedule determined by the Plan Administrator. Retired public employees enrolled in a medical plan through the Via Benefits may qualify for an HRA contribution based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employer.

- A. The following monthly amount will be credited on behalf of eligible retirees:
 - 1) For Eligible Retirees who retired prior to January 1, 1994, the dollar amount is equal to the base amount as determined by the Legislature during each legislative session. For detailed information regarding contribution amounts refer to the Benefits Guide located on the PEBP website at <https://pebp.nv.gov/www.pebp.state.nv.us> or contact PEBP at 775-684-7000 or 800-326-5496 to request the Benefits Guide.
 - 2) For Eligible Retirees who retired on or after January 1, 1994, the dollar amount is equal to the base amount as determined by the Legislature during each legislative session multiplied by the years of service credit (calculated pursuant to NAC 287.485) up to a maximum of 20 years of service. For detailed information regarding contribution amounts refer to PEBP’s Master Plan Document located on the PEBP website at <https://pebp.nv.gov/. www.pebp.state.nv.us>.
- B. No amount will be credited for certain retirees who do not meet the requirements to receive a years of service Medicare Exchange HRA Plan contribution (pursuant to NRS 287.046).

HRA Contribution Eligibility: To receive the PEBP HRA contribution, an Eligible Retiree must enroll in an individual Medigap, Medicare Advantage with Prescription Drug or Medicare Advantage Plan and maintain individual Medicare Plan coverage through the Via Benefits. If the Eligible Retiree does not enroll and maintain medical coverage as described above, the Eligible Retiree will NOT receive the PEBP HRA contribution amount and will lose their PEBP sponsored benefits entirely including but not limited to life insurance and dental insurance.

Effective July 1, 2015, the policy described under “HRA Contribution Eligibility” does not apply to Eligible Retirees or their spouses who have health coverage under TRICARE for Life and Medicare Parts A and B. To receive the PEBP HRA contribution, these individuals must submit a copy of their Military ID card(s) and Medicare Parts A and B card to PEBP.

Individual Market Medicare Exchange: The health care exchange for individuals who have Medicare Parts A and B and is operated by the Third-Party Administrator, whose name and address is provided in the *Plan information* section of this document, and its subcontractors.

Medicare: The coverage provided under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare Parts A and B).

Medicare Exchange Health Reimbursement Arrangement (HRA) Account is the bookkeeping account established by the Plan Administrator for an Eligible Retiree to hold his or her benefit credits.

Medicare Exchange HRA: The HRA is provided to Eligible Retirees enrolled in a Medicare Plan through Via Benefits and Eligible Retirees who have Tricare for Life and Medicare Parts A and B. The HRA Plan is an excepted benefit and not subject to the Patient Protection Affordable Care Act (PPACA) group market reforms.

Medicare Plan: One of the following plans which supplements the benefits provided by Medicare purchased through the Via Benefits:

- An individual Medicare Advantage Plan which excludes Medicare Part D prescription drug coverage (issued by an insurance carrier pursuant to a contract with the Centers for Medicare and Medicaid Services);
- An individual Medicare Advantage Plan which includes Medicare Part D prescription drug coverage (issued by an insurance carrier pursuant to a contract with the Centers for Medicare and Medicaid Services);
- A Medicare Supplement Plan (also called Medigap);
- A Special Needs Plan which is purchased through Via Benefits.

Medicare Supplement Plan: An individual plan which supplements the benefits provided by Medicare, and which meets the requirements of a standard Medicare Supplemental Plan under applicable law.

Plan: Public Employees’ Benefits Program Medicare Exchange Health Reimbursement Arrangement Plan (HRA Plan). Also referred to as the Plan.

Plan Year: The Plan Year as defined in the PEBP Master Plan Document, typically the 12-month period from July 1 through June 30. The PEBP Board has the authority to revise the Plan Year if necessary.

Protected Health Information (PHI): As described in 45 C.F.R. § 164.103, and generally includes individually identifiable health information held by or on behalf of the Medicare Exchange HRA Plan.

Qualifying Medical Expense: Eligible Expenses: Eligible expenses that do not exceed the balance in your HRA can be reimbursed from your HRA if the expenses are incurred during the time you participate in the HRA. Expenses are eligible only to the extent that they are not paid for by your health care coverage. Eligible expenses are the costs associated with the diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for eligible medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of medical equipment, supplies, and diagnostic services.

Eligible expenses must be primarily to treat or prevent a physical or mental illness. They do not include expenses that are provided only for the purpose of supporting general health, such as vitamins or vacations.

Eligible expenses include the premiums you pay for insurance that covers the expenses of medical care and the amounts you pay for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.

For a list of expenses eligible for reimbursement under the HRA refer to the Internal Revenue Service (IRS) Publication 502, available by calling 1-800-tax-form (1-800-829-3676) or by logging on to the IRS website at <http://www.irs.gov>. Publication 502 provides a list of eligible expenses and any applicable limitations. Below are examples of eligible expenses.

- Acupuncture
- Chiropractic
- Contact Lenses
- Durable Medical Equipment
- Hearing Aids
- Certain Insurance Premiums (Health, Long Term Care, etc.)

PEBP reserves the right to update/change this section at any time.

Residing outside of the United States: If an otherwise eligible retiree (see definition of eligible retiree) resides outside the United States, there is no PEBP requirement for the eligible retiree to maintain Medicare coverage or enroll with the Medicare Exchange. The eligible retiree may enroll in an eligible PEBP plan. If the eligible retiree returns to the United States and establishes permanent residency in the United States, the eligible retiree is required to enroll in Medicare and the Medicare Exchange. The eligible retiree must contact PEBP prior to their return to the United States or immediately after returning to the United States. If the eligible retiree fails to notify PEBP of their return, their coverage under PEBP may be terminated. If you have questions about your eligibility, please contact PEBP.

Spouse: The Eligible Retiree's lawful spouse I PEBP will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse of an employee or retiree is not an eligible spouse under this Plan.

Third-Party Administrator: Via Benefits; also referred to as the contracted Third-Party Administrator.

Timing of Benefit Credit: Benefit credit (see definition of Benefit Credit) will be credited to Medicare Exchange HRA accounts on the first business day of each calendar month as determined by PEBP.

Years of Service: Years of service as calculated pursuant to [NAC 287.485](#) and maintained in the eligibility records of PEBP. Retired public employees enrolled in a medical plan through Via Benefits may qualify for an HRA contribution based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employer.



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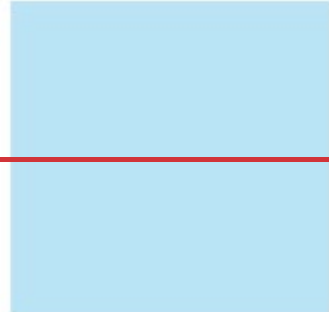


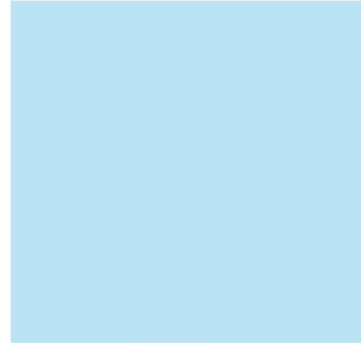
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(EFFECTIVE JULY 1, 20234 – JUNE 30, 20254)




NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM
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Public Employees' Benefits Program
3427 Goni Road, Suite 109
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Amendment Log

~~Article 4 Benefits:~~

~~4.2 Compliance with Federal Group Health Plan Benefits and Coverage Mandates: plan changes approved in March 2023 Board Meeting – Removed reference to coronavirus benefits.~~

Article 1. Introduction

1.1 Introduction

The Plan includes the Component Benefits listed in Schedule 1 of this Plan document for Employees and their eligible Dependents participating in the Public Employees' Benefits Program, hereafter referred to as PEBP. The provisions of the Component Benefits are contained in the Incorporated Documents.

- (a) This PEBP Plan is governed by the State of Nevada.
- (b) This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code 287 as amended and certain provisions of NRS 695G, NRS 689B, the Patient Protection and Affordable Care Act (PPACA), etc.

The Plan described in this document is effective **July 1, 2023~~4~~**, and unless stated differently, replaces prior medical and prescription drug benefit plan documents/summary plan descriptions. Per NRS 287.0485 no officer or Employee, of the State has any inherent right to benefits provided under the PEBP.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. As the Plan is amended from time to time, Participants will be sent information explaining the changes. This Plan is administered in accordance with regulations of Section 125 of the Internal Revenue Code ("Code") as described in the PEBP Section 125 Health and Welfare Benefits Plan Document available at <https://pebp.nv.gov/>.

This Plan is not established under and subject to the Employee Retirement Income Security Act of 1974, as amended, a federal law commonly known as ERISA. The self-funded portions of this Plan are funded with contributions from participating Employers and eligible Participants and held in an internal service fund. An independent Claims Administrator pays benefits out of the fund's assets. An independent Claims Administrator pays the claims for medical and prescription drug benefits.

1.2 Legal Status of Plan

The Plan is intended to qualify as an accident and health plan under Sections 105 and 106 of the Code and as a plan providing group-term life insurance coverage, as described in Section 79 of the Code. The Plan is intended to comply with the laws of the State of Nevada, the Code, and the Public Health Service Act (PHSA) and the regulations and rules promulgated under each, to the extent applicable, and any other applicable law.

The Plan shall be construed and interpreted in a manner consistent with the requirements of Sections 79, 105 and 106 of the Code, and any other applicable sections of the Code, the PHSA or any other applicable law.

1.3 Applicability of the Plan

Except as otherwise provided herein, the provisions of this Plan shall apply only to covered services and covered events (e.g., death) which are provided, or which occur on and after **July 1, 2023~~4~~**, to Eligible Employees. The terms of this Plan govern claims for benefits hereunder as of **July 1, 2024~~3~~**. In the case of services or events which are provided, or which occur prior to **July 1, 2024~~3~~**, coverage shall be available (if at all) under the terms of the applicable prior plan.

Article 2 Definitions

2.1 Definitions

The following words and phrases as used in the Plan shall have the following meanings unless a different meaning is required by the context:

“Allowable Expense” means a health care service or expense, including deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person, except as described below, or where a statute requires a different definition. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

“Benefit Option” means an option for coverage within an underlying Component Benefit (such as a particular “benefit package” within a group health plan).

“Cafeteria Plan” means the PEBP Section 125 Health and Welfare Benefits Plan, intended to meet the requirements of Code Section 125 and the regulations thereunder.

“Claims Administrator” means the person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified in the Plan.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means the Internal Revenue Code of 1986, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder, and any successor statute of similar import. Reference to any section or subsection of the Code includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

“Component Benefit” means an employee welfare benefit that is designated on Schedule 1 as one of the Component Benefits of the Plan and described in the Incorporated Documents. Incorporated Documents describing the specific benefits provided by each Component Benefit, the terms of eligibility and other terms and conditions, as they may be amended from time to time by the PEBP, are incorporated herein by reference, and are considered part of the Component Benefits.

“Covered Person” means an Eligible Employee or eligible Dependent who is covered under a Component Benefit who enrolls in the Plan in accordance with Article 3, who has commenced participation in the Plan accordingly and whose participation has not terminated under any other applicable provisions of the Plan.

“Dependent” generally refers to individuals other than an Eligible Employee who may be eligible for, and enrolled in, coverage under a Component Benefit, as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility, based on their relationship to the Eligible Employee (e.g., Dependent Child(ren), Spouse, or Domestic Partner).

“Dependent Child(ren)” means any of an Eligible Employee’s children under the age of 26 years including: (i) natural child; (ii) child(ren) of a Domestic Partner; (iii) stepchild; (iv) legally adopted child or child placed in anticipation of adoption (the term placed for adoption means the assumption and retention by the Employee or Retiree of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced); (v) child who qualifies for benefits under a Qualified Medical Child Support Order/National Public Employees' Benefits Program

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Medical Support Notice; and (vi) child under 19 years for whom an Employee or Retiree has legal guardianship under a court order.

“Domestic Partner” means a domestic partner as defined by [NRS 122A.030](#) and as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

“Effective Date” means the effective date of this Plan which is **July 1, 2023~~4~~**.

“Eligible Employee” means an Employee who is an “eligible employee” as defined in the Master Plan Document for the PEBP Enrollment and Eligibility. PEBP may at any time and from time to time remove any one or more Employees or any other group(s) or class(es) of Employees from eligibility for participation in this Plan.

“Employee” means a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

“Employer” means, unless specifically indicated otherwise when used in this document, an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

“Executive Officer” means the Executive Officer of PEBP.

“FMLA” means the Family and Medical Leave Act of 1993, as amended.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996 as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import.

“Incorporated Document” shall mean any and all of the following documents, each of which is incorporated by reference into this Plan document and made a part hereof, and as each is amended from time to time by the PEBP; an Incorporated Document describes the specifics of a Component Benefit(s) including eligibility:

- PEBP Exclusive Provider Organization Plan Master Plan Document (for Medical and Prescription Drug Benefits);
- Exclusive Provider Organization Plan Summary of Benefits and Coverage (for Individual and Family);
- Consumer Driven Health Plan (CDHP) Master Plan Document (Medical, Vision, Prescription Drug, Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA));
- Low Deductible PPO (LD PPO) Master Plan Document
- Consumer Driven Health Plan (CDHP) Summary of Benefits and Coverage (Individual);
- Consumer Driven Health Plan (CDHP) Summary of Benefits and Coverage (Family).
- PEBP Enrollment and Eligibility Master Plan Document;
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document.
- PEBP Section 125 Health and Welfare Benefits Plan Document;
- Health Reimbursement Arrangement Summary Plan Document

- Health Plan of Nevada Evidence of Coverage and Summary of Benefits and Coverage;
- Summaries of Coverage and Summaries of Insurance; Insurance Contract(s); and,
- Plan Materials.

“Insurer” means an insurance company with which the Plan Administrator has entered into an Insurance Contract.

“Insurance Contract” means a contract between the Plan Administrator and an Insurer for the provision of one or more Component Benefits.

“Leave of Absence” means the Employee has obtained an approved leave of absence from the Employer as provided for in the Employer’s rules, policies, procedures and/or practices, including absence under the FMLA and leave for duty in the Uniformed Services under USERRA. Leave of Absence shall also mean any other unpaid Leave of Absence as administered and approved by the Employer.

“Participant” means the Employee or their enrolled Spouse or Domestic Partner or Dependent Child(ren) per [NAC 287.095](#) and as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

“Participant Contributions” means contributions made by a Participant under the Cafeteria Plan, including, without limitation, Salary Reduction Contributions, as applicable. For this purpose, Participant Contributions shall also include contributions by Covered Persons, such as contributions required following an election of continuation coverage under COBRA.

“PEBP” means the Public Employees’ Benefits Program established pursuant to subsection 1 of [NRS 287.043](#).

“PEBP Board” or “Board” means the Board of the Public Employees’ Benefits Program created by [NRS 287.041](#).

“Plan” means the PEBP Active Employee Health and Welfare Wrap Plan as set forth herein, including the Component Benefits as set forth in Schedule 1 and other schedules hereto and Incorporated Documents, as each is amended from time to time.

“Plan Administrator” means the person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan. As of the Effective Date, the Plan Administrator is the Executive Officer of PEBP. The Executive Officer of PEBP may from time to time designate in writing an individual, group of individuals, or staff to formally act on its behalf (designee).

“Plan Materials” means updates to a Component Benefit that is communicated to Participants, to the extent that such update is approved by the Plan Administrator or a delegate of the Plan Administrator.

“Plan Year” means typically the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority, with respect to a Component Benefit, to revise the benefits and rates, if necessary, each Plan Year.

“Qualified Medical Child Support Order” means an order that creates or recognizes the existence of a child's right to health benefits under the Plan and must be in the form of a judgment, decree, or order (including a settlement agreement approved by the court) issued by a court (or state administrative Public Employees' Benefits Program Active Employee Health and Welfare Plan Year 2024⁴⁵

agency with jurisdiction) that is deciding the child support issues in a divorce or other family law action. A Qualified Medical Child Support Order must clearly specify:

- The name and last known mailing address of a Participant and the name and last known mailing address of each child covered by the order,
- a reasonable description of the type of coverage to be provided by the Plan to each child covered by the order, or the manner in which such type of coverage is to be determined,
- The period to which the order applies, and
- Each plan to which such order applies.

A Qualified Medical Child Support Order cannot require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan. The Plan Administrator shall adopt procedures respecting a Qualified Medical Child Support Order in accordance with Section 2714 of the PHSA and Section 401(e)-(f) of the Child Support Performance and Incentive Act of 1998 (CSPIA).

“PPACA” means the Patient Protection and Affordable Care Act enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act enacted on March 30, 2010, and as may be amended from time to time thereafter.

“Rescission” means a cancellation or discontinuance of coverage under the Plan that has a retroactive effect. In accordance with Section 2712 of the PHSA, rescission does not include a cancellation or discontinuance of coverage under the Plan if: (a) the cancellation or discontinuance of coverage has only a prospective effect; or (b) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or (c) fraud.

“Salary Reduction Contributions” means contributions made under the Cafeteria Plan based on an election by a Participant to have amounts withheld from the Participant’s compensation on a pre-tax or after-tax basis to pay for benefits or coverage provided under a Component Benefit.

“Spouse” means an Employee’s lawful Spouse (opposite sex or same sex) as determined by the laws of the State of Nevada, and as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

“State” means the State of Nevada.

“State Law” means the law of the State of Nevada, as set forth in the Nevada Revised Statutes (NRS) and the regulations thereunder.

“Subrogation” means the right of one party to be substituted in place of another party in a lawsuit. See Section 4.5 Third Party Liability of this document for an explanation of how the Plan may use the right of Subrogation to be substituted in place of a covered individual (any Employee and that person’s eligible Spouse or Dependent Child who has completed required formalities for enrollment for coverage under the Plan and is actually covered under a Component Benefit of the Plan) in that person’s claim against a third party who wrongfully caused that person’s injury or illness, so that the Plan may recover medical benefits paid if the covered individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

“Summary of Coverage” means the description of health care services and benefits prepared on behalf of the PEBP by the third-party administrator to describe the details of a self-insured benefit program.

“Summary of Insurance” means the description of health care services and benefits prepared by an Insurer.

“Tortfeasor” means an individual or entity who commits a wrongful act, either intentionally or through negligence, which injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

“Uniformed Services” means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

“USERRA” means the [Uniformed Services Employment and Reemployment Rights Act of 1994](#), as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import.

2.2 Construction

Whenever any words are used in the singular form, they shall be construed as though they were also used in the plural form in cases where the plural would so apply. Headings of articles and sections are inserted for convenience and reference, and they constitute no part of the Plan. Except where otherwise indicated by the context, any masculine terminology herein shall include the feminine and gender neutral.

Article 3 Eligibility and Participation

3.1 Eligibility

Active Employees and their eligible Dependents are eligible to enroll in this Plan, subject to the terms of the Master Plan Document for the PEBP Enrollment and Eligibility, which document is incorporated herein by reference.

3.2 Commencement of Participation

An Eligible Employee and his Dependent(s) shall become Covered Persons under the Plan, subject to the terms of the Master Plan Document for the PEBP Enrollment and Eligibility, which document is incorporated herein by reference.

3.3 Elections and Changes in Elections for Benefits

For purposes of the benefits provided under the Component Benefits, the Plan Administrator will designate an annual or open enrollment period and the Benefit Options available for election for the following Plan Year. The election of the Benefit Options and changes thereto shall be made in the manner, and subject to the conditions, specified by the Plan Administrator.

3.4 Participation During Leaves of Absence

Participation during Leaves of Absence is as set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

3.5 Effective Dates and Conditions

In order to participate in a Component Benefit and receive benefits under this Plan, an Employee and his Dependent(s) must meet any additional participation requirements of the Component Benefits as provided in the Incorporated Documents. An Employee must elect any such benefits on forms provided by the Plan Administrator or through electronic means designated by the Plan Administrator unless the benefit is automatically provided. Such coverage shall be effective as of the date or dates set forth in the applicable Component Benefit's Incorporated Documents.

3.6 Termination of Coverage

Termination of coverage under this Plan of any Participant/Covered Person will terminate in accordance with the rules and procedures set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

3.7 Continuation

Opportunities to continue coverage under this Plan shall be as set forth in the Master Plan Document for the PEBP Enrollment and Eligibility and provided in accordance with applicable state and federal law.

3.8 Incorporation of Plans and Policies and Master Plan Documents

The eligibility provisions, benefit provisions and such other provisions of the applicable Component Benefit's Incorporated Documents as may be modified from time-to-time hereafter, and as are consistent with the terms and conditions of this Plan are incorporated herein by reference and shall be of the same force and effect under this Plan as if they were set forth herein. Furthermore, if any provision of a Component Benefit shall at any time hereafter conflict with the provisions of this Plan, such provision of the Component Benefit shall no longer be deemed a part of this Plan.

3.9 Qualified Medical Child Support Orders

The Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

Article 4 Benefits

4.1 Generally

Benefits hereunder shall be provided through the Component Benefits listed in Schedule 1. As permitted by this Section 4.1, the PEBP, as Plan Administrator, has the authority to determine what Component Benefits will be provided to Eligible Employees and Dependents provided the availability of such Benefit Options are communicated to Eligible Employees.

The persons covered and the benefits provided by each Component Benefit shall be determined in accordance with the applicable Incorporated Documents; provided that, except to the extent the Master Plan Document for the PEBP Enrollment and Eligibility expressly provides otherwise, persons who are not Eligible Employees shall not be eligible for coverage or benefits under the Plan; and provided further that, except to the extent required by applicable law, coverage and benefits under the Plan shall not be provided in excess of the coverage and benefits described in the applicable Summary of Coverage, Summary of Insurance and/or Insurance Contract.

4.2 Compliance with Federal Group Health Plan Benefits and Coverage Mandates

A group health plan Benefit Option shall comply with benefit and coverage provisions to the extent required by law including:

Pediatric Vaccines. To the extent it applies, the Plan shall not reduce the continued coverage costs of a pediatric vaccine below the coverage the Plan provided as of May 1, 1993, under the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

Newborns and Mothers. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Sections 2725 and 2791 of the PHSA or has not opted out under Section 2722(a) of the PHSA, shall continue coverage for newborns and mothers in accordance with Section 2725 of the PHSA.

Mental Health Parity. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Sections 2726 and 2791 of the PHSA or has not opted out under Section 2722(a) of the PHSA, that provides mental health or substance use disorder benefits (MH/SUD), shall provide such MH/SUD benefits in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Women's Health and Cancer Rights Act. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Section 2791 of the PHSA, or has not opted out, shall provide coverage for reconstructive surgery following mastectomy to the extent required by Section 2727 of the PHSA.

Group Market (Insurance) Reforms. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Section 2791 of the PHSA, shall comply with the applicable group market (insurance) reforms that apply to a group health plan under PPACA. As of the Effective Date, no Benefit Option is a "grandfathered health plan." Further, the Health Reimbursement Arrangement is intended to be integrated for purposes of PPACA and related guidance.

PPACA group market (insurance) reforms that apply to grandfathered and non-grandfathered group health plan Benefit Options under the Plan that are not exempt or excepted benefits under Section 2791 of the PHSA are:

- Prohibition of preexisting condition exclusions under PHSA 2704.
- Prohibiting discrimination against Participants and beneficiaries based on a health factor under PHSA 2705.
- Prohibition on waiting periods that exceed 90 days under PHSA 2708.
- Prohibition on lifetime or annual dollar limits on essential health benefits under PHSA 2711.
- Prohibition on rescissions under PHSA 2712.
- Eligibility of children until at least age 26 under PHSA 2714.
- Summary of benefits and coverage and uniform glossary under PHSA 2715; and,
- Solely with respect to insured Benefit Options, the medical loss ratio requirements under PHSA 2718.

Additional PPACA group market (insurance) reforms that apply to group health plan Benefit Options that have lost grandfathered health plan status and are not exempt or excepted benefits under Section 2791 of the PHSA are:

- Provider non-discrimination under PHSA 2706(a).
- Limitations on cost sharing (i.e., the out-of-pocket expense maximum requirements) under PHSA 2707(b).
- Coverage for individuals participating in approved clinical trials under PHSA 2709.
- Coverage of preventive health services under PHSA 2713.
- Internal claims and appeals and external review process as discussed in Article 7 of the Plan and under PHSA 2719; and
- Consumer patient protections (choice of health care professional and coverage of emergency services) under PHSA 2719A.

While not referenced in this Plan document, the Benefit Options that are subject to the group market (insurance) reforms will comply with respect to both regulatory and sub-regulatory guidance to the extent applicable. To the extent that the U.S. Department of Labor, Internal Revenue Service or Department of Health and Human Services, as applicable, implements additional group market (insurance) reforms required by the PPACA, the Plan shall comply to the extent necessary.

National Defense Authorization Act (NDAA). The Plan shall comply with Section 585 of the National Defense Authorization Act (NDAA), which amends the Family and Medical Leave Act of 1993 (FMLA), to permit a “Spouse/ Domestic Partner, son, daughter, parent, or next of kin” to take up to 26 workweeks of leave to care for a “member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.” The NDAA also permits an employee to take FMLA leave for “any qualifying exigency (as the Secretary [of Labor] shall, by regulation, determine) arising out of the fact that the Spouse/Domestic Partner, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.”

Heroes Earning Assistance and Relief Tax Act (HEART Act). The Plan shall comply with the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act), which requires that certain retirement and welfare benefits be provided for returning military personnel and their beneficiaries.

Uniformed Services Employment and Reemployment Rights Act (USERRA). The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA, 38 U.S.C. § 4301 –4335) is a federal law intended to ensure that persons who serve or have served in the Armed Forces, Reserves, National Guard or other “uniformed services”: (1) are not disadvantaged in their civilian careers because of their service; (2) are promptly reemployed in their civilian jobs upon their return from duty; and (3) are not discriminated against in employment based on past, present, or future military service.

The Americans with Disability Amendments Act (ADA). To the extent applicable, the Plan shall comply with the Americans with Disability Act (ADA), including the requirement that any condition that substantially limits a major life activity will be considered a disability, even if the individual can offset or compensate for the disability with the mitigating measures such as hearing aids or artificial limbs.

Genetic Information Non-discrimination Act of 2008 (GINA). The Plan shall comply with the Genetic Information Non-discrimination Act of 2008 (GINA) to the extent applicable including: Title I (regarding genetic nondiscrimination in group health plans) and Title II (regarding genetic nondiscrimination in employment). Under GINA, the Plan shall not base enrollment decisions, premium costs, or Participant contributions on genetic information. The Plan shall not require that individuals undergo genetic testing. PEBP is prevented from conditioning hiring or firing decisions based on genetic information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information regarding either employment or the determination of benefits.

Michelle’s Law. The Plan shall comply with Michelle’s Law to the extent it applies to Dependent Child(ren)’s eligibility for health coverage conditioned on maintaining full-time student status as described in the Master Plan Document for the PEBP Enrollment and Eligibility. Should Michelle’s Law apply and a Dependent Child takes a medically necessary leave of absence for a serious illness or injury that causes loss of full-time student status, the Plan shall not terminate his or her coverage before the date that is the earlier of: (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the PEBP. A written certification stating that the Dependent Child is suffering from a serious illness or injury and that the leave of absence is medically necessary must be provided by a treating physician of the Dependent Child to PEBP for eligibility and coverage to continue.

4.3 Benefit Election

During the enrollment period, an Eligible Employee or Eligible Retiree may elect to either receive any or all the benefits described in the Component Benefits for which the Eligible Employee or Eligible Retiree and any eligible Dependent(s) is eligible as described in the enrollment materials. Each Participant shall be notified of the Eligible Employee’s or Eligible Retiree’s share of the cost, if any, of each Benefit Option prior to the enrollment period for the Plan Year.

4.4 Coordination of Benefits

When Participants have medical, dental or vision coverage from some other source, benefits are determined using Coordination of Benefits (COB). COB operates so that one of the plans (i.e., the primary plan) will pay its benefits first. The other plan or policy, (i.e., the secondary plan) may then provide additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

Participants must let the Plan Administrator, or its designee, know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and dental deductibles. This Plan's prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.

For the purposes of this COB section, the word "plan" refers to any group or individual medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual either on an individual basis or as part of a group of employees, retirees or other individuals.

A Participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such fully insured plan and the rules and procedures described in such fully insured plan's applicable Summary of Insurance.

A Participant in a self-insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures set forth in this Section 4.4. The PEBP delegates to the third-party administrator of such self-insured plan the duty to administer and interpret the provisions of this Section 4.4. and to adopt, document and communicate any rules and procedures necessary or appropriate to implement the COB procedures, as set forth herein:

Which Plan Pays First

Order of Benefit Determination Rules. PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any plan that does not use these same rules always pays its benefits first.

When two plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

These rules are:

(1) Non-Dependent /Dependent

The plan that covers a person other than as a dependent (e.g., as an employee, retiree, member, or subscriber) is primary and the plan that covers the person as a dependent is secondary. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

- Secondary to the plan covering the person as a dependent.
- Primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee).
- Then the order of benefits is reversed, so that the plan covering the person as a dependent will pay first; and the plan covering the person other than as a dependent (e.g., as a retired employee) pays second.

This rule applies when both spouses are employed and cover each other as dependents under their respective plans. The plan covering the person as an employee pays first, and the plan covering the same person as a dependent will pay benefits second.

(2) Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

- The parents are married.
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- If both parents have the same birthday, the plan that has covered one of the parents for a longer period pays first, and the plan that has covered the other parent for the shorter period of time pays second.
- The word “birthday” refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- The plan of the custodial parent pays first; and
- The plan of the spouse of the custodial parent pays second; and
- The plan of the non-custodial parent pays third; and
- The plan of the spouse of the non-custodial parent pays last.

(3) Active/Laid-Off or Retired Employee

The plan that covers a person, as an active employee (i.e., an employee who is neither laid-off nor retired) or as an active employee’s dependent pays first; the plan that covers the same person as a laid-off/retired employee or as a laid-off/retired employee’s dependent pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, Rule (1) determines the order of benefits Non-Dependent/Dependent rather than by this rule.

(4) Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a Dependent (that is, as an employee, former employee, retiree, member, or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, Rule (1) determines the order of benefits Non-Dependent/Dependent rather than by this rule.

(5) Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period pays first; and the plan that covered the person for the shorter period of time pays second. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan.

Administration of COB.

To administer COB, the Plan reserves the right to:

- Exchange information with other plans involved in paying claims.
- Require that Participants or Participants' health care provider(s) furnish any necessary information.
- Reimburse any plan that made payments this Plan should have made; or
- Recover any overpayment from a Participant's hospital, physician, dentist, other health care provider, other insurance company, or a Participant.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount the Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

This Plan follows the customary COB rule that the medical program coordinates with only other medical plans or programs (and not with any dental plan or program), and the dental program coordinates only with other dental plans or programs (and not with any other medical plan or program). Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

If this Plan is primary, and if the coordinating secondary plan is a health maintenance organization (HMO), Exclusive Provider Organization (EPO), or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan

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subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary Plan.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Participant may have against the other plan, and the Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

This Plan does not coordinate pharmacy benefits when PEBP is the secondary or tertiary payor.

Coordination with Medicare.

Coordination with Medicare is not applicable for Participants and their Dependents who are eligible for Medicare Part A and Medicare Part B and who are required to transition to the Medicare Exchange. The Enrollment and Eligibility Master Plan Document includes information regarding enrollment in the Medicare Exchange.

Entitlement to Medicare Coverage. When a Participant is retired and reaches Medicare eligible age, the Participant must enroll in the Medicare plan for which the Participant is eligible. Generally, anyone age 65 years or older is entitled to Medicare Part A and Medicare Part B coverage. Anyone under age 65 years who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

When the Participant is Not Eligible for Premium Free Medicare Part A. This Plan will pay as primary for services that would have been covered by Part A when a retired Participant is not eligible for Premium Free Medicare Part A. However, a retired Participant must enroll in Medicare Part B and PEBP will be the secondary payer for Medicare Part B services. This Plan will always be secondary to Medicare Part B, whether or not a retired Participant has enrolled. This Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

Coverage Under Medicare and This Plan When a Participant Has End-Stage Renal Disease. If, while actively employed, a Participant becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins, or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage or the first month after the individual receives a kidney transplant, Medicare pays first, and this Plan pays second.

If a retired Participant is under age 65 years and receiving Medicare ESRD benefits the Participant will not be required to transition to PEBP's Medicare Exchange program. When a Participant reaches age 65 years, the Participant will be transitioned to the Medicare Exchange in accordance with PEBP's eligibility requirements as stated in the Enrollment and Eligibility Master Plan Document.

How Much This Plan Pays When It Is Secondary to Medicare. When the Participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays as secondary to Medicare,

with the Medicare negotiated allowable fee taking precedence. If a service is not covered under Medicare but is covered under this Plan, this Plan will pay as Primary with the Plan's allowable fee for the service taking precedence.

When the Retiree or the Retiree's covered Spouse or Domestic Partner is enrolled in Medicare Part B:

This Plan will always be secondary to Medicare Part B. If eligible Retirees or their covered Spouses or Domestic Partners are not enrolled in Part B, this Plan will estimate Medicare's Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

When the Participant Enters into a Medicare Private Contract: A Medicare Participant is entitled to enter into a Medicare private contract with certain health care practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare Participant enters into such a contract this Plan will not pay any benefits for any health care services and/or supplies the Medicare Participant receives pursuant to it.

Coordination with Other Government Programs.

Medicaid. If a Participant is covered by both this Plan and Medicaid, this Plan pays first, and Medicaid pays second.

Tricare. If a Participant, or their covered Dependent, is covered by this Plan and Tricare (the program that provides health care services to active or retired armed services personnel and their eligible Dependents), this Plan pays first, and Tricare pays second. For an Employee called to active duty for more than 30 days, Tricare is primary, and this Plan is secondary.

Veterans Affairs Facility Services. If a Participant receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan at the in-network benefit level at the usual and customary charge, only to the extent those services are medically necessary and are not excluded by the Plan.

Worker's Compensation. This Plan does not provide benefits if the expenses are covered by workers' compensation or occupational disease law. If a Participant contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a Workers' Compensation or occupational disease law. However, before such payment will be made, a Participant must execute a Subrogation and reimbursement agreement (described in the Third-Party Liability Section 4.5) that is acceptable to the Plan Administrator or its designee.

4.5 Third Party Liability

Subrogation applies to situations where the Participant is injured and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the manner in which they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or

payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). Any and all payments made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The other person or entity who may be responsible, liable, or contractually obligated for the payment of damages or claims may be an individual, a corporation or other business entity, an insurance company (including the Participant's own insurance company), or a public or private entity. By way of example only, and without limitation, automobile accident injuries or personal injuries on another's property (i.e., a slip and fall) are examples of cases frequently subject to Subrogation.

Subrogation includes situations where the Injury is or may be covered by another insurance policy, including but not limited to the Participant's own first-party automobile insurance, any third-party automobile liability insurance, any applicable no-fault insurance or medical payments coverage, and premises medical payments coverage (including homeowner's insurance), irrespective of fault, negligence, or wrongdoing.

The Subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, negligence, or wrongdoing. Any and all payments made by the Plan relating in any way to the Injury may be recovered directly from the other person or from any judgment, verdict, or settlement obtained by the Participant in relation to the Injury. "Injury" means any harm or damage sustained to the person of a Participant resulting in some form of medical treatment.

Subrogation.

By accepting coverage under the Plan, the Participant automatically assigns to the Plan or its Board any and all rights the Participant may have to recover damages or payments from any other person or entity arising from or relating in any way to the Injury, with regard to any and all tort, contractual or other liability or obligation on the part of a person or entity other than the Participant. This includes payments made, or to be made, to or for the Participant from another insurance company, including the Participant's own insurance policy (a "first party" insurance policy). The Board may, but is not required to, function as the substitute for the Participant in the event any payment made by the Plan for health care or other benefits, including any payment for a known or discovered pre-existing condition, may be the responsibility or contractual liability of another person or entity. This express assignment allows the Plan or its Board to directly pursue any claim that the Participant may have, whether or not the Participant chooses to pursue that claim. The Plan or its Board may pursue any such claims on behalf of the Participant and/or in the Participant's own name, as if the Participant were pursuing the claim on his/her own behalf. This includes the right to sue the other person or entity in order to recover any and all payments made by the Plan relating in any way to the Injury. This also includes the right to pursue and/or make a claim against an insurance policy, on behalf of the Participant and/or in the Participant's own name.

The Participant must cooperate fully, at all times, and provide information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

- Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation.

- Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
- Filing a claim or demand with another insurance company, including but not limited to the Participant's own first-party insurance policy or another person's or entity's insurance policy.

Right of Reimbursement and Recovery.

By accepting coverage under the Plan, the Participant agrees that if he/she or someone else receives a recovery of any kind in the form of a judgment, verdict, settlement, payment, or other compensation, irrespective of fault, wrongdoing, or negligence, and irrespective of how the recovery is classified, the Plan or its Board has the unequivocal right to recover its Subrogated Payments from the Participant and/or from any other person or entity, including but not limited to the Participant's estate, survivors, or family members. This also includes, but is not limited to, the right of recovery from the following:

- Tortfeasor.
- Tortfeasor's insurance company; and/or
- Any other source, including but not limited to any form of first-party insurance coverage carried by, or insuring, the Participant; uninsured or underinsured motorist coverage; any medical payments coverage; no-fault coverage; school insurance coverage; sports insurance coverage; workers' compensation coverage; premises liability coverage, including homeowner's and boating coverage; any medical malpractice recovery; or any other form of insurance coverage, of whatever kind.

The Plan and its Board have an equitable lien against the recovery rights of the Participant. The Plan and its Board have the legal right to be paid from any such recovery, or potential recovery, an amount not to exceed the total amount of benefits paid or to be paid by the Plan, irrespective of whether or not the Participant has been "made whole" for the injuries received.

The Plan's right to Subrogation applies on a first-dollar basis, and has priority over other rights or claims, including the Participant's attorney fees. The Plan's right of Subrogation applies irrespective of whether the funds paid to (or for the benefit of) the Participant constitute a full or partial recovery and applies to recovered funds paid for non-health care charges or attorney fees, or other costs and expenses, including lost wages. The Plan's first priority right of Subrogation in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Participant or any other person or entity attempts to designate or characterize the Recovery, including but not limited to claims for loss of consortium or wrongful death, and irrespective of whether the Recovery itemizes or identifies an amount recovered, adjudicated, or characterized specifically as medical expenses, or is specifically linked to certain kinds of damages or payments.

The Plan's first priority right of Subrogation extends to any and all recoveries arising from or related in any way to the Injury, including but not limited to any recovery obtained by the Participant's estate, or obtained by the Participant's heirs, survivors, successors, assigns, dependents, and/or the like, and/or irrespective of whether the claim is characterized as a wrongful death claim or a survivorship claim.

The Plan's first priority right of Subrogation extends to the Participant's attorney and/or to other agents, successors, and assigns of the Participant.

Payment of Subrogated Payments shall be made without reduction, set-off, or abatement for attorney fees or costs incurred by the Participant in the collection of a Recovery.

The Plan or its Board shall be entitled to seek any equitable or legal remedy to recover money damages or claims against any person or entity possessing or controlling such monies or properties, including but not limited to the Participant and/or his/her attorney. At the sole discretion of the Plan and/or its Board, the Plan may reduce any and all eligible medical expenses, or deny any and all claims, otherwise available to the Participant under the Plan by an amount up to the total Subrogated Payments which are subject to the Plan's right of Subrogation. The Plan's right to reduce eligible medical expenses and to deny claims applies to eligible medical expenses and claims, irrespective of whether such eligible medical expenses and claims bear any relation to the Injury. All rights of the Plan's recovery will be limited to the amount of payments made under this Plan, plus the Plan's reasonable attorney fees and costs incurred to enforce the terms and conditions of the Plan.

The Plan or its Board shall be entitled to payment of reasonable attorney fees and costs incurred to enforce the terms and conditions of the Plan. This may include, but is not limited to, situations in which: (i) the Plan or its Board commence litigation; (ii) the Plan or its Board intervene in existing litigation; (iii) the Participant or his/her attorney has not paid the Plan the full amount of Subrogated Payments within fifteen (15) days of recovery, as required by NRS 287.0465(3); and/or (iv) the Participant or his/her attorney is not fully cooperative with respect to the Plan's right of Subrogation.

The Plan's equitable lien shall also attach to any money or property that is obtained, held, or to be paid by any person or entity, including but not limited to the Participant, the Participant's attorney, an insurance company, and/or a trust for the direct or indirect benefit of the Participant or for his/her "special needs," as a result of an exercise of the Participant's rights of recovery.

If the Participant attempts to assert that certain Subrogated Payments are not causally related to the Injury, it shall be the Participant's burden to prove the relatedness of the Subrogated Payments in question. If the Subrogated Payments in question are referred to, referenced, or included in any way by the Participant in any settlement negotiations or in any demand package tendered by the Participant to the person or entity from which a recovery is sought, it shall be deemed conclusive evidence that said Subrogated Payments are causally related to the Injury. At its sole discretion, the Plan or its Board may consider additional evidence concerning the causal relation of Subrogated Payments to the Injury.

The Plan or its Board may require the Participant or the Participant's attorney or substitute, as a pre-condition to receiving benefit payments, to sign a Subrogation agreement or acknowledgment and to agree in writing to assist the Plan and to protect the Plan's right to payment of the Subrogated Amount from any person or entity including the Participant.

In addition to Subrogation rights afforded to the Plan herein and by Nevada law, the following provisions also apply to the Plan's right of Subrogation, reimbursement, and/or creation of an equitable lien:

- (i) **"Pay and Pursue."** The Plan, in its sole discretion, may elect to process claims under the "pay and pursue" option. If the Plan elects to "pay and pursue," benefit payments will be made prior to, or concurrently with, necessarily applying the Subrogation, reimbursement, and lien rights under the Plan. This is at the sole discretion of the Plan or its Board and remains subject to the Participant's required cooperation with and protection of the Plan's right of Subrogation.

- (ii) **Scope of Subrogation, Reimbursement and Lien Rights.** The Subrogation, reimbursement, and lien rights apply to any and all benefits paid by the Plan for or on behalf of the Participant arising from or related in any way to the Injury, and apply to the following, enumerated without limitation:
- a. Any no-fault insurance.
 - b. Medical benefits/payments coverage under any automobile insurance coverage. This includes any first-party insurance plan under which the Participant is covered or an insured, or any third person's insurance policy under which the Participant may be entitled to benefits.
 - c. Underinsured and uninsured motorist coverage, and any other first-party insurance coverage.
 - d. Any automobile medical payments and personal injury protection ("PIP") benefits.
 - e. Any third person's liability insurance, whether automobile coverage or other.
 - f. Any premises/guest medical payments coverage, including homeowner's insurance.
 - g. Any medical malpractice recovery or insurance policies covering medical malpractice.
 - h. Any professional negligence or attorney malpractice recovery or insurance policies covering professional negligence.
 - i. Workers' compensation benefits or claims.
 - j. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds), to the extent permitted by law.
 - k. Restitution in a criminal matter.
- (iii) **Subrogated Payments.** The term "Subrogated Payments" refers to any benefit payments made by the Plan that are eligible for recovery from any other person as described hereinabove and/or any benefits payments for which the Plan asserts a right of Subrogation.
- (iv) **"Make Whole" and "Common Fund" Rules Do Not Apply.** The Plan's right of Subrogation, reimbursement, equitable liens, and other legal and equitable remedies are specifically intended to supersede the applicability of any and all common law doctrines and/or any and all local, state, and federal laws, including but not limited to the "make whole" rule and the "common fund" rule, to the extent permitted by law.

Role of the Executive Officer.

PEBP has delegated to the Executive Officer its powers and its authority and discretion to enforce its rights under this Section 4.5.

A Subrogation lien of the Executive Officer upon the proceeds of any recovery from an insurer providing first-party coverage to a member must be reduced by the applicable in-network or out-of-network out-of-pocket maximum balance of the member remaining at the time of the incident giving rise to the subrogation lien. If the subrogation lien includes medical claims from medical costs resulting from the incident giving rise to the subrogation lien which occurred over multiple plan years, the out-of-pocket maximum balances for each plan year must be used for purposes of reducing the subrogation lien amount. Notwithstanding the foregoing, the provisions of this paragraph do not apply to the coordination of benefits for coverage of the cost of medical services which may be provided under:

- The plan of self-insurance established by PEBP; and
- Any other health insurance coverage.

A decision of the Executive Officer is final and not subject to judicial review.

Applicable Law.

The Plan's right of Subrogation under Nevada law is set forth in part at NRS 287.0465. The Plan's Subrogation rights as set forth in this Section 4.5 are established, maintained, operated, and conducted in accordance with Nevada law, including but not limited to NRS 287.0465 and NAC 287.755, and in accordance with the statutory delegation to the Board of the powers and duties to establish and conduct PEBP.

4.6 Dual Coverage Rules

The rules with respect to a Covered Person who is an eligible Dependent and an Eligible Employee under the Plan are set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

4.7 Payment of Benefits

The Component Benefits shall be paid for by the Plan. The Plan (or the Plan Administrator acting on behalf of the Plan) may contract with an Insurer, or another third party to provide a Component Benefit under the Plan. The liability of the Plan, PEBP, the Plan Administrator, and, if applicable, the Insurer or other third-party provider to provide benefits under a Component Benefit shall be limited by the terms of this Plan instrument and the applicable Incorporated Document(s).

4.8 Payment to Participant/Covered Person

- (a) Except as otherwise provided in subsection (b) below, benefit payments under a Component Benefit shall be made to the Participant, the Participant on behalf of the Covered Person or if applicable, the Covered Person in accordance with the terms of this Plan, including the Incorporated Documents.
- (b) To the extent permitted under a Component Benefit, payments may be made to a third party to whom a Covered Person has made a valid assignment of his right to receive such payments. In addition, if the Plan Administrator determines that a Covered Person is unable to care for his own affairs, the Plan Administrator may authorize the Plan to make benefit payments to the court-appointed legal guardian of the Covered Person, to an individual who has become the legal guardian of the Covered Person by operation of state law, or to another individual who the Plan Administrator determines to be entitled to receive such payments on behalf of the Covered Person.
- (c) If a payment of benefits is made under a Component Benefit to a third party in accordance with subsection (b), above, the Plan, PEBP, the Plan Administrator, and, if applicable, the Insurer or other third-party provider shall be relieved, to the fullest extent permitted by law, of any obligation to make a duplicate payment to or on behalf of such Participant and/or Covered Person.

4.9 Tax Withholding

The amount of any benefit paid from the Plan to, or in respect of, a Participant under a Component Benefit shall be reduced by the amount of any income tax or employment tax that is required to be withheld pursuant to any applicable federal, state, or local law, or any applicable foreign law.

4.10 Other Adjustments—Overpayment Provision

If, for any reason, any benefit payable under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Covered Person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator or the applicable Insurer may recover that incorrect payment, whether or not it resulted from the Plan Administrator, an Insurer, or any other third-party provider's own error, from the person to whom it was made or from any other appropriate party.

In the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, or (c) any other method as may be permitted in the sole discretion of the Plan Administrator or Insurer and as permitted by law.

With respect to Component Benefits provided through an Insurer, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments exceeding the amount appropriately payable). With respect to self-insured Component Benefit programs, Subrogation or reimbursement rights may be set forth in Section 4.5 of this Plan.

4.11 Unclaimed Benefits

If, within the time period specified by the third party administrator or Insurer of the Component Benefit and communicated to Plan Participants or if not specified and communicated to Plan Participants twelve (12) months, after any amount becomes payable hereunder to a Covered Person and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care shall have been exercised in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

Article 5 Funding and Contributions

5.1 Plan is a Single Plan—Funding

The Plan and its Component Benefits shall be a single plan.

All costs of the Plan, including Plan benefits, Plan administrative expenses, and the retention of experts and advisors, are paid out of the fund and, in some cases, Insurance Contracts.

Benefits may be provided through one or more Insurance Contracts with insurance carriers or such other funding vehicles established with respect to the Component Benefits. The Plan may maintain reinsurance or stop-loss insurance to protect the Plan in the event claims exceed projections.

Component Benefits under the Plan may be provided on an insured or self-insured basis, or a combination thereof, at the discretion of the Plan Administrator. The Summary of Coverage or Summary of Insurance shall set forth whether a Component Benefit is provided on an insured or self-insured basis.

5.2 Contributions to the Plan

Employer Contributions.

The Employer shall make such contributions in such amounts and at such times as the Plan Administrator shall direct, in accordance with the funding policy and methods of the Plan.

Participant Contributions.

(1) To be eligible to receive benefits under any Component Benefit for which Participant Contributions are required (which may be pre-tax or after-tax, subject to the terms of the Cafeteria Plan and applicable Component Benefit program), each Participant shall make any required contributions in such amounts and at such time as the Plan Administrator shall from time to time direct, as outlined in the Incorporated Documents. Participant Contributions shall be made in accordance with procedures established by the Plan Administrator.

(2) Failure of a Participant to make Participant Contributions with respect to any Component Benefit by the required due date shall be deemed an election by such Participant to cease participation in such Component Benefit as of the date established by the Incorporated Documents or as directed by the Plan Administrator, for which the missed Participant Contribution was due; provided however, that termination of benefits under any Component Benefit shall, in all instances, be subject to and in accordance with applicable legal requirements, including but not limited to coverage requirements imposed by the FMLA.

(3) If a Participant fails to pay Participant Contributions during a Leave of Absence and the Plan Administrator in its discretion continues coverage under any Component Benefit in effect during such Leave of Absence, any unpaid Participant Contributions during such period will be collected in arrears through payroll deductions through the Cafeteria Plan, or as otherwise directed by the Plan Administrator upon the Participant's return to employment with the Employer or expiration of the Participant's Leave of Absence, as applicable.

Article 6 Insurance

6.1 Insurance Generally

If a Participant elects an insured benefit, any such benefit shall be provided solely and exclusively by the insurer under the applicable insurance contract. A Participant's or Covered Person's right to such benefit shall be limited to the amount payable under such insurance contract and the receipt thereof shall be subject to satisfaction of the terms, covenants, conditions, rules, and regulations of the insurer. The Plan Administrator shall have the right from time to time to change the coverage or carrier of any one or more insurance policies.

6.2 Provisions Relating to Insurers

No Insurer shall be required or permitted to issue an insurance policy or contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any policy or contract in connection with this Plan.

6.3 Conflicting Provisions

If any provision or term of any insurance policy or contract conflicts with or is inconsistent with any provision or term of this Plan, such Plan provision or term shall govern.

Article 7 Claims and Appeals Procedures

7.1 Claims and Appeals Procedures

(a) The claims procedure to be followed by Covered Persons to obtain payment of benefits under this Plan shall be in accordance with the rules and procedures set forth in the applicable Incorporated Documents for the Component Benefits. Benefits that are covered under this Plan shall be paid in accordance with the rules and procedures set forth in the Plan, as applicable, which shall govern the claims and appeals procedures. Notwithstanding the foregoing, unless a Component Benefit's Incorporated Document issued by the third-party administrator or Insurer who administers the Component Benefit specifically provides otherwise, a claim for benefits must be filed within 12 months from the date of service (for example, with respect to a medical claim, the date a medical service is provided and the charge is incurred).

(b) The claims procedure to be followed by Employees for eligibility under this Plan shall be in accordance with the rules and procedures set forth in the Master Plan Document for the PEBP Enrollment and Eligibility and in the Incorporated Documents for the Component Benefits. The Executive Officer or his designee makes final determinations concerning eligibility (NAC 287.313).

(c) The Plan Administrator has the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to eligibility for the Plan and entitlement to Plan Benefits. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in the Incorporated Documents. The claims procedures applicable to claims made for benefits under this Plan do not apply to casual or general inquiries regarding eligibility for Component Benefits that may be provided under the Plan. For an inquiry to constitute a claim for benefits or an appeal of a denial of a claim for benefits, a Plan Participant must follow the claim procedures under the applicable Component Benefit as set forth in the Incorporated Documents.

(d) For purposes of the determination of the amount of, and entitlement to, benefits under the Component Benefits provided under Insurance Contracts, the Insurer is the named fiduciary under the Component Benefit, with the full power to interpret and apply the terms of the Component Benefit as they relate to the benefits provided under the applicable Insurance Contract.

To obtain benefits from the Insurer of a Component Benefit, a claimant must follow the claims procedures under the applicable Insurance Contract, which may require a claimant to complete, sign and submit a written claim on the Insurer's form.

The Insurer will decide a claim in accordance with its reasonable claim's procedures, applicable state insurance law or other applicable law as required. The Insurer has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order to decide a claim. If the Insurer denies a claim, in whole or in part, a claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, a claimant may appeal to the Insurer for a review of the denied claim. The Insurer will decide the appeal in accordance with its reasonable claim's procedures.

Upon a final decision to deny a claim for benefits under a Component Benefit that is a non-grandfathered group health plan, the claimant may request an external review that follows the state external review process applicable to and binding on, that Component Benefit, per Section 2719 of the PHSA. To the extent that a Component Benefit is not required to comply with a state external review process under Section 2719 of the PHSA, it must comply with the federal external review process as set forth in Section 2719 of the PHSA. External review is not available for a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that an Employee, Retiree or Dependent fails to meet the requirements for eligibility under the terms of the Component Benefit.

(e) For purposes of determining the amount of or the entitlement to benefits under a Component Benefit provided through a self-funded arrangement, the applicable designated claims fiduciary (as provided in the applicable Incorporated Document) is the named fiduciary under the Component Benefit, with the full power to interpret and apply the terms of the Component Benefit as they relate to the benefits provided under the applicable self-funded arrangement. In addition, such procedures shall be described in the applicable Incorporated Documents in accordance with Section 2719 of the PHSA (applicable to non-grandfathered plans only); NAC 287.610-287.695; NAC 287.750; NRS 287.043; NRS 287.04335; NRS 689B.255; NRS 695G.200; NRS 695G.210; NRS 695G.220; NRS 695G.230; NRS 695G.241-695G.300; and NRS 695G.310.

(f) The Incorporated Documents shall specify the claims fiduciary for each Component Benefit.

Upon a final decision to deny a claim for benefits under a self-funded Component Benefit that is a non-grandfathered group health plan, the claimant may request an external review that follows the federal external review requirements set forth in Section 2719(b) of the PHSA, the terms of which are described in the applicable Incorporated Document. External review is not available for a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that an Employee, Retiree or Dependent fails to meet the requirements for eligibility under the terms of the Component Benefit.

(g) Unless otherwise specified in a Component Benefit or prohibited by federal law, any claimant seeking benefits under a Component Benefit must initiate legal action against the Plan no later than 1 (one) year from the deadline for filing a claim unless a different time frame is set forth in the applicable Incorporated Document.

7.2 Prohibition Against Rescission

Under Section 2712 of the PHSA, the Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a Covered Person under a Benefit Option that is a group health plan that is not excepted or exempt under Section 2712 of the PHSA, unless such Covered Person commits an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; provided, however, that the foregoing prohibition shall not prohibit retroactive termination in the event: (i) a Participant fails to timely pay premiums towards the cost of coverage; (ii) the Plan erroneously covers an ex-spouse of a Participant because the Participant failed to timely report a divorce to the Plan Administrator; (iii) the Plan erroneously covers a Participant due to a reasonable administrative delay in terminating coverage; or (iv) any other circumstance under which retroactive termination would not violate the PPACA.

The Plan Administrator shall provide a Covered Person with thirty (30) days' prior written notice of intent to rescind coverage. The Covered Person may appeal the rescission of coverage as a denial of a post-service claim under this Article 7. In the event the Plan Administrator rescinds a Covered Person's coverage on account of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent, such rescission shall not cause the individual to incur a "qualifying event" as provided under COBRA.

Article 8 Administration of Plan

8.1 Plan Administrator

The Plan Administrator shall have the discretionary authority to interpret the Plan, including each Component Benefit, and to decide any and all matters arising hereunder. The Plan Administrator's discretionary authority shall include, but shall not be limited to, the following authority:

- (a) To make and enforce such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Plan;
- (b) To construe and interpret the Plan, to decide questions concerning the Plan, including without limitation the discretionary authority to resolve questions of fact and to remedy possible ambiguities, inconsistencies, and/or omissions, in the Plan and related documents by general rule or particular decision, and to determine the eligibility of any person to participate in the Plan and the entitlement of any person to any benefits thereunder;
- (c) To establish and maintain the Component Benefits and to maintain records of pre-tax Salary Reduction Contributions;
- (d) To prescribe procedures to be followed and the format to be used by Eligible Employees and Participants to make elections pursuant to this Plan, including any Component Benefit;
- (e) To prepare and distribute information explaining this Plan and the benefits under this Plan or any Component Benefit in such manner as the Plan Administrator determines to be appropriate;
- (f) To make available to each Participant or Covered Person his or her records and related Plan Materials as may be required by applicable law;
- (g) To request and receive from Employees and Covered Persons such information as the Plan Administrator shall from time to time to determine to be necessary for the proper administration of the Plan;
- (h) To appoint, remove, or substitute agents, counsel, accountants, consultants, actuaries, or other persons to assist in administering the Plan or any Component Benefit;
- (i) To designate specified other persons to conduct any of its responsibilities under the Plan or any Component Benefit to the extent necessary;
- (j) To sign documents for purposes of administering the Plan, or to designate an individual or individuals to sign documents for purposes of administering this Plan;
- (k) To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
- (l) To prepare, file, and disseminate reports and disclosures required by applicable law.

The Plan Administrator's determination on any and all questions arising out of the interpretation or administration of the Plan shall be final, conclusive, and binding on the parties.

8.2 Records and Reports of the Plan Administrator

The Plan Administrator shall keep such written records as it shall deem necessary or proper, which records shall be open to inspection by the Employer.

8.3 Reliance on Participants and Tables

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of, accountants, counsel or other experts employed or engaged by the Plan Administrator. Actions taken in a good faith reliance on advice from such advisors are conclusive and binding upon persons.

8.4 Delegations of Authority by the Plan Administrator

The Plan Administrator may, in its discretion, delegate to any other person or persons the authority to act on behalf of the Plan Administrator, including but not limited to the authority to make any determination or to sign checks, warrants, or other instruments incidental to the operation of the Plan or any Component Benefit (or portion thereof) that the Plan Administrator administers, or to the making of any payment specified therein.

8.5 Employment of Assistants

The Plan Administrator is authorized to employ counsel and to employ persons to provide such actuarial, clerical, or other services as they may require in performing their duties under the Plan or any Component Benefit.

8.6 Availability of Documents

A copy of the Plan and any and all future amendments and such records and data as may be required under applicable law shall be available to any Covered Person, Employee, Retiree or an Employee organization that represents Employees of the Employer at reasonable times during normal business hours at the business office of the Plan Administrator or by contacting the Plan Administrator.

8.7 Legal Process

The Plan Administrator shall be the agent for service of legal process unless it designates another person to be such agent. See Section 10.2 for such designation.

8.8 Administrative Expenses

All expenses incurred prior to termination of the Plan that shall arise in connection with the administration of the Plan, including but not limited to administrative expenses, and compensation and other expenses and charges of any actuary, accountant, counsel, specialist, or other person who shall be employed by the Plan Administrator in connection with the administration, shall be paid by Employees, Retirees, and the fund.

8.9 Several Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act, except for its own willful misconduct or willful breach of this Plan.

8.10 Nondiscrimination

The Plan Administrator shall not operate the Plan in a manner that causes discrimination in favor of those Participants or Employees who are (or were) officers or highly compensated Employees or key Employees of the Employer. In addition, whenever in the administration of the Plan any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that persons similarly situated shall receive substantially the same treatment.

8.11 Electronic Administration

The Plan Administrator may distribute and collect information or conduct transactions by means of electronic media, including, but not limited to, electronic mail systems, Internet, or voice response system, except when a specific provision of the Code, or other guidance of general applicability sets forth rules or standards regarding the media through which such dissemination of information or transaction may be conducted.

8.12 Coordination with Component Benefits

Article 8 of this Plan applies with respect to each Component Benefit which appears in Schedule 1, unless the Component Benefit specifically addresses these issues in a manner that is consistent with applicable state and federal law. However, any references to the Plan Administrator shall be construed in accordance with the definition and description of duties contained in this Article 8.

8.13 Indemnification

A participating Employer shall only be liable for indemnification of the Board and its employees against liability relating to the administration of the Plan to the extent set forth in this section 8.13 and to the extent consistent with, and subject to the limitations specified in, NRS 41.0349 and any other provision of applicable state law.

A participating Employer shall indemnify and hold harmless the Plan Administrator or its designee who act as Plan fiduciary(ies) or act in an administrative capacity relating to the Plan and the Board and its employees relating to the administration of the PEBP from and against any and all liabilities, demands, claims, suits, proceedings, actions or causes of action, losses, approved settlements, penalties, costs, damages, and expenses (including reasonable attorneys' fees) (together, the "liabilities") sustained or incurred by act or omission of said Plan Administrator or its designee(s), or of the Board; provided, however, that this indemnification shall not apply to the extent such liabilities arise from such Plan Administrator's (or its designee's) or such Board's (or its employees') willful negligence, gross negligence, willful misconduct or criminal action.

Notwithstanding the foregoing, the provisions of this section 8.13 shall not apply to any person or entity seeking indemnification if:

- (1) The person or entity failed to submit a timely request for defense;

- (2) The person or entity failed to cooperate in good faith in the defense of the action;
- (3) The act or omission of the person or entity was not within the scope of the person's or entity's public duty or employment; or
- (4) The act or omission of the person or entity was wanton or malicious.

Article 9 Plan Adoption, Amendment, and Termination

9.1 Amendment and Termination

The Plan was established with the bona fide intention and expectation that it will be continued indefinitely. However, PEBP reserves the right to amend or terminate the Plan or any Component Benefit at any time and from time to time. Amendments may occur on the approval of the PEBP Board, or on such other date as may be specified in the document amending the Plan. The Plan or any coverage under it may be terminated by the PEBP Board, and new coverages may be added by the PEBP Board.

Such amendments or modifications may be made retroactively where necessary, including, for example, to ensure compliance with the Code's nondiscrimination rules.

The termination of a Component Benefit (including terminating an Insurance Contract through which such benefits are provided) is not a termination of the Plan; rather, it is an amendment to the Plan.

9.2 Termination of Insurance Contract

In the case of any Component Benefit paid by an Insurer pursuant to an Insurance Contract, the Plan Administrator may terminate such contract at any time by providing the Insurer with such notice as may be required under the terms of such contract. The Plan Administrator may enter into contracts with other Insurers or through other funding arrangements as the Plan Administrator may establish for the purpose of providing the Component Benefit.

9.3 Amendment of Schedule 1

The Plan Administrator may amend Schedule 1 to add or remove a Component Benefit. Such change will be subject to the laws of the State of Nevada, to the extent required. Any such modification shall not necessitate a formal amendment to this Plan document.

9.4 Effect of Amendment or Termination

(a) No amendment to or termination of the Plan or any Component Benefit shall cause or permit the assets of the Plan to be used for any purpose other than to defray administrative expenses with respect to Component Benefits and to pay benefits provided for under such Component Benefit.

(b) All changes to this Plan shall become effective as of a date established by the Plan Administrator, as appropriate, except that no increase or reduction in benefits shall be effective with respect to covered expenses incurred prior to the date such person(s) adopted a change, regardless of the effective date of the change. Upon termination or discontinuance, contributions, and benefits (including benefit elections) relating to the Plan shall terminate.

(c) Upon termination of any Component Benefit, any assets of the Plan funding such Component Benefit shall be used to pay benefits that Participants have become entitled to receive under the terms of such Component Benefit (or, if applicable, to pay premiums due to an Insurer with respect to such Component Benefit) as of the date of termination, and to pay the administrative expenses incurred by the Plan before, and in connection with, the termination, in accordance with the written direction of the Plan Administrator. The remaining assets shall be used to pay benefits that Participants have become entitled to receive under other Component Benefits (or, if applicable, to pay premiums due to an Insurer with

respect to such other Component Benefits) and to pay the related administrative expenses of such other Component Benefits in accordance with the written direction of the Plan Administrator. In no event shall the assets of the Plan inure to the benefit of the Employer.

(d) Upon termination of the Plan, the assets of the Plan shall be used to pay benefits that Participants have become entitled to receive under the terms of a Component Benefit, and to pay the administrative expenses incurred by the Plan relating to such Component Benefit before and in connection with the termination, both in accordance with the written direction of the Plan Administrator. The Plan's remaining assets shall be disposed of in accordance with the written direction of the Plan Administrator. In no event shall the assets of the Plan inure to the benefit of the Employer.

Article 10 Miscellaneous

10.1 Governing Law

(a) This Plan and Component Benefits shall be construed, administered, and enforced according to laws of the State of Nevada and federal law, including the PHSA, governing employee benefit plans. Any provision of this Plan in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

(b) In the case of Component Benefits provided by an Insurer under an Insurance Contract, the Insurance Contract shall be governed by the Code and applicable Nevada state law, as applicable to such Insurance Contract.

(c) Such federal laws to the extent applicable to a Component Benefit, in addition to the requirements in Section 4.2 of this Plan, shall include but shall not be limited to:

(1) Continuation of Coverage under COBRA. For each benefit made available under this Plan that is considered to be a "group health plan" under Section 2208(1) of the PHSA due to Employees and their spouses and Dependents being provided with health care benefits within the meaning of Section 213(d)(1) of the Code, the Plan shall provide health care continuation coverage to qualified beneficiaries in the manner and to the extent required by Sections 2201 – 2208 of the PHSA and related regulations, including applicable amendments to such Sections.

(2) USERRA. For each Component Benefit that is subject to continuation coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994, the Plan shall comply.

(3) HIPAA. The Plan shall administer the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") dealing with special enrollment rights in the manner and to the extent required by the applicable requirements of Section 9801 et seq. of the Code, as well as the provisions of the HIPAA Privacy Rule and the HIPAA Security Rule.

(4) GINA. The Plan shall comply with the provisions of GINA and accordingly, shall not, unless expressly permitted by GINA or corresponding regulations, restrict enrollment, or adjust premiums based on genetic information, or require or request genetic information or genetic testing, prior to, or in connection with, enrollment.

(5) PPACA. The Plan shall comply with the relevant provisions of the PPACA.

(d) NAC and NRS Regarding the PEBP Plan. The information provided below is a summary of the applicable NRS and NAC. For detailed information, refer to the Nevada Legislature website at <https://www.leg.state.nv.us/law1.cfm>.

(1) Nevada Revised Statute

- NRS 287: Programs for Public Employees
- NRS 439B: Restraining Costs of Health Care
- NRS 687B: Contracts of Insurance
- NRS 689B: Group and Blanket Health Insurance
- NRS 695G: Managed Care

(2) Nevada Administrative Code

- NAC 287: Programs for Public Employees

(3) 82nd Legislative Session (2023):

Pending

10.2 Agent for Service of Process

For disputes arising under the Plan, service of legal process may be made on the Plan Administrator, and must comply with [NRS 41.031](#), in care of:

Public Employees' Benefits Program (PEBP)
3427 Goni Road, Suite 109
Carson City, NV 89706
Phone: (775) 684-7000, (702) 486-3100, or (800) 326-5496

10.3 No Vested Rights

To the maximum extent permitted by law, no person shall acquire any right, title, or interest in or to any portion of an Insurance Contract otherwise than by the actual payment or distribution of such portion under the provisions of the Plan or a Component Benefit, or acquire any right, title, or interest in or to any benefit referred to or provided for in the Plan or any Component Benefit otherwise than by actual payment of such benefit. Further, no person has any right, title, or interest in or to the assets of the Employer because of the Plan.

10.4 Information to be Furnished

Any person eligible to receive benefits hereunder shall furnish to the Plan Administrator, its delegate, or to an Insurer, as applicable, any information or proof requested by the Plan Administrator, its delegate, or any such Insurer and reasonably required for the proper administration of the Plan or a Component Benefit. Failure on the part of any person to comply with any such request within a reasonable period of time shall be sufficient ground for delay in the payment of any benefits that may be due under the Plan or a Component Benefit until such information or proof is received by the Plan Administrator, its delegate, or Insurer, as the case may be. If any person claiming benefits under the Plan or a Component Benefit makes a false statement that is material to such person's claim for benefits, the Plan Administrator or Insurer, as the case may be, may offset against future payment any amount paid to such person to which such person was not entitled under the provisions of the Plan or a Component Benefit. Further, the Plan Administrator has the authority to take such additional action, as may be deemed necessary, to make the Plan whole, in accordance with the law.

10.5 Non-Alienation

To the extent permitted or required by law, the rights or interests of any Participant or his beneficiary to any benefits hereunder shall not be subject to attachment or garnishment or other legal process by any creditor of any such Participant or beneficiary, nor shall any such Participant or beneficiary have any right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits which he may expect to receive, contingently or otherwise, under this Plan, and any attempt to anticipate, alienate, commute, pledge, encumber, or assign any right to benefits hereunder shall be void. Notwithstanding the foregoing,

the Plan Administrator may pay Plan benefits directly to the provider of services. Such payment shall fully discharge the Plan Administrator from further liability under the Plan.

10.6 Non-Guarantee

Neither the Employer nor any fiduciary shall be held or deemed in any manner to guarantee the Plan or a Component Benefit against loss or depreciation.

10.7 No Guarantee of Employment

Neither the establishment and maintenance of this Plan, nor any modification thereof, nor the creation of any account, nor the payment of any benefits shall be construed as giving to any Employee or other person, any legal right or equitable right against the Employer, any officer, director or Employee of the Employer, or against the Plan Administrator, except as herein provided. Under no circumstances shall the terms of employment of any Participant or Employee be modified or in any way affected by this Plan nor shall such establishment or continuance interfere with the right of the Employer to discharge any Employee or any other person or to deal with him without regard to the existence of the Plan or the Component Benefit.

10.8 No Guarantee of Tax Consequences

Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid or allocated to or for the benefit of a Participant under the Plan or any Component Benefit will be excludable from Participant's gross income for federal, state, and/or local income tax purposes, or that any other federal, state, and/or local tax treatment will apply or be available to any Participant. It shall be the obligation of each Participant to determine whether any coverage, benefit, or other payment under the Plan is excludable from the Participant's gross income for federal, state, and/or local income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment treated by the Employer as nontaxable is, in fact, not so excludable.

If the Plan Administrator determines that any benefits which the Employer had treated as nontaxable to any Participant for federal, state, and/or local income tax purposes are, in fact, taxable to the Participant due to any reason, including but not limited to erroneous information provided by the Participant or otherwise used by the Employer, such Participant shall pay such taxes (including any related penalties and interest) directly or reimburse the Employer for any such taxes (including any related penalties and interest) paid by the Employer.

10.9 Incapacity

If the Plan Administrator determines that a Covered Person entitled to benefits hereunder is unable to care for his affairs because of illness or accident, any benefit payment due to such Covered Person shall be paid to his duly appointed guardian or legal representative; provided that, if there shall be no such duly appointed guardian or legal representative, any benefit payment due to such Covered Person may be paid for the benefit of such Covered Person to his spouse, parent, brother, sister, or other third party deemed by the Plan Administrator to have incurred expenses for such Covered Person unless specified otherwise by the Incorporated Documents. Benefit payments made to a third party pursuant to this section shall completely discharge the Plan, the Plan Administrator, and the Employer of any liability to such Participant or other person arising under the Plan.

10.10 Death

Unless otherwise provided under the terms of an applicable Summary of Coverage, Summary of Insurance, or Insurance Contract, claims on behalf of a Participant after the Participant's death may be made by, and, unless denied, shall be paid to, the Participant's estate. Payments made pursuant to this Section 10.10 shall completely discharge the Plan, the Employer, the Plan Administrator, and, if applicable, the Insurer of any liability to the Participant or other person arising under the Plan.

10.11 Clerical Error/Delay

Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

10.12 Responsibility for Health Care

The provisions of any health benefit program under the Plan shall not be construed to limit a Participant with regard to the choice of medical treatment or services, such choices including, but not limited to, the kind, type, duration, amount, or results thereof. Obtaining medical or other health care treatment or services and determining which services to utilize shall be at the sole discretion of the Participant/Covered Person and shall not be construed, interpreted, or deemed as resulting from the Plan.

Each Participant/Covered Person shall be solely responsible for deciding the health care that the individual receives and shall make such a decision as to his or her health care independent of any determinations to whether reimbursement will or will not be made under the Plan for a health care service or supply. The determination of whether or not a service or supply is medically necessary is made solely for purposes of determining whether benefits will be paid under the Plan and is not intended to be advice to an individual concerning that individual's health care treatment. Each Participant/Covered Person shall be solely responsible for selecting the health care professionals, hospitals, and other institutions that will provide health care services and supplies to that individual.

10.13 Covered Person's Responsibilities

Each Covered Person shall be responsible for providing the Plan Administrator and/or the Employer with the Covered Person's current U.S. mailing address and/or electronic address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address furnished by the Covered Person and mailed either by regular United States mail or by electronic means as specified in the applicable Treasury Regulations and other guidance. The Plan Administrator and the Employer shall not have any obligation or duty to locate a Covered Person. If a Covered Person becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

- Because of conflicting claims to such payments; or
- For any other reason, the amount of such payment, if and when made, shall be determined under the provisions of this Plan without payment of any interest or earnings.

10.14 No Examination or Accounting

Neither the Plan nor any action taken thereunder shall be construed as giving any person the right to an accounting or to examine the books or affairs of the Employer.

10.15 Severability

If any provision of the Plan (including a Component Benefit) is held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of the Plan, and the Plan shall be construed and enforced as if the illegal or invalid provision had not been included in the Plan. The Plan Administrator shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

10.16 Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator shall have the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

10.17 Legal Actions

In any action or proceeding involving the Plan assets or any property constituting part or all thereof, or the administration thereof, no Employee, former Employee, Dependent, Covered Person, or any other person having or claiming to have an interest in this Plan shall be necessary parties and no such person shall be entitled to any notice or process, except to the extent required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive on the parties hereto and upon persons having or claiming to have any interest in this Plan.

10.18 Employee Authorization of Payroll Deductions

By using electronic media as discussed in Section 8.11 of the Plan, a Participant consents to deductions from his compensation in accordance with his elections made through the system.

10.19 Misrepresentation or Fraud

A person who receives a benefit under the Plan as a result of false information or a misleading or fraudulent representation shall repay amounts paid by the Plan and shall be liable for costs of collection, including attorneys' fees. Notwithstanding the foregoing, the Plan shall comply with respect to the rules pertaining to rescissions as discussed in Section 4.2(e)(5) and Section 7.2 of the Plan.

10.20 Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan's control, the time for performance of the act will be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused. In such event, however, parties shall use reasonable efforts to perform their respective obligations under the Plan.

Article 11 HIPAA Privacy and Security of Protected Health Information

The Component Benefits of the Plan that are a “group health plan” shall comply with the provisions of HIPAA, in accordance with this Article. The Component Benefits of the Plan that are not subject to HIPAA shall not be subject to this Article.

11.1 Introduction

This Article describes the requirements under a federal law known as HIPAA that apply to health benefits for Employees and certain Retirees, and their eligible Dependents, participating in the PEBP. The confidentiality of Participant Health Information is important to the PEBP. The PEBP is committed to ensuring that the privacy of Participants is protected and legal requirements under HIPAA are satisfied. Accordingly, the PEBP will not use or disclose Protected Health Information other than as permitted or required by HIPAA, the HIPAA regulations, and this Article.

The PEBP provides medical, dental, vision, and prescription drug benefits, which are considered “Health Care Components” under HIPAA. The PEBP also provides other benefits that are not subject to HIPAA and some non-covered benefits. Under HIPAA, the PEBP is considered a “Hybrid Entity.” The HIPAA Privacy and Security provisions of this Article apply only to:

- The Health Care Components of the PEBP and to the Health Plan, Health Care Provider, or Health Care Clearinghouse functions performed by the Health Care Component;
- Protected Health Information that is created or received by or on behalf of the Health Care Component of the Plan; and
- Electronic Protected Health Information created, received, maintained, or transmitted by or on behalf of the Health Care Component of the Plan.

11.2 Definitions

The following are definitions of specific terms and words used in this Article 11. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

“Breach” means the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted by HIPAA which compromises the security or privacy of the Protected Health Information, unless the acquisition, access, use, or disclosure is otherwise excluded in the definition of “Breach” under 45 CFR Section 164.402.

“Business Associate” has the meaning set forth in 45 CFR Section 160.103, including any third-party administrator or actuarial, legal, accounting, consulting, or similar firm that performs services involving the disclosure of Protected Health Information.

“Electronic Protected Health Information” means Protected Health Information that is transmitted by or maintained in electronic media.

“Covered Entity” means

- A Health Plan
- A Health Care Clearinghouse; or

- A Health Care Provider that transmits any Health Information in electronic form in connection with a transaction covered by HIPAA, as defined more fully in 45 CFR Section 160.103.

The Plan is a Covered Entity.

“Genetic Information” has the meaning set forth in 45 CFR Section 160.103.

“Health Care” means care, services, or supplies related to the health of an Individual within the meaning of 45 CFR Section 160.103. Health care includes, but is not limited to, the following:

Preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to physical or mental condition or functional status of an Individual or that affects the structure or function of the body; and

Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

“Health Care Clearinghouse” has the meaning set forth in 45 CFR Section 160.103 and includes a public or private entity, including a billing service, repricing company, community health management information system or community Health Information system, and “value-added” networks and switches, which performs either of the following functions:

Processes or facilitates the processing of Health Information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

Receives a standard transaction from another entity and processes or facilitates the processing of Health Information into a nonstandard format or nonstandard data content for the receiving party.

“Health Care Component” means a Component or combination of Components of a Hybrid Entity that are designated by the Hybrid Entity in accordance with 45 CFR Section 164.105(a)(2)(iii)(D) and from whom the PEBP receives Protected Health Information subject to HIPAA. The medical, dental, vision, and prescription drug benefits offered under the Plan are Health Care Components.

“Health Care Operations” means any of the following activities of the Plan, to the extent such activities relate to the covered functions of the Plan, including, but not limited to:

Conducting quality assessment and improvement activities including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;

Patient safety activities;

Population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, disease management, contacting Health Care Providers and patients with information about Treatment alternatives and related functions that do not include Treatment;

Article 11 HIPAA Privacy and Security of Protected Health Information

Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner and Provider performance, rating Health Care Provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

Underwriting (subject to the prohibition in this Article 11), premium rating and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, securing or placing a contract for reinsurance of risk relating to Health Care claims, including stop-loss insurance and excess of loss insurance;

Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

Business planning and development, such as conducting cost-management and planning- related analysis associated with managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

Business management and general administrative activities of the Plan, including, but not limited to:

Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

Customer service, including the provision of data analysis for policyholders, Plan Sponsors, or other customers;

Resolution of internal grievances;

The sale, transfer, merger or consolidation of all or part of the Plan with another Covered Entity, or an entity that following such activity will become a Covered Entity, and due diligence related to such activity;

Consistent with the applicable requirements of 45 CFR Section 164.514, creating de-identified Health Information or a limited data set, and fundraising for the benefit of the Covered Entity; and

Any other activity that falls within the definition of the term "Health Care Operations" as set forth in 45 CFR Section 164.501.

"Health Care Provider" has the meaning set forth in 45 CFR Section 160.103 and includes a provider of medical or health services, as well as any other person or organization that furnishes, bills, or is paid for Health Care in the normal course of business.

"Health Care Treatment" means the provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party, consultation between Health Care Providers relating to a patient, or the referral of a patient for Health Care from one Health Care Provider to another, and such other activities that may be included in the definition of "Treatment" as set forth in 45 CFR Section 164.501.

"Health Information" has the meaning set forth in 45 CFR Section 160.103 and includes information (including Genetic Information), whether oral or recorded in any form or medium, including, but not limited to, verbal conversations, telephonic communications, electronic mail or messaging over computer

networks, the Internet and intranets, as well as written documentation, photocopies, facsimiles and electronic data, that is created or received by a Health Care Provider, a Health Plan, the PEBP, a life insurer, school or university, or a Health Care Clearinghouse that relates to

The past, present, or future physical or mental health or condition of an Individual;

The provision of Health Care to an Individual; or

The past, present, or future payment for the provision of Health Care to an Individual.

“Health Insurance Issuer” has the meaning set forth in 45 CFR Section 160.103 and includes an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. The term does not include a Group Health Plan (within the meaning of 45 CFR Section 160.103).

“Health Plan” means an Individual or Group Health Plan that provides or pays the cost of medical care, and includes a Group Health Plan, a Health Insurance Issuer, an HMO and such other plans or arrangements as are set forth in the definition of a “Health Plan” in 45 CFR Section 160.103, including the Plan.

“HHS” means the U.S. Department of Health and Human Services.

“HHS-Approved Technology” means:

With respect to data in motion, the encryption guidelines in Federal Information Processing Standard 140-2 (or successor guidelines).

For data at rest, HHS-Approved Technology means the encryption guidelines in National Institute of Standards and Technology (NIST) Special Publication 800-111 (or successor guidelines).

With respect to the destruction of data containing Protected Health Information, an HHS- Approved Technology requires the destruction of the media on which the Protected Health Information is stored such that, for paper, film, or other hard copy media, destruction requires shredding or otherwise destroying the media so that Protected Health Information cannot be read or reconstructed; for electronic media, destruction requires that the data be cleared, purged, or destroyed consistent with NIST Special Publication 800-88 (or successor guidelines) such that the information cannot be retrieved. HHS-Approved Technology may be updated from time to time based on guidance from the Secretary of HHS.

“HITECH” means the Health Information Technology for Economic and Clinical Health Act.

“Hybrid Entity” means a single legal entity that is a Covered Entity whose business activities include both covered functions and non-covered functions and that designates Health Care Components (in accordance with 45 CFR Section 164.105(a)(2)(iii)(D)) for purposes of fulfilling the Hybrid Entity requirements of HIPAA, as defined in 45 CFR Section 164.103. For purposes of this definition, “covered functions” means those functions performed by a Covered Entity that make the entity a Health Plan, Health Care Provider, or Health Care Clearinghouse. The Plan is a Hybrid Entity.

“Individual” has the meaning set forth in 45 CFR Section 164.103 as the person who is the subject of Protected Health Information.

“Individually Identifiable Health Information” has the meaning set forth in 45 CFR Section 160.103, and includes Health Information, including demographic information, collected from an Individual and created or received by a Health Care Provider, Health Plan, employer, or Health Care Clearinghouse that identifies the Individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual involved.

“Organized Health Care Arrangement” has the meaning set forth in 45 CFR Section 160.103 and includes:

A Group Health Plan (within the meaning of 45 CFR Section 160.103) and a Health Insurance Issuer or HMO with respect to such Group Health Plan, but only with respect to Protected Health Information created or received by such Health Insurance Issuer or HMO that relates to Individuals who are or who have been participants or beneficiaries in such Group Health Plan;

A Group Health Plan and one or more other Group Health Plans each of which are maintained by the same PEBP; or

The Group Health Plans described in the second bullet of this definition and Health Insurance Issuers or HMOs with respect to such Group Health Plans, but only with respect to Protected Health Information created or received by such Health Insurance Issuers or HMOs that relates to Individuals who are or have been participants or beneficiaries in any of such Group Health Plans.

“PEBP Workforce” means the Executive Director, the agency staff, and the attorneys (for claim purposes).

“Plan Administration Functions” means administrative functions performed by the PEBP on behalf of the Plan, excluding functions performed by the PEBP in connection with any other benefit or benefit Plan of the PEBP.

“Plan Sponsor” means the State of Nevada. The HIPAA regulations incorporate the ERISA definition of “Plan Sponsor,” which generally means the employer that establishes or maintains the employee benefit Plan.

“Privacy Notice” means the notice of privacy practices that sets forth the uses and disclosures of Protected Health Information by the Plan that are required or permissible under HIPAA, as more fully described in 45 CFR Section 164.520.

“Privacy Official” means the person appointed by the PEBP, or its delegate, on behalf of the Plan, who is responsible for developing and implementing policies and procedures for protecting the privacy and confidentiality of Protected Health Information that is held by or on behalf of the Plan, in accordance with 45 CFR Section 164.530.

“Privacy Rule” means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

“Protected Health Information” means Individually Identifiable Health Information that is transmitted by electronic media, maintained in electronic media, transmitted, or maintained in any other form or medium, including oral or written information. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended (within the meaning of 20 USC Section 1232g), employment records held by the Covered

Entity in its role as an Employer, other records described in 20 USC Section 1232g(a)(4)(B)(iv), and information regarding a person who has been deceased for more than 50 years.

“Required by Law” means

A mandate contained in law that compels a Covered Entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law including, but not limited to, a court order, a court-ordered warrant, subpoena, or summons issued by a court, grand jury, a governmental inspector general, or an administrative body authorized to require the production of information;

A civil or an authorized investigative demand;

Medicare conditions of participation with respect to Health Care Providers participating in the program; and

Statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

“Secured Protected Health Information” means Protected Health Information to the extent that the information is protected by using an HHS-Approved Technology identified by HHS for rendering Protected Health Information unusable, unreadable, or indecipherable to unauthorized Individuals.

“Security Official” means the person appointed by the PEBP on behalf of the Plan who is responsible for the development, implementation, and maintenance of the HIPAA data security policies and procedures required for the Plan in accordance with 45 CFR Section 164.308(a)(2).

“Security Standards” means the Standards for the Security of Electronic Protected Health Information, as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C.

“Subcontractor” means a person to whom a Business Associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of the Business Associate.

“Summary Health Information” has the meaning set forth in 45 CFR Section 164.504 and includes information that summarizes the claims history, claims expenses, or types of claims experienced by Individuals for whom the PEBP has provided benefits under the Plan, and from which the following information has been removed:

Names;

Geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code (if permitted under 45 CFR Section 164.514(b)(2)(i)(B));

Elements of dates (except year) relating to the Individual(s) involved (e.g., birth date) or their medical Treatment (e.g., admission, discharge date, or date of death), ages over 89, and elements of dates (including years) indicative of age, except that such ages and elements may be aggregated into a single category of age 90 or older);

Other identifying numbers, such as Social Security, telephone, fax, account, or medical record numbers, e-mail, or Internet addresses, URLs, or Internal Protocol (IP) address numbers, vehicle identifiers and serial numbers;

Facial photographs or biometric identifiers (e.g., fingerprints or voice prints);

Any other unique identifying number, characteristic, or code; and

Any information of which the PEBP has knowledge that could be used alone or in combination with other information to identify an Individual.

“Unsecured Protected Health Information” means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized Individuals using an HHS- Approved Technology.

11.3 Provision of Protected Health Information to the PEBP Workforce

Certain individuals who work for the PEBP have access to the Individually Identifiable Health Information of PEBP Participants for administration functions. These individuals are known as the PEBP Workforce and are identified in Schedule 2. When this Health Information is provided to the PEBP Workforce, it is Protected Health Information and, if it is transmitted by or maintained in electronic media, it is Electronic Protected Health Information. This Section 11.3 describes the circumstances under which Protected Health Information may be received, used, disclosed by the PEBP Workforce.

Permitted Disclosure of Enrollment/Disenrollment Information. A Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose to the PEBP Workforce, information on whether an Individual is participating in the PEBP or is enrolled in or has disenrolled from a Health Insurance Issuer or HMO offered by the PEBP.

Permitted Uses and Disclosure of Summary Health Information. A Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose Summary Health Information to the PEBP Workforce, provided that the PEBP Workforce requests the Summary Health Information for the purpose of:

- Obtaining premium bids for providing Health Insurance coverage under the PEBP; or
- Modifying, amending, or terminating the PEBP.

Summary Health Information means information that summarizes the claims history, claims expenses, or type of claims experienced by Individuals who have received health benefits under the PEBP; and from which the names and other personal identifiers described at 45 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, a Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose Protected Health Information and Electronic Protected Health Information to the PEBP Workforce, provided that the PEBP Workforce uses or discloses the Protected Health Information and Electronic Protected Health Information only for Plan administration purposes.

Plan administration purposes means administration functions performed by the PEBP Workforce, a Health Care Component of the PEBP, or a Health Insurance Issuer or HMO with respect to the PEBP. Plan Administration Functions include quality assurance, claims processing, auditing, and monitoring. Enrollment and disenrollment of the participants and their covered dependents (beneficiaries) is performed by the PEBP Workforce. The PEBP Workforce also performs quality assurance, auditing and monitoring in its role as the Plan Administrator. The Plan contracts with certain Health Care Components such as third-party claims administrators and HMOs to perform claims administration, auditing, and monitoring. Plan Administration Functions do not include functions performed by the employer in connection with any other benefit or benefit plan (e.g., retirement) or any employment-related actions or decisions. Employment information held by the employer is held in its capacity as an employer and is not Protected Health Information. Enrollment and disenrollment functions performed by the PEBP Workforce are performed on behalf of participant and beneficiaries and are not Plan Administration Functions. Employment and enrollment and disenrollment information generally is not Protected Health Information.

The PEBP Workforce or any of its Health Care Components shall not use or disclose Protected Health Information or Electronic Protected Health Information in a manner that is inconsistent with 45 CFR Section 164.504(f).

With respect to any Protected Health Information, the PEBP Workforce or any of its Health Care Components shall:

- (1) Not use or further disclose the Protected Health Information of a Plan Participant or their covered Dependent(s) other than as permitted or required by the PEBP or as Required by Law;
- (2) Ensure that any agent, including a Subcontractor, to whom it provides Protected Health Information received from the PEBP Workforce agrees to the same restrictions and conditions that apply to the PEBP Workforce or any of its Health Care Components with respect to Protected Health Information;
- (3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the employer;
- (4) Report any use or disclosure of Protected Health Information in compliance with 45 CFR Section 164.400-414 of which it becomes aware that is inconsistent with the uses or disclosures;
- (5) Make available Protected Health Information to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;
- (6) Make available Protected Health Information for amendment, and incorporate any amendments to Protected Health Information, in accordance with 45 CFR Section 164.526;
- (7) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

(8) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

(9) If feasible, return or destroy Protected Health Information that it still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Other Uses and Disclosures of Protected Health Information. The PEBP may disclose Protected Health Information to such other persons or entities and under such circumstances as permitted under HIPAA, HITECH, and the rules, regulations, and other guidance issued by the U.S. Department of Health and Human Services under HIPAA and HITECH.

Nondisclosure of Genetic Information for Underwriting Purposes. The PEBP shall not use or disclose Protected Health Information that is Genetic Information (within the meaning of 45 CFR Section 160.103) for underwriting purposes as defined in 45 CFR Section 164.502(a)(5)(i).

Adequate Separation. The Plan shall allow the HIPAA Privacy Official, HIPAA Security Official, the PEBP Board, the Executive Officer of the PEBP, or any person under the supervision of the Executive Officer of the PEBP who receives Protected Health Information relating to payment, Health Care Treatment, or Health Care Operations of, or other matters pertaining to, the PEBP in the ordinary course of business.

No other persons shall have access to Protected Health Information. These specified employees (or classes of employees) shall only have access to and use of Protected Health Information to the extent necessary to perform the Plan Administration Functions of the Plan. Please refer to Schedule 2 that describes adequate separation of PHI. If a specified employee does not comply with the provisions of this Article 11, the employee shall be subject to disciplinary action by the PEBP for non-compliance pursuant to the PEBP's employee discipline and termination procedures.

The PEBP shall ensure that the provisions of this Article 11 are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic Protected Health Information on behalf of the PEBP.

Organized Health Care Arrangement. The Plan (including the Component Benefits), and the other fully insured and self-insured medical options offered or maintained by the PEBP, shall be deemed part of an Organized Health Care Arrangement, to the fullest extent permitted under the Privacy Rule.

Interpretation. The Plan and this Section shall be interpreted and administered in accordance with the Privacy Rule, any applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Privacy Rule, statute, regulation, or guidance, such Privacy Rule, statute, regulation, or guidance shall govern.

11.4 HIPAA Security Rule

(a) PEBP Security Practices. By law, PEBP is required to:

- (1) Put in place administrative, physical, and technical safety measures to reasonably and appropriately protect the confidentiality, integrity, and availability of Participant personal medical information that is stored electronically, consistent with the requirements of the Security Standards;
 - (2) Make sure there are reasonable and appropriate security measures in place to protect and separate Participant personal medical information that is stored electronically from other agencies, Employees, or Employers who do not need access to it, consistent with the requirements of the Security Standards;
 - (3) Make sure that any agents, including a subcontractor, or vendors who help PEBP with its operations also have in place reasonable and appropriate security measures to protect PEBP personal medical information; and
 - (4) Report to the PEBP Security Officer any security problems or incidences resulting from unauthorized access, use or interference of systems operations in a system containing PEBP personal medical information, known by PEBP or any agent or vendor.
- (b) Interpretation. The Plan and this Section shall be interpreted and administered in accordance with the Security Standards, any applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Security Standards, statute, regulation, or guidance, such Security Standards, statute, regulation, or guidance shall govern. The Plan shall adopt written policies and procedures to implement the provisions of this Section.

11.5 HIPAA Breach Notification Standards

PEBP shall comply with the breach of unsecured protected health information notification provisions as set forth in HITECH and addressed under Notification in the Case of Breach of Unsecured Protected Health Information at 45 CFR Part 164, Subpart D.

11.6 Certification

The Plan Sponsor certifies that this Article incorporates the provisions set forth in 45 CFR Section 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii).

11.7 Amendment of Schedule 2

The Plan Administrator may amend Schedule 2 to add or remove a PEBP position, access, or access level, or to update the Privacy Official, Security Official, and HIPAA contact office information. Any such modification shall not necessitate a formal amendment to this Plan document.

Schedule 1. Component Benefits

The Plan shall provide for the following Component Benefits, as provided for, and described in the applicable Incorporated Documents:

- Medical and Prescription Drugs
 - PEBP Exclusive Provider Organization Plan, Low Deductible PPO Plan, Consumer Driven Health Plan, Health Maintenance Organization
- Dental
- Vision
- Basic Life Insurance
- Supplemental Life Insurance and Accidental Death and Dismemberment Insurance, Dependent Life Insurance, Short-Term Disability Insurance, Long-Term Disability Insurance, etc.
- Health Reimbursement Arrangement

Component Benefits are described in the applicable Incorporated Documents and the applicable Summary of Coverage or Summary of Insurance. A Summary of Coverage or Summary of Insurance that describes benefits under this Plan will reference the name of the Plan as the PEBP Active Employee Health and Welfare Wrap Plan.

Schedule 2. HIPAA Privacy and Security Provisions

PEBP Position	Access	Access Level
PEBP Board		
PEBP Board Member	PHI, PII, Minimum Necessary	Level 1
PEBP Executives		
Executive Officer	PHI, PII, Minimum Necessary	Level 4
Executive Assistant	PHI, PII, Minimum Necessary	Level 2
Accounting		
Chief Financial Officer	PHI, PII, Minimum Necessary	Level 3
Administrative Services Officer II	PHI, PII, Minimum Necessary	Level 3
Management Analyst II	PHI, PII, Minimum Necessary	Level 2
Accounting Technician II	PHI, PII, Minimum Necessary	Level 2
Accounting Assistant II, III	PHI, PII, Minimum Necessary	Level 2
Information Technology		
Chief Information Officer	PHI, PII, Minimum Necessary	Level 3
IT Professional II, III	PHI, PII, Minimum Necessary	Level 2
Operations		
Operations Officer	PHI, PII, Minimum Necessary	Level 3
Management Analyst III	PHI, PII, Minimum Necessary	Level 2
Program Officer III	PHI, PII, Minimum Necessary	Level 2
Program Officer I	PHI, PII, Minimum Necessary	Level 2
Member Services Administrative Assistant II, III, IV	PHI, PII, Minimum Necessary	Level 2
Eligibility Administrative Assistant I, IV	PHI, PII, Minimum Necessary	Level 2
Education Information Officer	PHI, PII, Minimum Necessary	Level 2

Quality Control		
Quality Control Officer	PHI, PII, Minimum Necessary	Level 4
Management Analyst III	PHI, PII, Minimum Necessary	Level 4
Management Analyst I	PHI, PII, Minimum Necessary	Level 4

Access Level

- **Level 1:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants.
- **Level 2:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants. Credit Card, Debit Card and Financial Account information.
- **Level 3:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants. Credit Card, Debit Card and Financial Account information. Minimum necessary claims data as provided by PEBP Vendors (limited to special projects as authorized by the Executive Officer).
- **Level 4:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants. Physical and mental condition information (past, present, future) to include clinical reports regarding PEBP participants only when necessary to administer health care benefits.

HIPAA Privacy Officer, HIPAA Security Officer, HIPAA Contact Office

PEBP Privacy Officer: If a Participant feels his/her privacy rights have been violated, he/she may file a complaint with the PEBP's Quality Control Officer or with the HHS Office for Civil Rights.

PEBP Quality Control Officer
 3427 Goni Road, Suite 109
 Carson City, NV 89706
 Phone: (775) 684-7000; (702) 486-3100; (800) 326-5496
 Fax: (775) 684-7028

PEBP Security Officer: The PEBP CIO is responsible for coordinating compliance with the HIPAA Security Rules as defined by the Code of Federal Regulations, 45 C.F.R. 160, 162 and 164.

PEBP Chief Information Officer (CIO)
 3427 Goni Road, Suite 109
 Carson City, NV 89706
 Phone: (775) 684-7000; (702) 486-3100; (800) 326-5496
 Fax: (775) 684-7028

HIPAA Contact Office: PEBP as the Plan Administrator

PEBP

Schedule 2. HIPAA Privacy and Security Provisions

3427 Goni Road, Suite 109
Carson City, NV 89706
Phone: (775) 684-7000; (702) 486-3100; (800) 326-5496
Fax: (775) 684-7028

Schedule 3. Section 1557 Notice

The State of Nevada Public Employees' Benefits Program's (PEBP) Consumer Driven Health Plan (CDHP), Low Deductible Plan (LD), and Exclusive Provider Organization Plan (EPO) for Medical and Prescription Drug Benefits complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. PEBP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The PEBP CDHP, LD, and EPO for Medical and Prescription Drug Benefits:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact PEBP.

If you believe that the PEBP CDHP, LD, or EPO for Medical and Prescription Drug Benefits has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

PEBP's Civil Rights Coordinator
 3427 Goni Road, Suite 109
 Carson City, NV 89706
 Phone: (775) 684-7000; (702) 486-3100; (800) 326-5496
 Fax: (775) 684-7028

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, contact PEBP's Civil Rights Coordinator.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201
 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-326-5496 (TTY: 1-800-545-8279).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-326-5496 (TTY: 1-800-545-8279).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-326-5496 (TTY: 1-800-545-8279)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-326-5496 (TTY: 1-800-545-8279) 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-326-5496 (TTY: 1-800-545-8279).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ፡ 1-800-326-5496 (መስማት ለተሳናቸው፡1-800-545-8279)፡፡

เรียน: ถ้าคุณพูด ภาษา ไทยคุณสามารถ ใช้บริการช่วยเหลือทางภาษา ได้ฟรี โทร 1-800-326-5496 (TTY: 1-800-545-8279)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-326-5496 (TTY: 1-800-545-8279) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-326-5496 (رقم هاتف الصم والبكم: 1-800-545-9728).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-326-5496 (телетайп: 1-800-545-8279).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-326-5496 (ATS: 1-800-545-8279).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. تماس بگیرید 1-800-326-5496 (TTY: 1-800-545-8279).

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-326-5496.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-326-5496 (TTY: 1-800-545-8279).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-326-5496 (TTY: 1-800-545-8279).



Access.
Quality.
Affordability.



RETIREE HEALTH AND WELFARE WRAP PLAN DOCUMENT

PLAN YEAR 20245

(EFFECTIVE JULY 1, 202~~43~~ – JUNE 30, 202~~54~~)



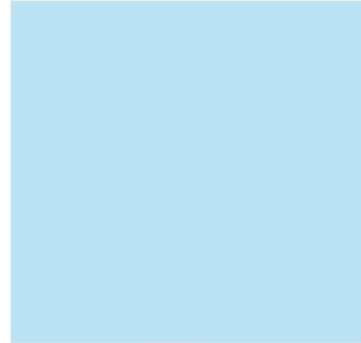
NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

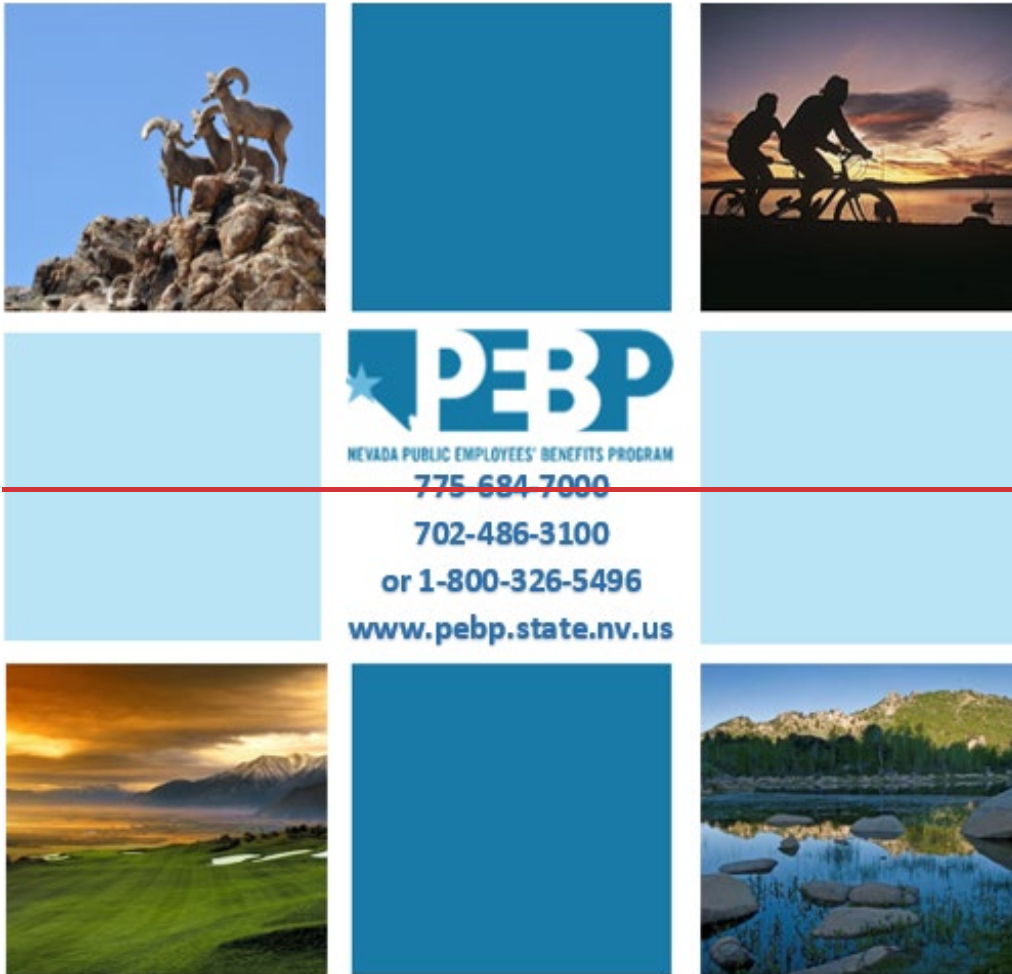
775-684-7000

702-486-3100

or 1-800-326-5496

<https://pebp.nv.gov>





Public Employees' Benefits Program

3427 Goni Road, Suite 109
Carson City, Nevada 89706

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Amendment Log

~~Article 4 Benefits:~~

~~4.2 Compliance with Federal Group Health Plan Benefits and Coverage Mandates: plan changes approved in March 2023 Board Meeting – Removed reference to coronavirus benefits.~~

Article 1 Introduction

1.1 Introduction

The Plan includes the Component Benefits listed in Schedule 1 to this Plan document for certain Retirees and their eligible Dependents participating in the Public Employees' Benefits Program, hereafter referred to as PEBP. The provisions of the Component Benefits are contained in the Incorporated Documents.

This PEBP Plan is governed by the State of Nevada.

This document is intended to comply with the Nevada Revised Statutes (NRS) [Chapter 287](#), and the [Nevada Administrative Code 287](#) as amended and certain provisions of [NRS 695G](#), [NRS 689B](#) and the Patient Protection and Affordable Care Act (PPACA)

The Plan described in this document is effective **July 1, 2023~~4~~**, and unless stated differently, replaces prior medical and prescription drug benefit plan documents/summary plan descriptions. Per [NRS 287.0485](#) no officer, Employee, or Retiree of the State has any inherent right to benefits provided under the PEBP.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. As the Plan is amended from time to time, Participants will be sent information explaining the changes. This Plan is administered in accordance with regulations of Section 125 of the Internal Revenue Code ("Code") as described in the PEBP Section 125 Health and Welfare Benefits Plan Document available at www.pebp.state.nv.us.

This Plan is **not** established under and subject to the Employee Retirement Income Security Act of 1974, as amended, a federal law commonly known as ERISA. The self-funded portions of this Plan are funded with contributions from participating Employers and eligible Participants, held in an internal service fund. An independent Claims Administrator pays benefits out of the fund's assets. An independent Claims Administrator pays the claims for medical and prescription drug benefits.

1.2 Legal Status of Plan

The Plan is intended to qualify as an accident and health plan under Sections 105 and 106 of the Code and as a plan providing group-term life insurance coverage, as described in Section 79 of the Code. The Plan is intended to comply with the laws of the State of Nevada, the Code, and the Public Health Service Act (PHSA) and the regulations and rules promulgated under each, to the extent applicable, and any other applicable law.

The Plan shall be construed and interpreted in a manner consistent with the requirements of Sections 79, 105 and 106 of the Code, and any other applicable sections of the Code, the PHSA or any other applicable law.

1.3 Applicability of the Plan

Except as otherwise provided herein, the provisions of this Plan shall apply only to covered services and covered events (e.g., death) which are provided, or which occur on and after **July 1, 2023~~4~~**, to certain Eligible Retirees. The terms of this Plan govern claims for benefits hereunder as of **July 1, 2024~~3~~**. In the case of services or events which are provided, or which occur prior to **July 1, 2024~~3~~**, coverage shall be available (if at all) under the terms of the applicable prior plan.

Article 2 Definitions

2.1 Definitions

The following words and phrases as used in the Plan shall have the following meanings unless a different meaning is required by the context:

“Allowable Expense” means a health care service or expense, including deductibles, coinsurance, or copayments, which is covered in full or in part by any of the plans covering the person, except as described below, or where a statute requires a different definition. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

“Benefit Option” means an option for coverage within an underlying Component Benefit (such as a particular “benefit package” within a group health plan).

“Cafeteria Plan” means the PEBP Section 125 Health and Welfare Benefits Plan, intended to meet the requirements of Code Section 125 and the regulations thereunder.

“Claims Administrator” means the person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified in the Plan.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means the Internal Revenue Code of 1986, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder, and any successor statute of similar import. Reference to any section or subsection of the Code includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

“Component Benefit” means a welfare benefit that is designated on Schedule 1 as one of the Component Benefits of the Plan and described in the Incorporated Documents. Incorporated Documents describing the specific benefits provided by each Component Benefit, the terms of eligibility and other terms and conditions, as they may be amended from time to time by the PEBP, are incorporated herein by reference, and are considered part of the Component Benefits.

“Covered Person” means an Eligible Retiree, or eligible Dependent who is covered under a Component Benefit who enrolls in the Plan in accordance with Article 3, who has commenced participation in the Plan accordingly and whose participation has not terminated under any other applicable provisions of the Plan.

“Dependent” generally refers to individuals other than an Eligible Retiree who may be eligible for, and enrolled in, coverage under a Component Benefit, as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility, based on their relationship to the Eligible Employee or Eligible Retiree (e.g., Dependent Child(ren), Spouse, or Domestic Partner).

“Dependent Child(ren)” means any of an Eligible Retiree’s children under the age of 26 years including: (i) natural child; (ii) child(ren) of a Domestic Partner; (iii) stepchild; (iv) legally adopted child or child placed in anticipation of adoption (the term placed for adoption means the assumption and retention by the Employee or Retiree of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced); (v) child who qualifies for benefits under a Qualified Medical Child Support Order/National Medical Support Notice; and (vi) child under 19 years for whom an Employee or Retiree has legal guardianship under a court order.

“Domestic Partner” means a domestic partner as defined by NRS 122A.030 and as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

“Effective Date” means the effective date of this Plan which is **July 1, 2023~~4~~**.

“Eligible Employee” means an Employee who is an “eligible employee” as defined in the Master Plan Document for the PEBP Enrollment and Eligibility. PEBP may at any time and from time to time remove any one or more Employees or any other group(s) or class(es) of Employees from eligibility for participation in this Plan.

“Eligible Retiree” means a Retiree who is eligible to become a Participant under the terms of the Master Plan Document for the PEBP Enrollment and Eligibility. PEBP may at any time and from time to time remove any one or more Retirees or any other group(s) or class(es) of Retirees from eligibility for participation in this Plan.

“Employee” means a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

“Employer” means, unless specifically indicated otherwise when used in this document, an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

“Executive Officer” means the Executive Officer of PEBP.

“FMLA” means the Family and Medical Leave Act of 1993, as amended.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996 as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import.

“Incorporated Document” shall mean any and all of the following documents, each of which is incorporated by reference into this Plan document and made a part hereof, and as each is amended from time to time by the PEBP; an Incorporated Document describes the specifics of a Component Benefit(s) including eligibility:

- PEBP Exclusive Provider Organization Plan Master Plan Document (for Medical and Prescription Drug Benefits);
- Exclusive Provider Organization Plan Summary of Benefits and Coverage (for Employee and Family);
- Consumer Driven Health Plan (CDHP) Master Plan Document (Medical, Vision, Prescription Drug, Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA));
- Low Deductible PPO (LD PPO) Master Plan Document; Summary of Benefits and Coverage (for Employee and Family);
- Consumer Driven Health Plan (CDHP) Summary of Benefits and Coverage (for Employee and Family);
- PEBP Active Employee Health and Welfare Wrap Plan Document
- PEBP Enrollment and Eligibility Master Plan Document;
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document;
- PEBP Section 125 Health and Welfare Benefits Plan Document;
- Health Reimbursement Arrangement Master Plan Document
- Medicare Exchange Health Reimbursement Arrangement Summary Plan Description;
- Health Plan of Nevada Evidence of Coverage and Summary of Benefits and Coverage;
- Summaries of Coverage and Summaries of Insurance; Insurance Contract(s); and,
- Plan Materials.

“Insurer” means an insurance company with which the Plan Administrator has entered into an Insurance Contract.

“Insurance Contract” means a contract between the Plan Administrator and an Insurer for the provision of one or more Component Benefits.

“Participant” means the Retiree or their enrolled Spouse or Domestic Partner or Dependent Child(ren) or a surviving Spouse or Dependent of a Retiree per NAC 287.095 and as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

“Participant Contributions” means contributions made by a Participant under the Cafeteria Plan, including, without limitation, Salary Reduction Contributions, as applicable. For this purpose, Participant Contributions shall also include contributions by Covered Persons, such as contributions required following an election of continuation coverage under COBRA.

“PEBP” means the Public Employees’ Benefits Program established pursuant to subsection 1 of [NRS 287.043](#).

“PEBP Board” or “Board” means the Board of the Public Employees’ Benefits Program created by [NRS 287.041](#).

“Plan” means the PEBP Health and Welfare Wrap Plan as set forth herein, including the Component Benefits as set forth in Schedule 1 and other schedules hereto and Incorporated Documents, as each is amended from time to time.

“Plan Administrator” means the person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan. As of the Effective Date, the Plan Administrator is the Executive Officer of PEBP. The Executive Officer of PEBP may from time to time designate in writing an individual, group of individuals, or staff to formally act on its behalf (designee).

“Plan Materials” means updates to a Component Benefit that is communicated to Participants, to the extent that such update is approved by the Plan Administrator or a delegate of the Plan Administrator.

“Plan Year” means typically the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority, with respect to a Component Benefit, to revise the benefits and rates, if necessary, each Plan Year.

“Qualified Medical Child Support Order” means an order that creates or recognizes the existence of a child's right to health benefits under the Plan and must be in the form of a judgment, decree, or order (including a settlement agreement approved by the court) issued by a court (or state administrative agency with jurisdiction) that is deciding the child support issues in a divorce or other family law action. A Qualified Medical Child Support Order must clearly specify:

The name and last known mailing address of a Participant and the name and last known mailing address of each child covered by the order,

a reasonable description of the type of coverage to be provided by the Plan to each child covered by the order, or the manner in which such type of coverage is to be determined,

The period to which the order applies, and

Each plan to which such order applies.

A Qualified Medical Child Support Order cannot require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan. The Plan Administrator shall adopt procedures respecting a Qualified Medical Child Support Order in accordance with Section 2714 of the PHSA and Section 401(e)-(f) of the Child Support Performance and Incentive Act of 1998 (CSPIA).

“PPACA” means the Patient Protection and Affordable Care Act enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act enacted on March 30, 2010, and as may be amended from time to time thereafter.

“Rescission” means a cancellation or discontinuance of coverage under the Plan that has a retroactive effect. In accordance with Section 2712 of the PHSA, rescission does not include a

cancellation or discontinuance of coverage under the Plan if: (a) the cancellation or discontinuance of coverage has only a prospective effect; or (b) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or (c) fraud.

“Retiree” means, unless specifically indicated otherwise, when used in this document, a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

“Salary Reduction Contributions” means contributions made under the Cafeteria Plan based on an election by a Participant to have amounts withheld from the Participant’s compensation on a pre-tax or after-tax basis to pay for benefits or coverage provided under a Component Benefit.

“Spouse” means an Employee’s lawful Spouse (opposite sex or same sex) as determined by the laws of the State of Nevada, and as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

“State” means the State of Nevada.

“State Law” means the law of the State of Nevada, as set forth in the Nevada Revised Statutes (NRS) and the regulations thereunder.

“Subrogation” means the right of one party to be substituted in place of another party in a lawsuit. See Section 4.5 Third Party Liability of this document for an explanation of how the Plan may use the right of Subrogation to be substituted in place of a covered individual (any Retiree and that person’s eligible Spouse or Dependent Child who has completed required formalities for enrollment for coverage under the Plan and is actually covered under a Component Benefit of the Plan) in that person’s claim against a third party who wrongfully caused that person’s injury or illness, so that the Plan may recover medical benefits paid if the covered individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

“Summary of Coverage” means the description of health care services and benefits prepared on behalf of the PEBP by the third-party administrator to describe the details of a self-insured benefit program.

“Summary of Insurance” means the description of health care services and benefits prepared by an Insurer.

“Tortfeasor” means an individual or entity who commits a wrongful act, either intentionally or through negligence, which injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

“Uniformed Services” means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard

duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import.

2.2 Construction

Whenever any words are used in the singular form, they shall be construed as though they were also used in the plural form in cases where the plural would so apply. Headings of articles and sections are inserted for convenience and reference, and they constitute no part of the Plan. Except where otherwise indicated by the context, any masculine terminology herein shall include the feminine and gender neutral.

Article 3 Eligibility and Participation

3.1 Eligibility

Retirees and their eligible Dependents as well Medicare retirees and their eligible Dependents are eligible to enroll in this Plan or the Medicare Exchange, subject to the terms of the Master Plan Document for the PEBP Enrollment and Eligibility, which document is incorporated herein by reference.

3.2 Commencement of Participation

Pre-Medicare and certain Medicare-eligible Retirees and their eligible Dependents shall become Covered Persons under the Plan, subject to the terms of the Master Plan Document for the PEBP Enrollment and Eligibility, which document is incorporated herein by reference.

3.3 Elections and Changes in Elections for Benefits

For purposes of the benefits provided under the Component Benefits, the Plan Administrator will designate an annual or open enrollment period and the Benefit Options available for election for the following Plan Year. The election of the Benefit Options and changes thereto shall be made in the manner, and subject to the conditions, specified by the Plan Administrator.

3.4 Effective Dates and Conditions

In order to participate in a Component Benefit and receive benefits under this Plan, pre-Medicare-eligible Retirees and their eligible Dependents must meet any additional participation requirements of the Component Benefits as provided in the Incorporated Documents. A Retiree must elect any such benefits on forms provided by the Plan Administrator or through electronic means designated by the Plan Administrator unless the benefit is automatically provided. Such coverage shall be effective as of the date or dates set forth in the applicable Component Benefit's Incorporated Documents.

3.5 Termination of Coverage

Termination of coverage under this Plan of any Participant/Covered Person will terminate in accordance with the rules and procedures set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

3.6 Continuation

Opportunities to continue coverage under this Plan shall be as set forth in the Master Plan Document for the PEBP Enrollment and Eligibility and provided in accordance with applicable state and federal law.

3.7 Incorporation of Plans and Policies and Master Plan Documents

The eligibility provisions, benefit provisions and such other provisions of the applicable Component Benefit's Incorporated Documents as may be modified from time-to-time hereafter,

and as are consistent with the terms and conditions of this Plan are incorporated herein by reference and shall be of the same force and effect under this Plan as if they were set forth herein. Furthermore, if any provision of a Component Benefit shall at any time hereafter conflict with the provisions of this Plan, such provision of the Component Benefit shall no longer be deemed a part of this Plan.

3.8 Qualified Medical Child Support Orders

The Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

Article 4 Benefits

4.1 Generally

Benefits hereunder shall be provided through the Component Benefits listed in Schedule 1. As permitted by this Section 4.1, the PEBP, as Plan Administrator, has the authority to determine what Component Benefits will be provided to Eligible Retirees and Dependents provided the availability of such Benefit Options are communicated to Eligible Employees.

The persons covered and the benefits provided by each Component Benefit shall be determined in accordance with the applicable Incorporated Documents; provided that, except to the extent the Master Plan Document for the PEBP Enrollment and Eligibility expressly provides otherwise, persons who are not Eligible Retirees shall not be eligible for coverage or benefits under the Plan; and provided further that, except to the extent required by applicable law, coverage and benefits under the Plan shall not be provided in excess of the coverage and benefits described in the applicable Summary of Coverage, Summary of Insurance and/or Insurance Contract.

4.2 Compliance with Federal Group Health Plan Benefits and Coverage Mandates

A group health plan Benefit Option shall comply with benefit and coverage provisions to the extent required by law including:

Pediatric Vaccines. To the extent it applies, the Plan shall not reduce the continued coverage costs of a pediatric vaccine below the coverage the Plan provided as of May 1, 1993, under the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

Newborns and Mothers. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Sections 2725 and 2791 of the PHSA or has not opted out under Section 2722(a) of the PHSA, shall continue coverage for newborns and mothers in accordance with Section 2725 of the PHSA.

Mental Health Parity. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Sections 2726 and 2791 of the PHSA or has not opted out under Section 2722(a) of the PHSA, that provides mental health or substance use disorder benefits (MH/SUD), shall provide such MH/SUD benefits in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Women's Health and Cancer Rights Act. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Section 2791 of the PHSA, or has not opted out, shall provide coverage for reconstructive surgery following mastectomy to the extent required by Section 2727 of the PHSA.

Group Market (Insurance) Reforms. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Section 2791 of the PHSA, shall comply with the applicable group market (insurance) reforms that apply to a group health plan under PPACA. As of the Effective

Date, no Benefit Option is a “grandfathered health plan.” Further, the Health Reimbursement Arrangement is intended to be integrated for purposes of PPACA and related guidance.

PPACA group market (insurance) reforms that apply to grandfathered and non-grandfathered group health plan Benefit Options under the Plan that are not exempt or excepted benefits under Section 2791 of the PHSA are:

Prohibition of preexisting condition exclusions under PHSA 2704;

Prohibiting discrimination against Participants and beneficiaries based on a health factor under PHSA 2705;

Prohibition on waiting periods that exceed 90 days under PHSA 2708;

Prohibition on lifetime or annual dollar limits on essential health benefits under PHSA 2711;

Prohibition on rescissions under PHSA 2712;

Eligibility of children until at least age 26 under PHSA 2714;

Summary of benefits and coverage and uniform glossary under PHSA 2715; and,

Solely with respect to insured Benefit Options, the medical loss ratio requirements under PHSA 2718.

Additional PPACA group market (insurance) reforms that apply to group health plan Benefit Options that have lost grandfathered health plan status and are not exempt or excepted benefits under Section 2791 of the PHSA are:

Provider non-discrimination under PHSA 2706(a);

Limitations on cost sharing (i.e., the out-of-pocket expense maximum requirements) under PHSA 2707(b);

Coverage for individuals participating in approved clinical trials under PHSA 2709.

Coverage of preventive health services under PHSA 2713;

Internal claims and appeals and external review process as discussed in Article 7 of the Plan and under PHSA 2719; and

Consumer patient protections (choice of health care professional and coverage of emergency services) under PHSA 2719A.

While not referenced in this Plan document, the Benefit Options that are subject to the group market (insurance) reforms will comply with respect to both regulatory and sub-regulatory guidance to the extent applicable. To the extent that the U.S. Department of Labor, Internal

Revenue Service or Department of Health and Human Services, as applicable, implements additional group market (insurance) reforms required by the PPACA, the Plan shall comply to the extent necessary.

National Defense Authorization Act (NDAA). The Plan shall comply with Section 585 of the National Defense Authorization Act (NDAA), which amends the Family and Medical Leave Act of 1993 (FMLA), to permit a “Spouse/ Domestic Partner, son, daughter, parent, or next of kin” to take up to 26 workweeks of leave to care for a “member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.” The NDAA also permits an employee to take FMLA leave for “any qualifying exigency (as the Secretary [of Labor] shall, by regulation, determine) arising out of the fact that the Spouse/Domestic Partner, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.”

Heroes Earning Assistance and Relief Tax Act (HEART Act). The Plan shall comply with the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act), which requires that certain retirement and welfare benefits be provided for returning military personnel and their beneficiaries.

Uniformed Services Employment and Reemployment Rights Act (USERRA). The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA, 38 U.S.C. § 4301–4335) is a federal law intended to ensure that persons who serve or have served in the Armed Forces, Reserves, National Guard or other “uniformed services”: (1) are not disadvantaged in their civilian careers because of their service; (2) are promptly reemployed in their civilian jobs upon their return from duty; and (3) are not discriminated against in employment based on past, present, or future military service.

The Americans with Disability Amendments Act (ADA). To the extent applicable, the Plan shall comply with the Americans with Disability Act (ADA), including the requirement that any condition that substantially limits a major life activity will be considered a disability, even if the individual can offset or compensate for the disability with the mitigating measures such as hearing aids or artificial limbs.

Genetic Information Non-discrimination Act of 2008 (GINA). The Plan shall comply with the Genetic Information Non-discrimination Act of 2008 (GINA) to the extent applicable including: Title I (regarding genetic nondiscrimination in group health plans) and Title II (regarding genetic nondiscrimination in employment). Under GINA, the Plan shall not base enrollment decisions, premium costs, or Participant contributions on genetic information. The Plan shall not require that individuals undergo genetic testing. PEBP is prevented from conditioning hiring or firing decisions based on genetic information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information regarding either employment or the determination of benefits.

Michelle's Law. The Plan shall comply with Michelle's Law to the extent it applies to Dependent Child(ren)'s eligibility for health coverage conditioned on maintaining full-time student status as described in the Master Plan Document for the PEBP Enrollment and Eligibility. Should Michelle's Law apply and a Dependent Child takes a medically necessary leave of absence for a serious illness or injury that causes loss of full-time student status, the Plan shall not terminate his or her coverage before the date that is the earlier of: (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the PEBP. A written certification stating that the Dependent Child is suffering from a serious illness or injury and that the leave of absence is medically necessary must be provided by a treating physician of the Dependent Child to PEBP for eligibility and coverage to continue.

4.3 Benefit Election

During the enrollment period, an Eligible Retiree may elect to either receive any or all the benefits described in the Component Benefits for which the Eligible Retiree and any eligible Dependent(s) is eligible as described in the enrollment materials. Each Participant shall be notified of the Eligible Retiree's share of the cost, if any, of each Benefit Option prior to the enrollment period for the Plan Year.

4.4 Coordination of Benefits

When Participants have medical, dental or vision coverage from some other source, benefits are determined using Coordination of Benefits (COB). COB operates so that one of the plans (i.e., the primary plan) will pay its benefits first. The other plan or policy, (i.e., the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

Participants must let the Plan Administrator, or its designee know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and dental deductibles. This Plan's prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. Meaning there will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.

For the purposes of this COB section, the word "plan" refers to any group or individual medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual either on an individual basis or as part of a group of employees, retirees or other individuals.

A Participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such fully insured plan and the rules and procedures described in such fully insured plan's applicable Summary of Insurance.

A Participant in a self-insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures set forth in this Section 4.4. The PEBP delegates to the third-party administrator of such self-insured plan the duty to administer and interpret the provisions of this Section 4.4. and to adopt, document and communicate any rules and procedures necessary or appropriate to implement the COB procedures, as set forth herein:

Which Plan Pays First: Order of Benefit Determination Rules. PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any plan that does not use these same rules always pays its benefits first.

When two plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

These rules are:

Non-Dependent /Dependent

The plan that covers a person other than as a dependent (e.g., as an employee, retiree, member, or subscriber) is primary and the plan that covers the person as a dependent is secondary. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

Secondary to the plan covering the person as a dependent;

Primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);

Then the order of benefits is reversed, so that the plan covering the person as a dependent will pay first; and the plan covering the person other than as a dependent (e.g., as a retired employee) pays second.

This rule applies when both spouses are employed and cover each other as dependents under their respective plans. The plan covering the person as an employee pays first, and the plan covering the same person as a dependent will pay benefits second.

Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

The parents are married;

The parents are not separated (whether or not they ever have been married); or

A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period pays first, and the plan that has covered the other parent for the shorter period of time pays second.

The word “birthday” refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

The plan of the custodial parent pays first; and

The plan of the spouse of the custodial parent pays second; and

The plan of the non-custodial parent pays third; and

The plan of the spouse of the non-custodial parent pays last.

Retired Employee

The plan that covers a person, as a retired employee or as a retired employee’s dependent pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule (1) Non-Dependent/Dependent rather than by this rule.

Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member, or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a Dependent (that is, as an employee, former employee, retiree, member, or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule (1) Non-Dependent/Dependent rather than by this rule.

Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period pays first; and the plan that covered the person for the shorter period of time pays second. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan.

Administration of COB. To administer COB, the Plan reserves the right to:

Exchange information with other plans involved in paying claims;

Require that Participants or Participants' health care provider(s) furnish any necessary information;

Reimburse any plan that made payments this Plan should have made; or

Recover any overpayment from a Participant's hospital, physician, dentist, other health care provider, other insurance company, or a Participant.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount the Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

This Plan follows the customary COB rule that the medical program coordinates with only other medical plans or programs (and not with any dental plan or program), and the dental program coordinates only with other dental plans or programs (and not with any other medical plan or program). Therefore, when this Plan is secondary, it will pay secondary medical benefits only

when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

If this Plan is primary, and if the coordinating secondary plan is a health maintenance organization (HMO), Exclusive Provider Organization (EPO) or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary Plan.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to rights the Participant may have against the other plan, and the Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

This Plan does not coordinate pharmacy benefits when PEBP is the secondary or tertiary payor.

Coordination with Medicare. Coordination with Medicare is not applicable for Participants and their Dependents who are eligible for Medicare Part A and Medicare Part B and who are required to transition to the Medicare Exchange. The Enrollment and Eligibility Master Plan Document includes information regarding enrollment in the Medicare Exchange.

Entitlement to Medicare Coverage. When a Participant reaches Medicare eligible age, the Participant must enroll in the Medicare plan for which the Participant is eligible. Generally, anyone age 65 years or older is entitled to Medicare Part A and Medicare Part B coverage. Anyone under age 65 years who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

When the Participant is Not Eligible for Premium Free Medicare Part A. This Plan will pay as primary for services that would have been covered by Part A when a Participant is not eligible for Premium Free Medicare Part A. However, a Participant must enroll in Medicare Part B and PEBP will be the secondary payer for Medicare Part B services. This Plan will always be secondary to Medicare Part B, whether or not a Participant has enrolled. This Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

Coverage Under Medicare and This Plan When a Participant Has End-Stage Renal Disease. If, while actively employed, a Participant becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins, or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage or the first month after the individual receives a kidney transplant, Medicare pays first, and this Plan pays second.

If a Participant is under age 65 years and receiving Medicare ESRD benefits the Participant will not be required to transition to PEBP's Medicare Exchange program. When a Participant reaches age 65 years, the Participant will be transitioned to the Medicare Exchange in accordance with PEBP's eligibility requirements as stated in the Enrollment and Eligibility Master Plan Document.

How Much This Plan Pays When It Is Secondary to Medicare. When the Participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays as secondary to Medicare, with the Medicare negotiated allowable fee taking precedence. If a service is not covered under Medicare but is covered under this Plan, this Plan will pay as Primary with the Plan's allowable fee for the service taking precedence.

When the Retiree or the Retiree's covered Spouse or Domestic Partner is enrolled in Medicare Part B: This Plan will always be secondary to Medicare Part B. If eligible Retirees or their covered Spouses or Domestic Partners are not enrolled in Part B, this Plan will estimate Medicare's Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

When the Participant Enters into a Medicare Private Contract: A Medicare Participant is entitled to enter into a Medicare private contract with certain health care practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare Participant enters into such a contract this Plan will not pay any benefits for any health care services and/or supplies the Medicare Participant receives pursuant to it.

Coordination with Other Government Programs.

Medicaid. If a Participant is covered by both this Plan and Medicaid, this Plan pays first, and Medicaid pays second.

Tricare. If a Participant or their covered Dependent is covered by this Plan and Tricare (the program that provides health care services to active or retired armed services personnel and their eligible Dependents), this Plan pays first, and Tricare pays second. For an Employee called to active duty for more than 30 days, Tricare is primary, and this Plan is secondary.

Veterans Affairs Facility Services. If a Participant receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military

service-related illness or injury, benefits are payable by the Plan at the in-network benefit level at the usual and customary charge, only to the extent those services are medically necessary and are not excluded by the Plan.

Worker's Compensation. This Plan does not provide benefits if the expenses are covered by workers' compensation or occupational disease law. If a Participant contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a Workers' Compensation or occupational disease law. However, before such payment will be made, a Participant must execute a Subrogation and reimbursement agreement (described in the Third-Party Liability Section 4.5) that is acceptable to the Plan Administrator or its designee.

4.5 Third Party Liability

Subrogation applies to situations where the Participant is injured and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the manner in which they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). Any and all payments made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The other person or entity who may be responsible, liable, or contractually obligated for the payment of damages or claims may be an individual, a corporation or other business entity, an insurance company (including the Participant's own insurance company), or a public or private entity. By way of example only, and without limitation, automobile accident injuries or personal injury on another's property (i.e., a slip and fall) are examples of cases frequently subject to Subrogation.

Subrogation includes situations where the Injury is or may be covered by another insurance policy, including but not limited to the Participant's own first-party automobile insurance, any third-party automobile liability insurance, any applicable no-fault insurance or medical payments coverage, and premises medical payments coverage (including homeowner's insurance), irrespective of fault, negligence, or wrongdoing.

The Subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, negligence, or wrongdoing. Any and all payments made by the Plan relating in any way to the Injury may be recovered directly from the other person or from any judgment, verdict, or settlement obtained by the Participant in relation to the Injury. "Injury" means any harm or damage sustained to the person of a Participant resulting in some form of medical treatment.

(a) Subrogation. By accepting coverage under the Plan, the Participant automatically assigns to the Plan or its Board any and all rights the Participant may have to recover damages or payments from any other person or entity arising from or relating in any way to the Injury, with regard to any and all tort, contractual or other liability or obligation on the part of a person or entity other than the Participant. This includes payments made, or to be made, to or for the Participant from another insurance company, including the Participant's own insurance policy (a "first party" insurance policy). The Board may, but is not required to, act as the substitute for the Participant in the event any payment made by the Plan for health care or other benefits, including any payment for a known or discovered pre-existing condition, may be the responsibility or contractual liability of another person or entity. This express assignment allows the Plan or its Board to directly pursue any claim that the Participant may have, whether or not the Participant chooses to pursue that claim. The Plan or its Board may pursue any such claims on behalf of the Participant and/or in the Participant's own name, as if the Participant were pursuing the claim on his/her own behalf. This includes the right to sue the other person or entity in order to recover any and all payments made by the Plan relating in any way to the Injury. This also includes the right to pursue and/or make a claim against an insurance policy, on behalf of the Participant and/or in the Participant's own name.

The Participant must cooperate fully, at all times, and provide information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

- (1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation;
- (2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
- (3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first-party insurance policy or another person's or entity's insurance policy.

Right of Reimbursement and Recovery. By accepting coverage under the Plan, the Participant agrees that if he/she or someone else receives a recovery of any kind in the form of a judgment, verdict, settlement, payment, or other compensation, irrespective of fault, wrongdoing, or negligence, and irrespective of how the recovery is classified, the Plan or its Board has the unequivocal right to recover its Subrogated Payments from the Participant and/or from any other person or entity, including but not limited to the Participant's estate, survivors, or family members. This also includes, but is not limited to, the right of recovery from the following:

- (1) Tortfeasor;

- (2) Tortfeasor's insurance company; and/or
- (3) Any other source, including but not limited to: any form of first-party insurance coverage carried by, or insuring, the Participant; uninsured or underinsured motorist coverage; any medical payments coverage; no-fault coverage; school insurance coverage; sports insurance coverage; workers' compensation coverage; premises liability coverage, including homeowner's and boating coverage; any medical malpractice recovery; or any other form of insurance coverage, of whatever kind.

The Plan and its Board have an equitable lien against the recovery rights of the Participant. The Plan and its Board have the legal right to be paid from any such recovery, or potential recovery, an amount not to exceed the total amount of benefits paid or to be paid by the Plan, irrespective of whether or not the Participant has been "made whole" for the injuries received.

The Plan's right to Subrogation applies on a first-dollar basis, and has priority over other rights or claims, including the Participant's attorney fees. The Plan's right of Subrogation applies irrespective of whether the funds paid to (or for the benefit of) the Participant constitute a full or partial recovery and applies to recovered funds paid for non-health care charges or attorney fees, or other costs and expenses, including lost wages. The Plan's first priority right of Subrogation in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Participant or any other person or entity attempts to designate or characterize the Recovery, including but not limited to claims for loss of consortium or wrongful death, and irrespective of whether the Recovery itemizes or identifies an amount recovered, adjudicated, or characterized specifically as medical expenses, or is specifically linked to certain kinds of damages or payments.

The Plan's first priority right of Subrogation extends to any and all recoveries arising from or related in any way to the Injury, including but not limited to any recovery obtained by the Participant's estate, or obtained by the Participant's heirs, survivors, successors, assigns, dependents, and/or the like, and/or irrespective of whether the claim is characterized as a wrongful death claim or a survivorship claim.

The Plan's first priority right of Subrogation extends to the Participant's attorney and/or to other agents, successors, and assigns of the Participant.

Payment of Subrogated Payments shall be made without reduction, set-off, or abatement for attorney fees or costs incurred by the Participant in the collection of a Recovery.

The Plan or its Board shall be entitled to seek any equitable or legal remedy to recover money damages or claims against any person or entity possessing or controlling such monies or properties, including but not limited to the Participant and/or his/her attorney. At the sole discretion of the Plan and/or its Board, the Plan may reduce any and all eligible medical expenses, or deny any and all claims, otherwise available to the Participant under the Plan by an amount up to the total Subrogated Payments which are subject to the Plan's right of Subrogation. The Plan's right to reduce eligible medical expenses and to deny claims applies to eligible medical

expenses and claims, irrespective of whether such eligible medical expenses and claims bear any relation to the Injury. Rights of the Plan's recovery will be limited to the amount of payments made under this Plan, plus the Plan's reasonable attorney fees and costs incurred to enforce the terms and conditions of the Plan.

The Plan or its Board shall be entitled to payment of reasonable attorney fees and costs incurred to enforce the terms and conditions of the Plan. This may include, but is not limited to, situations in which: (i) the Plan or its Board commence litigation; (ii) the Plan or its Board intervene in existing litigation; (iii) the Participant or his/her attorney has not paid the Plan the full amount of Subrogated Payments within fifteen (15) days of recovery, as required by NRS 287.0465(3); and/or (iv) the Participant or his/her attorney is not fully cooperative with respect to the Plan's right of Subrogation.

The Plan's equitable lien shall also attach to any money or property that is obtained, held, or to be paid by any person or entity, including but not limited to the Participant, the Participant's attorney, an insurance company, and/or a trust for the direct or indirect benefit of the Participant or for his/her "special needs," as a result of an exercise of the Participant's rights of recovery.

If the Participant attempts to assert that certain Subrogated Payments are not causally related to the Injury, it shall be the Participant's burden to prove the relatedness of the Subrogated Payments in question. If the Subrogated Payments in question are referred to, referenced, or included in any way by the Participant in any settlement negotiations or in any demand package tendered by the Participant to the person or entity from which a recovery is sought, it shall be deemed conclusive evidence that said Subrogated Payments are causally related to the Injury. At its sole discretion, the Plan or its Board may consider additional evidence concerning the causal relation of Subrogated Payments to the Injury.

The Plan or its Board may require the Participant or the Participant's attorney or substitute, as a pre-condition to receiving benefit payments, to sign a Subrogation agreement or acknowledgment and to agree in writing to assist the Plan and to protect the Plan's right to payment of the Subrogated Amount from any person or entity including the Participant.

In addition to Subrogation rights afforded to the Plan herein and by Nevada law, the following provisions also apply to the Plan's right of Subrogation, reimbursement, and/or creation of an equitable lien:

(i) "Pay and Pursue." The Plan, in its sole discretion, may elect to process claims under the "pay and pursue" option. If the Plan elects to "pay and pursue," benefit payments will be made prior to, or concurrently with, necessarily applying the Subrogation, reimbursement, and lien rights under the Plan. This is at the sole discretion of the Plan or its Board and remains subject to the Participant's required cooperation with and protection of the Plan's right of Subrogation.

(ii) Scope of Subrogation, Reimbursement and Lien Rights. The Subrogation, reimbursement, and lien rights apply to any and all benefits paid by the Plan for or on behalf of the Participant arising from or related in any way to the Injury, and apply to the following, enumerated without limitation:

- 1) Any no-fault insurance.
- 2) Medical benefits/payments coverage under any automobile insurance coverage. This includes any first-party insurance plan under which the Participant is covered or an insured, or any third person's insurance policy under which the Participant may be entitled to benefits.
- 3) Underinsured and uninsured motorist coverage, and any other first-party insurance coverage.
- 4) Any automobile medical payments and personal injury protection ("PIP") benefits.
- 5) Any third person's liability insurance, whether automobile coverage or other.
- 6) Any premises/guest medical payments coverage, including homeowner's insurance.
- 7) Any medical malpractice recovery or insurance policies covering medical malpractice.
- 8) Any professional negligence or attorney malpractice recovery or insurance policies covering professional negligence.
- 9) Workers' compensation benefits or claims.
- 10) Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds), to the extent permitted by law.
- 11) Restitution in a criminal matter.

(iii) Subrogated Payments. The term "Subrogated Payments" refers to any benefit payments made by the Plan that are eligible for recovery from any other person as described hereinabove and/or any benefits payments for which the Plan asserts a right of Subrogation.

(iv) "Make Whole" and "Common Fund" Rules Do Not Apply. The Plan's right of Subrogation, reimbursement, equitable liens, and other legal and equitable remedies are specifically intended to supersede the applicability of any and all common law doctrines and/or any and all local, state, and federal laws, including but not limited to the "make whole" rule and the "common fund" rule, to the extent permitted by law.

Role of the Executive Officer. PEBP has delegated to the Executive Officer its powers and its authority and discretion to enforce its rights under this Section 4.5.

A Subrogation lien of the Executive Officer upon the proceeds of any recovery from an insurer providing first-party coverage to a member must be reduced by the applicable in-network or out-of-network out-of-pocket maximum balance of the member remaining at the time of the incident giving rise to the subrogation lien. If the subrogation lien includes medical claims from medical costs resulting from the incident giving rise to the subrogation lien which occurred over multiple plan years, the out-of-pocket maximum balances for each plan year must be used for purposes of reducing the subrogation lien amount. Notwithstanding the foregoing, the provisions of this paragraph do not apply to the coordination of benefits for coverage of the cost of medical services which may be provided under:

- (a) The plan of self-insurance established by PEBP; and
- (b) Any other health insurance coverage.

A decision of the Executive Officer is final and not subject to judicial review.

Applicable Law. The Plan's right of Subrogation under Nevada law is set forth in part at NRS 287.0465. The Plan's Subrogation rights as set forth in this Section 4.5 are established, maintained, operated, and carried out in accordance with Nevada law, including but not limited to NRS 287.0465 and NAC 287.755, and in accordance with the statutory delegation to the Board of the powers and duties to establish and carry out PEBP.

4.6 Dual Coverage Rules

The rules with respect to a Covered Person who is an eligible Dependent and an Eligible Participant under the Plan are set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

4.7 Payment of Benefits

The Component Benefits shall be paid for by the Plan. The Plan (or the Plan Administrator acting on behalf of the Plan) may contract with an Insurer, or another third party to provide a Component Benefit under the Plan. The liability of the Plan, PEBP, the Plan Administrator, and, if applicable, the Insurer or other third-party provider to provide benefits under a Component Benefit shall be limited by the terms of this Plan instrument and the applicable Incorporated Document(s).

4.8 Payment to Participant/Covered Person

Except as otherwise provided in subsection (b) below, benefit payments under a Component Benefit shall be made to the Participant, the Participant on behalf of the Covered Person or if applicable, the Covered Person in accordance with the terms of this Plan, including the Incorporated Documents.

To the extent permitted under a Component Benefit, payments may be made to a third party to whom a Covered Person has made a valid assignment of his right to receive such payments. In addition, if the Plan Administrator determines that a Covered Person is unable to care for his own affairs, the Plan Administrator may authorize the Plan to make benefit payments to the court-appointed legal guardian of the Covered Person, to an individual who has become the legal guardian of the Covered Person by operation of state law, or to another individual who the Plan Administrator determines to be entitled to receive such payments on behalf of the Covered Person.

If a payment of benefits is made under a Component Benefit to a third party in accordance with subsection (b), above, the Plan, PEBP, the Plan Administrator, and, if applicable, the Insurer or other third-party provider shall be relieved, to the fullest extent permitted by law, of any obligation to make a duplicate payment to or on behalf of such Participant and/or Covered Person.

4.9 Tax Withholding

The amount of any benefit paid from the Plan to, or in respect of, a Participant under a Component Benefit shall be reduced by the amount of any income tax or employment tax that is required to be withheld pursuant to any applicable federal, state, or local law, or any applicable foreign law.

4.10 Other Adjustments—Overpayment Provision

If, for any reason, any benefit payable under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Covered Person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator or the applicable Insurer may recover that incorrect payment, whether or not it resulted from the Plan Administrator, an Insurer, or any other third-party provider's own error, from the person to whom it was made or from any other appropriate party.

In the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, or (c) any other method as may be permitted in the sole discretion of the Plan Administrator or Insurer and as permitted by law.

With respect to Component Benefits provided through an Insurer, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable). With respect to self-insured Component Benefit programs, Subrogation or reimbursement rights may be set forth in Section 4.5 of this Plan.

4.11 Unclaimed Benefits

If, within the time period specified by the third party administrator or Insurer of the Component Benefit and communicated to Plan Participants or if not specified and communicated to Plan Participants twelve (12) months, after any amount becomes payable hereunder to a Covered Person and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care shall have been exercised in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

Article 5 Funding and Contributions

5.1 Plan is a Single Plan—Funding

The Plan and its Component Benefits shall be a single plan.

All costs of the Plan, including Plan benefits, Plan administrative expenses, and the retention of experts and advisors, are paid out of the fund and, in some cases, Insurance Contracts.

Benefits may be provided through one or more Insurance Contracts with insurance carriers or such other funding vehicles established with respect to the Component Benefits. The Plan may maintain reinsurance or stop-loss insurance to protect the Plan in the event claims exceed projections.

Component Benefits under the Plan may be provided on an insured or self-insured basis, or a combination thereof, at the discretion of the Plan Administrator. The Summary of Coverage or Summary of Insurance shall set forth whether a Component Benefit is provided on an insured or self-insured basis.

5.2 Contributions to the Plan

Employer Contributions. The Employer shall make such contributions in such amounts and at such times as the Plan Administrator shall direct, in accordance with the funding policy and methods of the Plan.

Participant Contributions.

To be eligible to receive benefits under any Component Benefit for which Participant Contributions are required (which may be pre-tax or after-tax, subject to the terms of the Cafeteria Plan and applicable Component Benefit program), each Participant shall make any required contributions in such amounts and at such time as the Plan Administrator shall from time to time direct, as outlined in the Incorporated Documents. Participant Contributions shall be made in accordance with procedures established by the Plan Administrator.

Failure of a Participant to make Participant Contributions with respect to any Component Benefit by the required due date shall be deemed an election by such Participant to cease participation in such Component Benefit as of the date established by the Incorporated Documents or as directed by the Plan Administrator, for which the missed Participant Contribution was due; provided however, that termination of benefits under any Component Benefit shall in all instances be subject to and in accordance with applicable legal requirements, including but not limited to coverage requirements imposed by the FMLA.

If a Participant fails to pay Participant Contributions during a Leave of Absence and the Plan Administrator in its discretion continues coverage under any Component Benefit in effect during such Leave of Absence, any unpaid Participant Contributions during such period will be collected in arrears through payroll deductions through the Cafeteria Plan, or as otherwise directed by the

Plan Administrator upon the Participant's return to employment with the Employer or expiration of the Participant's Leave of Absence, as applicable.

Article 6 Insurance

6.1 Insurance Generally

If a Participant elects an insured benefit, any such benefit shall be provided solely and exclusively by the insurer under the applicable insurance contract. A Participant's or Covered Person's right to such benefit shall be limited to the amount payable under such insurance contract and the receipt thereof shall be subject to satisfaction of the terms, covenants, conditions, rules, and regulations of the insurer. The Plan Administrator shall have the right from time to time to change the coverage or carrier of any one or more insurance policies.

6.2 Provisions Relating to Insurers

No Insurer shall be required or permitted to issue an insurance policy or contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any policy or contract in connection with this Plan.

6.3 Conflicting Provisions

If any provision or term of any insurance policy or contract conflicts with or is inconsistent with any provision or term of this Plan, such Plan provision or term shall govern.

Article 7 Claims and Appeals Procedures

7.1 Claims and Appeals Procedures

The claims procedure to be followed by Covered Persons to obtain payment of benefits under this Plan shall be in accordance with the rules and procedures set forth in the applicable Incorporated Documents for the Component Benefits. Benefits that are covered under this Plan shall be paid in accordance with the rules and procedures set forth in the Plan, as applicable, which shall govern the claims and appeals procedures. Notwithstanding the foregoing, unless a Component Benefit's Incorporated Document issued by the third-party administrator or Insurer who administers the Component Benefit specifically provides otherwise, a claim for benefits must be filed within 12 months from the date of service (for example, with respect to a medical claim, the date a medical service is provided and the charge is incurred).

The claims procedure to be followed by Retirees for eligibility under this Plan shall be in accordance with the rules and procedures set forth in the Master Plan Document for the PEBP Enrollment and Eligibility and in the Incorporated Documents for the Component Benefits. The Executive Officer or his designee makes final determinations concerning eligibility ([NAC 287.313](#)).

The Plan Administrator has the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to eligibility for the Plan and entitlement to Plan Benefits. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in the Incorporated Documents. The claims procedures applicable to claims made for benefits under this Plan do not apply to casual or general inquiries regarding eligibility for Component Benefits that may be provided under the Plan. For an inquiry to constitute a claim for benefits or an appeal of a denial of a claim for benefits, a Plan Participant must follow the claim procedures under the applicable Component Benefit as set forth in the Incorporated Documents.

For purposes of the determination of the amount of, and entitlement to, benefits under the Component Benefits provided under Insurance Contracts, the Insurer is the named fiduciary under the Component Benefit, with the full power to interpret and apply the terms of the Component Benefit as they relate to the benefits provided under the applicable Insurance Contract.

To obtain benefits from the Insurer of a Component Benefit, a claimant must follow the claims procedures under the applicable Insurance Contract, which may require a claimant to complete, sign and submit a written claim on the Insurer's form.

The Insurer will decide a claim in accordance with its reasonable claim's procedures, applicable state insurance law or other applicable law as required. The Insurer has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order

to decide a claim. If the Insurer denies a claim, in whole or in part, a claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, a claimant may appeal to the Insurer for a review of the denied claim. The Insurer will decide the appeal in accordance with its reasonable claim's procedures.

Upon a final decision to deny a claim for benefits under a Component Benefit that is a non-grandfathered group health plan, the claimant may request an external review that follows the state external review process applicable to and binding on, that Component Benefit, per Section 2719 of the PHSA. To the extent that a Component Benefit is not required to comply with a state external review process under Section 2719 of the PHSA, it must comply with the federal external review process as set forth in Section 2719 of the PHSA. External review is not available for a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that an Employee, Retiree or Dependent fails to meet the requirements for eligibility under the terms of the Component Benefit.

For purposes of determining the amount of or the entitlement to benefits under a Component Benefit provided through a self-funded arrangement, the applicable designated claims fiduciary (as provided in the applicable Incorporated Document) is the named fiduciary under the Component Benefit, with the full power to interpret and apply the terms of the Component Benefit as they relate to the benefits provided under the applicable self-funded arrangement. In addition, such procedures shall be described in the applicable Incorporated Documents in accordance with Section 2719 of the PHSA (applicable to non-grandfathered plans only); NAC 287.610-287.695; NAC 287.750; NRS 287.043; NRS 287.04335; NRS 689B.255; NRS 695G.200; NRS 695G.210; NRS 695G.220; NRS 695G.230; NRS 695G.241-695G.300; and NRS 695G.310.

The Incorporated Documents shall specify the claims fiduciary for each Component Benefit.

Upon a final decision to deny a claim for benefits under a self-funded Component Benefit that is a non-grandfathered group health plan, the claimant may request an external review that follows the federal external review requirements set forth in Section 2719(b) of the PHSA, the terms of which are described in the applicable Incorporated Document. External review is not available for a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that an Employee, Retiree or Dependent fails to meet the requirements for eligibility under the terms of the Component Benefit.

Unless otherwise specified in a Component Benefit or prohibited by federal law, any claimant seeking benefits under a Component Benefit must initiate legal action against the Plan no later than 1 (one) year from the deadline for filing a claim unless a different time frame is set forth in the applicable Incorporated Document.

7.2 Prohibition Against Rescission

Under Section 2712 of the PHSA, the Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a Covered Person under a Benefit Option that is a group health plan that is not excepted or exempt under Section 2712 of the PHSA, unless such Covered

Person commits an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; provided, however, that the foregoing prohibition shall not prohibit retroactive termination in the event: (i) a Participant fails to timely pay premiums towards the cost of coverage; (ii) the Plan erroneously covers an ex-spouse of a Participant because the Participant failed to timely report a divorce to the Plan Administrator; (iii) the Plan erroneously covers a Participant due to a reasonable administrative delay in terminating coverage; or (iv) any other circumstance under which retroactive termination would not violate the PPACA.

The Plan Administrator shall provide a Covered Person with thirty (30) days' prior written notice of intent to rescind coverage. The Covered Person may appeal the rescission of coverage as a denial of a post-service claim under this Article 7. In the event the Plan Administrator rescinds a Covered Person's coverage on account of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent, such rescission shall not cause the individual to incur a "qualifying event" as provided under COBRA.

Article 8 Administration of Plan

8.1 Plan Administrator

The Plan Administrator shall have the discretionary authority to interpret the Plan, including each Component Benefit, and to decide any and all matters arising hereunder. The Plan Administrator's discretionary authority shall include, but shall not be limited to, the following authority:

To make and enforce such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Plan;

To construe and interpret the Plan, to decide questions concerning the Plan, including without limitation the discretionary authority to resolve questions of fact and to remedy possible ambiguities, inconsistencies, and/or omissions, in the Plan and related documents by general rule or particular decision, and to determine the eligibility of any person to participate in the Plan and the entitlement of any person to any benefits thereunder;

To establish and maintain the Component Benefits and to maintain records of pre-tax Salary Reduction Contributions;

To prescribe procedures to be followed and the format to be used by Eligible Employees and Participants to make elections pursuant to this Plan, including any Component Benefit;

To prepare and distribute information explaining this Plan and the benefits under this Plan or any Component Benefit in such manner as the Plan Administrator determines to be appropriate;

To make available to each Participant or Covered Person his or her records and related Plan Materials as may be required by applicable law;

To request and receive from Employees and Covered Persons such information as the Plan Administrator shall from time to time to determine to be necessary for the proper administration of the Plan;

To appoint, remove, or substitute agents, counsel, accountants, consultants, actuaries, or other persons to assist in administering the Plan or any Component Benefit;

To designate specified other persons to carry out any of its responsibilities under the Plan or any Component Benefit to the extent necessary;

To sign documents for purposes of administering the Plan, or to designate an individual or individuals to sign documents for purposes of administering this Plan;

To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

To prepare, file, and disseminate reports and disclosures required by applicable law.

The Plan Administrator's determination on any and all questions arising out of the interpretation or administration of the Plan shall be final, conclusive, and binding on all parties.

8.2 Records and Reports of the Plan Administrator

The Plan Administrator shall keep such written records as it shall deem necessary or proper, which records shall be open to inspection by the Employer.

8.3 Reliance on Participants and Tables

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, accountants, counsel or other experts employed or engaged by the Plan Administrator. Actions taken in a good faith reliance on advice from such advisors are conclusive and binding upon all persons.

8.4 Delegations of Authority by the Plan Administrator

The Plan Administrator may, in its discretion, delegate to any other person or persons the authority to act on behalf of the Plan Administrator, including but not limited to the authority to make any determination or to sign checks, warrants, or other instruments incidental to the operation of the Plan or any Component Benefit (or portion thereof) that the Plan Administrator administers, or to the making of any payment specified therein.

8.5 Employment of Assistants

The Plan Administrator is authorized to employ counsel and to employ persons to provide such actuarial, clerical, or other services as they may require in carrying out their duties under the Plan or any Component Benefit.

8.6 Availability of Documents

A copy of the Plan and any and all future amendments and such records and data as may be required under applicable law shall be available to any Covered Person, Employee, Retiree, or an Employee organization that represents Employees of the Employer at reasonable times during normal business hours at the business office of the Plan Administrator or by contacting the Plan Administrator.

8.7 Legal Process

The Plan Administrator shall be the agent for service of legal process unless it designates another person to be such agent. See Section 10.2 for such designation.

8.8 Administrative Expenses

All expenses incurred prior to termination of the Plan that shall arise in connection with the administration of the Plan, including but not limited to administrative expenses, and compensation and other expenses and charges of any actuary, accountant, counsel, specialist or other person who shall be employed by the Plan Administrator in connection with the administration, shall be paid by Employees, Retirees, and the fund.

8.9 Several Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act, except for its own willful misconduct or willful breach of this Plan.

8.10 Nondiscrimination

The Plan Administrator shall not operate the Plan in a manner that causes discrimination in favor of those Participants who were officers or highly compensated Employees or key Employees of the Employer. In addition, whenever in the administration of the Plan any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that persons similarly situated shall receive substantially the same treatment.

8.11 Electronic Administration

The Plan Administrator may distribute and collect information or conduct transactions by means of electronic media, including, but not limited to, electronic mail systems, Internet, or voice response system, except when a specific provision of the Code, or other guidance of general applicability sets forth rules or standards regarding the media through which such dissemination of information or transaction may be conducted.

8.12 Coordination with Component Benefits

Article 8 of this Plan applies with respect to each Component Benefit which appears in Schedule 1, unless the Component Benefit specifically addresses these issues in a manner that is consistent with applicable state and federal law. However, any references to the Plan Administrator shall be construed in accordance with the definition and description of duties contained in this Article 8.

8.13 Indemnification

A participating Employer shall only be liable for indemnification of the Board and its employees against liability relating to the administration of the Plan to the extent set forth in this section 8.13 and to the extent consistent with, and subject to the limitations specified in, NRS 41.0349 and any other provision of applicable state law.

A participating Employer shall indemnify and hold harmless the Plan Administrator or its designee who act as Plan fiduciary(ies) or act in an administrative capacity relating to the Plan and the Board and its employees relating to the administration of the PEBP from and against any and all

liabilities, demands, claims, suits, proceedings, actions or causes of action, losses, approved settlements, penalties, costs, damages, and expenses (including reasonable attorneys' fees) (together, the "liabilities") sustained or incurred by act or omission of said Plan Administrator or its designee(s), or of the Board; provided, however, that this indemnification shall not apply to the extent such liabilities arise from such Plan Administrator's (or its designee's) or such Board's (or its employees') willful negligence, gross negligence, willful misconduct or criminal action.

Notwithstanding the foregoing, the provisions of this section 8.13 shall not apply to any person or entity seeking indemnification if:

The person or entity failed to submit a timely request for defense;

The person or entity failed to cooperate in good faith in the defense of the action;

The act or omission of the person or entity was not within the scope of the person's or entity's public duty or employment; or

The act or omission of the person or entity was wanton or malicious.

Article 9 Plan Adoption, Amendment, and Termination

8.1 Amendment and Termination

The Plan was established with the bona fide intention and expectation that it will be continued indefinitely. However, PEBP reserves the right to amend or terminate the Plan or any Component Benefit at any time and from time to time. Amendments may occur on the approval of the PEBP Board, or on such other date as may be specified in the document amending the Plan. The Plan or any coverage under it may be terminated by the PEBP Board, and new coverages may be added by the PEBP Board.

Such amendments or modifications may be made retroactively where necessary, including, for example, to ensure compliance with the Code's nondiscrimination rules.

The termination of a Component Benefit (including terminating an Insurance Contract through which such benefits are provided) is not a termination of the Plan; rather, it is an amendment to the Plan.

9.2 Termination of Insurance Contract

In the case of any Component Benefit paid by an Insurer pursuant to an Insurance Contract, the Plan Administrator may terminate such contract at any time by providing the Insurer with such notice as may be required under the terms of such contract. The Plan Administrator may enter into contracts with other Insurers or through other funding arrangements as the Plan Administrator may establish for the purpose of providing the Component Benefit.

9.3 Amendment of Schedule 1

The Plan Administrator may amend Schedule 1 to add or remove a Component Benefit. Such change will be subject to the laws of the State of Nevada, to the extent required. Any such modification shall not necessitate a formal amendment to this Plan document.

9.4 Effect of Amendment or Termination

No amendment to or termination of the Plan or any Component Benefit shall cause or permit the assets of the Plan to be used for any purpose other than to defray administrative expenses with respect to Component Benefits and to pay benefits provided for under such Component Benefit.

All changes to this Plan shall become effective as of a date established by the Plan Administrator, as appropriate, except that no increase or reduction in benefits shall be effective with respect to covered expenses incurred prior to the date a change was adopted by such person(s), regardless of the effective date of the change. Upon termination or discontinuance, contributions, and benefits (including benefit elections) relating to the Plan shall terminate.

Upon termination of any Component Benefit, any assets of the Plan funding such Component Benefit shall be used to pay benefits that Participants have become entitled to receive under the terms of such Component Benefit (or, if applicable, to pay premiums due to an Insurer with

respect to such Component Benefit) as of the date of termination, and to pay the administrative expenses incurred by the Plan before, and in connection with, the termination, in accordance with the written direction of the Plan Administrator. The remaining assets shall be used to pay benefits that Participants have become entitled to receive under other Component Benefits (or, if applicable, to pay premiums due to an Insurer with respect to such other Component Benefits) and to pay the related administrative expenses of such other Component Benefits in accordance with the written direction of the Plan Administrator. In no event shall the assets of the Plan inure to the benefit of the Employer.

Upon termination of the Plan, the assets of the Plan shall be used to pay benefits that Participants have become entitled to receive under the terms of a Component Benefit, and to pay the administrative expenses incurred by the Plan relating to such Component Benefit before and in connection with the termination, both in accordance with the written direction of the Plan Administrator. The Plan's remaining assets shall be disposed of in accordance with the written direction of the Plan Administrator. In no event shall the assets of the Plan inure to the benefit of the Employer.

Article 10 Miscellaneous

10.1 Governing Law

(a) This Plan and Component Benefits shall be construed, administered, and enforced according to laws of the State of Nevada and federal law, including the PHSA, governing employee benefit plans. Any provision of this Plan in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

(b) In the case of Component Benefits provided by an Insurer under an Insurance Contract, the Insurance Contract shall be governed by the Code and applicable Nevada state law, as applicable to such Insurance Contract.

(c) Such federal laws to the extent applicable to a Component Benefit, in addition to the requirements in Section 4.2 of this Plan, shall include but shall not be limited to:

- (1) Continuation of Coverage under COBRA. For each benefit made available under this Plan that is considered to be a “group health plan” under Section 2208(1) of the PHSA due to Employees and their spouses and Dependents being provided with health care benefits within the meaning of Section 213(d)(1) of the Code, the Plan shall provide health care continuation coverage to qualified beneficiaries in the manner and to the extent required by Sections 2201–2208 of the PHSA and related regulations, including applicable amendments to such Sections.
- (2) USERRA. For each Component Benefit that is subject to continuation coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994, the Plan shall comply.
- (3) HIPAA. The Plan shall administer the provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) dealing with special enrollment rights in the manner and to the extent required by the applicable requirements of Section 9801 et seq. of the Code, as well as the provisions of the HIPAA Privacy Rule and the HIPAA Security Rule.
- (4) GINA. The Plan shall comply with the provisions of GINA and accordingly, shall not, unless expressly permitted by GINA or corresponding regulations, restrict enrollment, or adjust premiums based on genetic information, or require or request genetic information or genetic testing, prior to, or in connection with, enrollment.
- (5) PPACA. The Plan shall comply with the relevant provisions of the PPACA.

(d) NAC and NRS Regarding the PEBP Plan. The information provided below is a summary of the applicable NRS and NAC. For detailed information, refer to the Nevada Legislature website at <https://www.leg.state.nv.us/law1.cfm>.

(1) Nevada Revised Statute

- NRS 287: Programs for Public Employees

- NRS 439B: Restraining Costs of Health Care
- NRS 687B: Contracts of Insurance
- NRS 689B: Group and Blanket Health Insurance
- NRS 695G: Managed Care

(2) Nevada Administrative Code

- NAC 287: Programs for Public Employees

(3) 82nd Legislative Session (2023)

Pending

10.2 Agent for Service of Process

For disputes arising under the Plan, service of legal process may be made on the Plan Administrator, and must comply with NRS 41.031, in care of:

Public Employees' Benefits Program (PEBP)
3427 Goni Road, Suite 109
Carson City, NV 89706
Phone: (775) 684-7000, (702) 486-3100, or (800) 326-5496
Fax: (775) 684-7028

10.3 No Vested Rights

To the maximum extent permitted by law, no person shall acquire any right, title, or interest in or to any portion of an Insurance Contract otherwise than by the actual payment or distribution of such portion under the provisions of the Plan or a Component Benefit, or acquire any right, title, or interest in or to any benefit referred to or provided for in the Plan or any Component Benefit otherwise than by actual payment of such benefit. Further, no person has any right, title, or interest in or to the assets of the Employer because of the Plan.

10.4 Information to be Furnished

Any person eligible to receive benefits hereunder shall furnish to the Plan Administrator, its delegate, or to an Insurer, as applicable, any information or proof requested by the Plan Administrator, its delegate, or any such Insurer and reasonably required for the proper administration of the Plan or a Component Benefit. Failure on the part of any person to comply with any such request within a reasonable period of time shall be sufficient ground for delay in the payment of any benefits that may be due under the Plan or a Component Benefit until such information or proof is received by the Plan Administrator, its delegate, or Insurer, as the case may be. If any person claiming benefits under the Plan or a Component Benefit makes a false statement that is material to such person's claim for benefits, the Plan Administrator or Insurer, as the case may be, may offset against future payment any amount paid to such person to which such person was not entitled under the provisions of the Plan or a Component Benefit. Further, the Plan Administrator has the authority to take such additional action, as may be deemed necessary, to make the Plan whole, in accordance with the law.

10.5 Non-Alienation

To the extent permitted or required by law, the rights or interests of any Participant or his beneficiary to any benefits hereunder shall not be subject to attachment or garnishment or other legal process by any creditor of any such Participant or beneficiary, nor shall any such Participant or beneficiary have any right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits which he may expect to receive, contingently or otherwise, under this Plan, and any attempt to anticipate, alienate, commute, pledge, encumber, or assign any right to benefits hereunder shall be void. Notwithstanding the foregoing, the Plan Administrator may pay Plan benefits directly to the provider of services. Such payment shall fully discharge the Plan Administrator from further liability under the Plan.

10.6 Non-Guarantee

Neither the Employer nor any fiduciary shall be held or deemed in any manner to guarantee the Plan or a Component Benefit against loss or depreciation.

10.7 No Guarantee of Tax Consequences

Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid or allocated to or for the benefit of a Participant under the Plan or any Component Benefit will be excludable from Participant's gross income for federal, state, and/or local income tax purposes, or that any other federal, state, and/or local tax treatment will apply or be available to any Participant. It shall be the obligation of each Participant to determine whether any coverage, benefit, or other payment under the Plan is excludable from the Participant's gross income for federal, state, and/or local income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment treated by the Employer as nontaxable is, in fact, not so excludable.

If the Plan Administrator determines that any benefits which the Employer had treated as nontaxable to any Participant for federal, state, and/or local income tax purposes are, in fact, taxable to the Participant due to any reason, including but not limited to erroneous information provided by the Participant or otherwise used by the Employer, such Participant shall pay such taxes (including any related penalties and interest) directly or reimburse the Employer for any such taxes (including any related penalties and interest) paid by the Employer.

10.8 Incapacity

If the Plan Administrator determines that a Covered Person entitled to benefits hereunder is unable to care for his affairs because of illness or accident, any benefit payment due to such Covered Person shall be paid to his duly appointed guardian or legal representative; provided that, if there shall be no such duly appointed guardian or legal representative, any benefit payment due to such Covered Person may be paid for the benefit of such Covered Person to his spouse, parent, brother, sister, or other third party deemed by the Plan Administrator to have incurred expenses for such Covered Person unless specified otherwise by the Incorporated Documents. Benefit payments made to a third party pursuant to this section shall completely

discharge the Plan, the Plan Administrator, and the Employer of any liability to such Participant or other person arising under the Plan.

10.9 Death

Unless otherwise provided under the terms of an applicable Summary of Coverage, Summary of Insurance, or Insurance Contract, claims on behalf of a Participant after the Participant's death may be made by, and, unless denied, shall be paid to, the Participant's estate. Payments made pursuant to this Section 10.10 shall completely discharge the Plan, the Employer, the Plan Administrator, and, if applicable, the Insurer of any liability to the Participant or other person arising under the Plan.

10.10 Clerical Error/Delay

Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

10.11 Responsibility for Health Care

The provisions of any health benefit program under the Plan shall not be construed to limit a Participant with regard to the choice of medical treatment or services, such choices including, but not limited to, the kind, type, duration, amount, or results thereof. Obtaining medical or other health care treatment or services and determining which services to utilize shall be at the sole discretion of the Participant/Covered Person and shall not be construed, interpreted, or deemed as resulting from the Plan.

Each Participant/Covered Person shall be solely responsible for deciding the health care that the individual receives and shall make such a decision as to his or her health care independent of any determinations to whether reimbursement will or will not be made under the Plan for a health care service or supply. The determination of whether or not a service or supply is medically necessary is made solely for purposes of determining whether benefits will be paid under the Plan and is not intended to be advice to an individual concerning that individual's health care treatment. Each Participant/Covered Person shall be solely responsible for selecting the health care professionals, hospitals, and other institutions that will provide health care services and supplies to that individual.

10.12 Covered Person's Responsibilities

Each Covered Person shall be responsible for providing the Plan Administrator and/or the Employer with the Covered Person's current U.S. mailing address and/or electronic address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address furnished by the Covered Person and mailed either by regular United States mail or by electronic means as specified in the applicable Treasury Regulations and other guidance. The Plan

Administrator and the Employer shall not have any obligation or duty to locate a Covered Person. If a Covered Person becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

Because of conflicting claims to such payments; or

For any other reason, the amount of such payment, if and when made, shall be determined under the provisions of this Plan without payment of any interest or earnings.

10.13 No Examination or Accounting

Neither the Plan nor any action taken thereunder shall be construed as giving any person the right to an accounting or to examine the books or affairs of the Employer.

10.14 Severability

If any provision of the Plan (including a Component Benefit) is held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of the Plan, and the Plan shall be construed and enforced as if the illegal or invalid provision had not been included in the Plan. The Plan Administrator shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

10.15 Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator shall have the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

10.16 Legal Actions

In any action or proceeding involving the Plan assets or any property constituting part or all thereof, or the administration thereof, no Employee, former Employee, Dependent, Covered Person, or any other person having or claiming to have an interest in this Plan shall be necessary parties and no such person shall be entitled to any notice or process, except to the extent required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive on the parties hereto and upon persons having or claiming to have any interest in this Plan.

10.17 Misrepresentation or Fraud

A person who receives a benefit under the Plan as a result of false information or a misleading or fraudulent representation shall repay amounts paid by the Plan and shall be liable for costs of collection, including attorneys' fees. Notwithstanding the foregoing, the Plan shall comply with respect to the rules pertaining to rescissions as discussed in Section 4.2(e)(5) and Section 7.2 of the Plan.

10.18 Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan's control, the time for performance of the act will be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused. In such event, however, parties shall use reasonable efforts to perform their respective obligations under the Plan.

Article 11 HIPAA Privacy and Security of Protected Health Information

The Component Benefits of the Plan that are a “group health plan” shall comply with the provisions of HIPAA, in accordance with this Article. The Component Benefits of the Plan that are not subject to HIPAA shall not be subject to this Article.

11.1 Introduction

This Article describes the requirements under a federal law known as HIPAA that apply to health benefits for certain Retirees, and their eligible Dependents, participating in the PEBP. The confidentiality of Participant Health Information is important to the PEBP. The PEBP is committed to ensuring that the privacy of Participants is protected and legal requirements under HIPAA are satisfied. Accordingly, the PEBP will not use or disclose Protected Health Information other than as permitted or required by HIPAA, the HIPAA regulations, and this Article.

The PEBP provides medical, dental, vision, and prescription drug benefits, which are considered “Health Care Components” under HIPAA. The PEBP also provides other benefits that are not subject to HIPAA and some non-covered benefits. Under HIPAA, the PEBP is considered a “Hybrid Entity.” The HIPAA Privacy and Security provisions of this Article apply only to:

The Health Care Components of the PEBP and to the Health Plan, Health Care Provider, or Health Care Clearinghouse functions performed by the Health Care Component;

Protected Health Information that is created or received by or on behalf of the Health Care Component of the Plan; and

Electronic Protected Health Information created, received, maintained, or transmitted by or on behalf of the Health Care Component of the Plan.

11.2 Definitions

The following are definitions of specific terms and words used in this Article 11. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

“**Breach**” means the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted by HIPAA which compromises the security or privacy of the Protected Health Information, unless the acquisition, access, use, or disclosure is otherwise excluded in the definition of “Breach” under 45 CFR Section 164.402.

“**Business Associate**” has the meaning set forth in 45 CFR Section 160.103, including any third-party administrator or actuarial, legal, accounting, consulting, or similar firm that performs services involving the disclosure of Protected Health Information.

“**Electronic Protected Health Information**” means Protected Health Information that is transmitted by or maintained in electronic media.

“Covered Entity” means

A Health Plan

A Health Care Clearinghouse; or

A Health Care Provider that transmits any Health Information in electronic form in connection with a transaction covered by HIPAA, as defined more fully in 45 CFR Section 160.103.

The Plan is a Covered Entity.

“Genetic Information” has the meaning set forth in 45 CFR Section 160.103.

“Health Care” means care, services, or supplies related to the health of an Individual within the meaning of 45 CFR Section 160.103. Health care includes, but is not limited to, the following:

Preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to physical or mental condition or functional status of an Individual or that affects the structure or function of the body; and

Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

“Health Care Clearinghouse” has the meaning set forth in 45 CFR Section 160.103 and includes a public or private entity, including a billing service, repricing company, community health management information system or community Health Information system, and “value-added” networks and switches, which performs either of the following functions:

- Processes or facilitates the processing of Health Information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
- Receives a standard transaction from another entity and processes or facilitates the processing of Health Information into a nonstandard format or nonstandard data content for the receiving party.

“Health Care Component” means a Component or combination of Components of a Hybrid Entity that are designated by the Hybrid Entity in accordance with 45 CFR Section 164.105(a)(2)(iii)(D) and from whom the PEBP receives Protected Health Information subject to HIPAA. The medical, dental, vision, and prescription drug benefits offered under the Plan are Health Care Components.

“Health Care Operations” means any of the following activities of the Plan, to the extent such activities relate to the covered functions of the Plan, including, but not limited to:

Conducting quality assessment and improvement activities including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;

Patient safety activities;

Population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, disease management, contacting Health Care Providers and patients with information about Treatment alternatives and related functions that do not include Treatment;

Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner and Provider performance, rating Health Care Provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

Underwriting (subject to the prohibition in this Article 11), premium rating and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, securing or placing a contract for reinsurance of risk relating to Health Care claims, including stop-loss insurance and excess of loss insurance;

Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

Business planning and development, such as conducting cost-management and planning-related analysis associated with managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

Business management and general administrative activities of the Plan, including, but not limited to:

Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

Customer service, including the provision of data analysis for policyholders, Plan Sponsors, or other customers;

Resolution of internal grievances;

The sale, transfer, merger or consolidation of all or part of the Plan with another Covered Entity, or an entity that following such activity will become a Covered Entity, and due diligence related to such activity;

Consistent with the applicable requirements of 45 CFR Section 164.514, creating de-identified Health Information or a limited data set, and fundraising for the benefit of the Covered Entity; and

Any other activity that falls within the definition of the term "Health Care Operations" as set forth in 45 CFR Section 164.501.

“Health Care Provider” has the meaning set forth in 45 CFR Section 160.103 and includes a provider of medical or health services, as well as any other person or organization that furnishes, bills, or is paid for Health Care in the normal course of business.

“Health Care Treatment” means the provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party, consultation between Health Care Providers relating to a patient, or the referral of a patient for Health Care from one Health Care Provider to another, and such other activities that may be included in the definition of “Treatment” as set forth in 45 CFR Section 164.501.

“Health Information” has the meaning set forth in 45 CFR Section 160.103 and includes information (including Genetic Information), whether oral or recorded in any form or medium, including, but not limited to, verbal conversations, telephonic communications, electronic mail or messaging over computer networks, the Internet and intranets, as well as written documentation, photocopies, facsimiles and electronic data, that is created or received by a Health Care Provider, a Health Plan, the PEBP, a life insurer, school or university, or a Health Care Clearinghouse that relates to

The past, present, or future physical or mental health or condition of an Individual;

The provision of Health Care to an Individual; or

The past, present, or future payment for the provision of Health Care to an Individual.

“Health Insurance Issuer” has the meaning set forth in 45 CFR Section 160.103 and includes an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. The term does not include a Group Health Plan (within the meaning of 45 CFR Section 160.103).

“Health Plan” means an Individual or Group Health Plan that provides or pays the cost of medical care, and includes a Group Health Plan, a Health Insurance Issuer, an HMO and such other plans or arrangements as are set forth in the definition of a “Health Plan” in 45 CFR Section 160.103, including the Plan.

“HHS” means the U.S. Department of Health and Human Services.

“HHS-Approved Technology” means:

With respect to data in motion, the encryption guidelines in Federal Information Processing Standard 140-2 (or successor guidelines).

For data at rest, HHS-Approved Technology means the encryption guidelines in National Institute of Standards and Technology (NIST) Special Publication 800-111 (or successor guidelines).

With respect to the destruction of data containing Protected Health Information, an HHS-Approved Technology requires the destruction of the media on which the Protected Health Information is stored such that, for paper, film, or other hard copy media, destruction requires shredding or otherwise destroying the media so that Protected Health Information cannot be read or reconstructed; for electronic media, destruction requires that the data be cleared, purged, or destroyed consistent with NIST Special Publication 800-88 (or successor guidelines) such that the information cannot be retrieved. HHS-Approved Technology may be updated from time to time based on guidance from the Secretary of HHS.

“HITECH” means the Health Information Technology for Economic and Clinical Health Act.

“Hybrid Entity” means a single legal entity that is a Covered Entity whose business activities include both covered functions and non-covered functions and that designates Health Care Components (in accordance with 45 CFR Section 164.105(a)(2)(iii)(D)) for purposes of fulfilling the Hybrid Entity requirements of HIPAA, as defined in 45 CFR Section 164.103. For purposes of this definition, “covered functions” means those functions performed by a Covered Entity that make the entity a Health Plan, Health Care Provider, or Health Care Clearinghouse. The Plan is a Hybrid Entity.

“Individual” has the meaning set forth in 45 CFR Section 164.103 as the person who is the subject of Protected Health Information.

“Individually Identifiable Health Information” has the meaning set forth in 45 CFR Section 160.103, and includes Health Information, including demographic information, collected from an Individual and created or received by a Health Care Provider, Health Plan, employer, or Health Care Clearinghouse that identifies the Individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual involved.

“Organized Health Care Arrangement” has the meaning set forth in 45 CFR Section 160.103 and includes:

A Group Health Plan (within the meaning of 45 CFR Section 160.103) and a Health Insurance Issuer or HMO with respect to such Group Health Plan, but only with respect to Protected Health Information created or received by such Health Insurance Issuer or HMO that relates to Individuals who are or who have been participants or beneficiaries in such Group Health Plan;

A Group Health Plan and one or more other Group Health Plans each of which are maintained by the same PEBP; or

The Group Health Plans described in the second bullet of this definition and Health Insurance Issuers or HMOs with respect to such Group Health Plans, but only with respect to Protected Health Information created or received by such Health Insurance Issuers or HMOs that relates to Individuals who are or have been participants or beneficiaries in any of such Group Health Plans.

“PEBP Workforce” means the Executive Director, the agency staff, and the attorneys (for claim purposes).

“Plan Administration Functions” means administrative functions performed by the PEBP on behalf of the Plan, excluding functions performed by the PEBP in connection with any other benefit or benefit Plan of the PEBP.

“Plan Sponsor” means the State of Nevada. The HIPAA regulations incorporate the ERISA definition of “Plan Sponsor,” which generally means the employer that establishes or maintains the employee benefit Plan.

“Privacy Notice” means the notice of privacy practices that sets forth the uses and disclosures of Protected Health Information by the Plan that are required or permissible under HIPAA, as more fully described in 45 CFR Section 164.520.

“Privacy Official” means the person appointed by the PEBP, or its delegate, on behalf of the Plan, who is responsible for developing and implementing policies and procedures for protecting the privacy and confidentiality of Protected Health Information that is held by or on behalf of the Plan, in accordance with 45 CFR Section 164.530.

“Privacy Rule” means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

“Protected Health Information” means Individually Identifiable Health Information that is transmitted by electronic media, maintained in electronic media, transmitted, or maintained in any other form or medium, including oral or written information. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended (within the meaning of 20 USC Section 1232g), employment records held by the Covered Entity in its role as an Employer, other records described in 20 USC Section 1232g(a)(4)(B)(iv), and information regarding a person who has been deceased for more than 50 years.

“Required by Law” means

A mandate contained in law that compels a Covered Entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law including, but not limited to, a court order, a court-ordered warrant, subpoena, or summons issued by a court, grand jury, a governmental inspector general, or an administrative body authorized to require the production of information;

A civil or an authorized investigative demand;

Medicare conditions of participation with respect to Health Care Providers participating in the program; and

Statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

“Secured Protected Health Information” means Protected Health Information to the extent that the information is protected by using an HHS-Approved Technology identified by HHS for rendering Protected Health Information unusable, unreadable, or indecipherable to unauthorized Individuals.

“Security Official” means the person appointed by the PEBP on behalf of the Plan who is responsible for the development, implementation, and maintenance of the HIPAA data security policies and procedures required for the Plan in accordance with 45 CFR Section 164.308(a)(2).

“Security Standards” means the Standards for the Security of Electronic Protected Health Information, as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C.

“Subcontractor” means a person to whom a Business Associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of the Business Associate.

“Summary Health Information” has the meaning set forth in 45 CFR Section 164.504 and includes information that summarizes the claims history, claims expenses, or types of claims experienced by Individuals for whom the PEBP has provided benefits under the Plan, and from which the following information has been removed:

Names;

Geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code (if permitted under 45 CFR Section 164.514(b)(2)(i)(B));

All elements of dates (except year) relating to the Individual(s) involved (e.g., birth date) or their medical Treatment (e.g., admission, discharge date, or date of death), ages over 89, and elements of dates (including years) indicative of age, except that such ages and elements may be aggregated into a single category of age 90 or older);

Other identifying numbers, such as Social Security, telephone, fax, account, or medical record numbers, e-mail, or Internet addresses, URLs, or Internal Protocol (IP) address numbers, vehicle identifiers and serial numbers;

Facial photographs or biometric identifiers (e.g., fingerprints or voice prints);

Any other unique identifying number, characteristic, or code; and

Any information of which the PEBP has knowledge that could be used alone or in combination with other information to identify an Individual.

“Unsecured Protected Health Information” means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized Individuals using an HHS-Approved Technology.

11.3 Provision of Protected Health Information to the PEBP Workforce

Certain individuals who work for the PEBP have access to the Individually Identifiable Health Information of PEBP Participants for administration functions. These individuals are known as the PEBP Workforce and are identified in Schedule 2. When this Health Information is provided to the PEBP Workforce, it is Protected Health Information and, if it is transmitted by or maintained in electronic media, it is Electronic Protected Health Information. This Section 11.3 describes the circumstances under which Protected Health Information may be received, used, disclosed by the PEBP Workforce.

Permitted Disclosure of Enrollment/Disenrollment Information. A Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose to the PEBP Workforce, information on whether an Individual is participating in the PEBP or is enrolled in or has disenrolled from a Health Insurance Issuer or HMO offered by the PEBP.

Permitted Uses and Disclosure of Summary Health Information. A Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose Summary Health Information to the PEBP Workforce, provided that the PEBP Workforce requests the Summary Health Information for the purpose of:

Obtaining premium bids for providing Health Insurance coverage under the PEBP; or

Modifying, amending, or terminating the PEBP.

Summary Health Information means information that summarizes the claims history, claims expenses, or type of claims experienced by Individuals who have received health benefits under the PEBP; and from which the names and other personal identifiers described at 45 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, a Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose Protected Health Information and Electronic Protected Health Information to the PEBP Workforce, provided that the PEBP Workforce uses or discloses the Protected Health Information and Electronic Protected Health Information only for Plan administration purposes.

Plan administration purposes means administration functions performed by the PEBP Workforce, a Health Care Component of the PEBP, or a Health Insurance Issuer or HMO with respect to the PEBP. Plan Administration Functions include quality assurance, claims processing, auditing, and

monitoring. Enrollment and disenrollment of the participants and their covered dependents (beneficiaries) is performed by the PEBP Workforce. The PEBP Workforce also performs quality assurance, auditing and monitoring in its role as the Plan Administrator. The Plan contracts with certain Health Care Components such as third-party claims administrators and HMOs to perform claims administration, auditing, and monitoring. Plan Administration Functions do not include functions performed by the employer in connection with any other benefit or benefit plan (e.g., retirement) or any employment-related actions or decisions. Employment information held by the employer is held in its capacity as an employer and is not Protected Health Information. Enrollment and disenrollment functions performed by the PEBP Workforce are performed on behalf of participant and beneficiaries and are not Plan Administration Functions. Employment and enrollment and disenrollment information generally is not Protected Health Information.

The PEBP Workforce or any of its Health Care Components shall not use or disclose Protected Health Information or Electronic Protected Health Information in a manner that is inconsistent with 45 CFR Section 164.504(f).

With respect to any Protected Health Information, the PEBP Workforce or any of its Health Care Components shall:

Not use or further disclose the Protected Health Information of a Plan Participant or their covered Dependent(s) other than as permitted or required by the PEBP or as Required by Law;

Ensure that any agent, including a Subcontractor, to whom it provides Protected Health Information received from the PEBP Workforce agrees to the same restrictions and conditions that apply to the PEBP Workforce or any of its Health Care Components with respect to Protected Health Information;

Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the employer;

Report any use or disclosure of Protected Health Information in compliance with 45 CFR Section 164.400-414 of which it becomes aware that is inconsistent with the uses or disclosures;

Make available Protected Health Information to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;

Make available Protected Health Information for amendment, and incorporate any amendments to Protected Health Information, in accordance with 45 CFR Section 164.526;

Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.

If feasible, return or destroy Protected Health Information that it still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Other Uses and Disclosures of Protected Health Information. The PEBP may disclose Protected Health Information to such other persons or entities and under such circumstances as permitted under HIPAA, HITECH, and the rules, regulations, and other guidance issued by the U.S. Department of Health and Human Services under HIPAA and HITECH.

Nondisclosure of Genetic Information for Underwriting Purposes. The PEBP shall not use or disclose Protected Health Information that is Genetic Information (within the meaning of 45 CFR Section 160.103) for underwriting purposes as defined in 45 CFR Section 164.502(a)(5)(i).

Adequate Separation. The Plan shall allow the HIPAA Privacy Official, HIPAA Security Official, the PEBP Board, the Executive Officer of the PEBP, or any person under the supervision of the Executive Officer of the PEBP who receives Protected Health Information relating to payment, Health Care Treatment, or Health Care Operations of, or other matters pertaining to, the PEBP in the ordinary course of business.

No other persons shall have access to Protected Health Information. These specified employees (or classes of employees) shall only have access to and use of Protected Health Information to the extent necessary to perform the Plan Administration Functions of the Plan. Please refer to Schedule 2 that describes adequate separation of PHI. If a specified employee does not comply with the provisions of this Article 11, the employee shall be subject to disciplinary action by the PEBP for non-compliance pursuant to the PEBP's employee discipline and termination procedures.

The PEBP shall ensure that the provisions of this Article 11 are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic Protected Health Information on behalf of the PEBP.

Organized Health Care Arrangement. The Plan (including the Component Benefits), and the other fully insured and self-insured medical options offered or maintained by the PEBP, shall be deemed part of an Organized Health Care Arrangement, to the fullest extent permitted under the Privacy Rule.

Interpretation. The Plan and this Section shall be interpreted and administered in accordance with the Privacy Rule, any applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Privacy Rule, statute, regulation, or guidance, such Privacy Rule, statute, regulation, or guidance shall govern.

11.4 HIPAA Security Rule

PEBP Security Practices. By law, PEBP is required to:

Put in place administrative, physical, and technical safety measures to reasonably and appropriately protect the confidentiality, integrity, and availability of Participant personal medical information that is stored electronically, consistent with the requirements of the Security Standards;

Make sure there are reasonable and appropriate security measures in place to protect and separate Participant personal medical information that is stored electronically from other agencies, Employees, or Employers who do not need access to it, consistent with the requirements of the Security Standards;

Make sure that any agents, including a subcontractor, or vendors who help PEBP with its operations also have in place reasonable and appropriate security measures to protect PEBP personal medical information; and

Report to the PEBP Security Officer any security problems or incidences resulting from unauthorized access, use or interference of systems operations in a system containing PEBP personal medical information, known by PEBP or any agent or vendor.

Interpretation. The Plan and this Section shall be interpreted and administered in accordance with the Security Standards, any applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Security Standards, statute, regulation, or guidance, such Security Standards, statute, regulation, or guidance shall govern. The Plan shall adopt written policies and procedures to implement the provisions of this Section.

11.5 HIPAA Breach Notification Standards

PEBP shall comply with the breach of unsecured protected health information notification provisions as set forth in HITECH and addressed under Notification in the Case of Breach of Unsecured Protected Health Information at 45 CFR Part 164, Subpart D.

11.6 Certification

The Plan Sponsor certifies that this Article incorporates the provisions set forth in 45 CFR Section 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii).

11.7 Amendment of Schedule 2

The Plan Administrator may amend Schedule 2 to add or remove a PEBP position, access, or access level, or to update the Privacy Official, Security Official, and HIPAA contact office information. Any such modification shall not necessitate a formal amendment to this Plan document.

Schedule 1. Component Benefits

The Plan shall provide for the following Component Benefits, as provided for, and described in the applicable Incorporated Documents:

- Medical and Prescription Drugs
 - PEBP Exclusive Provider Organization Plan, Low Deductible PPO Plan, Consumer Driven Health Plan, Health Maintenance Organization
- Dental
- Vision
- Basic Life Insurance
- Supplemental Life Insurance and Accidental Death and Dismemberment Insurance, Dependent Life Insurance, Short-Term Disability Insurance, Long-Term Disability Insurance, etc.
- Health Reimbursement Arrangement

All Component Benefits are described in the applicable Incorporated Documents and the applicable Summary of Coverage or Summary of Insurance. A Summary of Coverage or Summary of Insurance that describes benefits under this Plan will reference the name of the Plan as the PEBP Active Employee Health and Welfare Wrap Plan.

Schedule 2. HIPAA Privacy and Security Provisions

PEBP Position	Access	Access Level
PEBP Board		
PEBP Board Member	PHI, PII, Minimum Necessary	Level 1
PEBP Executives		
Executive Officer	PHI, PII, Minimum Necessary	Level 4
Executive Assistant	PHI, PII, Minimum Necessary	Level 2
Accounting		
Chief Financial Officer	PHI, PII, Minimum Necessary	Level 3
Administrative Services Officer II	PHI, PII, Minimum Necessary	Level 3
Management Analyst II	PHI, PII, Minimum Necessary	Level 2
Accounting Technician II	PHI, PII, Minimum Necessary	Level 2
Accounting Assistant II, III	PHI, PII, Minimum Necessary	Level 2
Information Technology		
Chief Information Officer	PHI, PII, Minimum Necessary	Level 3
IT Professional II, III	PHI, PII, Minimum Necessary	Level 2
Operations		
Operations Officer	PHI, PII, Minimum Necessary	Level 3
Management Analyst III	PHI, PII, Minimum Necessary	Level 2
Program Officer III	PHI, PII, Minimum Necessary	Level 2
Program Officer I	PHI, PII, Minimum Necessary	Level 2
Member Services Administrative Assistant II, III, IV	PHI, PII, Minimum Necessary	Level 2

Eligibility Administrative Assistant I, IV	PHI, PII, Minimum Necessary	Level 2
Education Information Officer	PHI, PII, Minimum Necessary	Level 2
Quality Control		
Quality Control Officer	PHI, PII, Minimum Necessary	Level 4
Management Analyst III	PHI, PII, Minimum Necessary	Level 4
Management Analyst I	PHI, PII, Minimum Necessary	Level 4

Access Level

- **Level 1:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants.
- **Level 2:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants. Credit Card, Debit Card and Financial Account information.
- **Level 3:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants. Credit Card, Debit Card and Financial Account information. Minimum necessary claims data as provided by PEBP Vendors (limited to special projects as authorized by the Executive Officer).
- **Level 4:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants. Physical and mental condition information (past, present, future) to include clinical reports regarding PEBP participants only when necessary to administer health care benefits.

HIPAA Privacy Officer, HIPAA Security Officer, HIPAA Contact Office

PEBP Privacy Officer: If a Participant feels his/her privacy rights have been violated, he/she may file a complaint with the PEBP's Quality Control Officer or with the HHS Office for Civil Rights.

PEBP Quality Control Officer
Public Employees' Benefits Program (PEBP)
3427 Goni Road, Suite 109
Carson City, NV 89706
Phone: (775) 684-7000, (702) 486-3100, or (800) 326-5496
Fax: (775) 684-7028

PEBP Security Officer: The PEBP CIO is responsible for coordinating compliance with the HIPAA Security Rules as defined by the Code of Federal Regulations, 45 C.F.R. 160, 162 and 164.

PEBP Chief Information Officer (CIO)
Public Employees' Benefits Program (PEBP)
3427 Goni Road, Suite 109
Carson City, NV 89706
Phone: (775) 684-7000, (702) 486-3100, or (800) 326-5496
Fax: (775) 684-7028

HIPAA Contact Office: PEBP as the Plan Administrator

Public Employees' Benefits Program (PEBP)
3427 Goni Road, Suite 109
Carson City, NV 89706
Phone: (775) 684-7000, (702) 486-3100, or (800) 326-5496
Fax: (775) 684-7028

Schedule 3. Section 1557 Notice

The State of Nevada Public Employees' Benefits Program's (PEBP) Consumer Driven Health Plan (CDHP), Low Deductible Plan (LD), and Exclusive Provider Organization Plan (EPO) for Medical and Prescription Drug Benefits complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. PEBP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The PEBP CDHP, LD, and EPO for Medical and Prescription Drug Benefits:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact PEBP at 775-684-7000 or 800-326-5496.

If you believe that the PEBP CDHP, LD, or EPO for Medical and Prescription Drug Benefits has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

PEBP's Civil Rights Coordinator
 Public Employees' Benefits Program (PEBP)
 3427 Goni Road, Suite 109
 Carson City, NV 89706
 Phone: (775) 684-7000, (702) 486-3100, or (800) 326-5496
 Fax: (775) 684-7028

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, contact PEBP's Civil Rights Coordinator.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201
 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-326-5496 (TTY: 1-800-545-8279).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-326-5496 (TTY: 1-800-545-8279).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-326-5496 (TTY: 1-800-545-8279)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-326-5496 (TTY: 1-800-545-8279) 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-326-5496 (TTY: 1-800-545-8279).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-326-5496 (መስማት ለተሳናቸው: 1-800-545-8279)፡፡

เรียน: ถ้าคุณพูด ภาษา ไทยคุณสามารถ ใช้บริการช่วยเหลือทางภาษา ได้ฟรี โทร 1-800-326-5496 (TTY: 1-800-545-8279)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-326-5496 (TTY: 1-800-545-8279) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-326-5496 (TTY: 1-800-545-8279) رقم هاتف الصم والبكم 1-800-545-8279.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-326-5496 (телетайп: 1-800-545-8279).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-326-5496 (ATS : 1-800-545-8279).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. تماس بگیرید 1-800-326-5496 (TTY: 1-800-545-8279).

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-326-5496.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-326-5496 (TTY: 1-800-545-8279).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-326-5496 (TTY: 1-800-545-8279).



Access.
Quality.
Affordability.



SECTION 125

HEALTH AND WELFARE BENEFITS PLAN DOCUMENT

PLAN YEAR 20245

(EFFECTIVE JULY 1, 202~~43~~ – June 30, 20245)




NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM
775-684-7000
702-486-3100
or 1-800-326-5496
<https://pebp.nv.gov>





Public Employees' Benefits Program

3427 Goni Road, Suite 109
Carson City, Nevada 89706

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AMENDMENT LOG

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

INTRODUCTION

This amendment and restatement of the State of Nevada Public Participants' Benefits (PEBP) Program Health and Welfare Benefits Plan (the Plan) is effective **July 1, 2023~~4~~**.

The purpose of the Plan is to allow eligible PEBP Participants to choose benefits from among those benefits provided under the Plan.

The Plan includes provisions for a "cafeteria plan" meeting the requirements of §125 of the Internal Revenue Code of 1986, as amended, but some benefits offered under the Plan (or benefits offered to certain Participants) may not be offered pursuant to the Plan's cafeteria plan feature.

Accessing Other Benefit Information:

Review the following documents for information related to dental, life, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA and Privacy and Security and mandatory notices. These documents are available on your member E-PEBP portal account which can be accessed www.pebp.state.nv.us and clicking on the orange log in icon, or by contacting PEBP at 775-684-7000 or 800-326-5496.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan (CDHP) Master Plan Document; CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO Plan (LD PPO) Master Plan Document; LD PPO Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- Exclusive Provider Organization Plan (EPO) Master Plan Document; EPO Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- Health Reimbursement Arrangement Summary Plan Document
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

ARTICLE 1: DEFINITIONS

The following terms have the meanings indicated unless the context clearly requires otherwise:

1.1 ADMINISTRATOR

means the Plan Administrator referred to in Article 8.

1.2 BENEFIT ACCOUNT

is defined in Section 4.1.

1.3 BENEFITS

mean those benefits or coverage available for election by a Participant under Article 6.

1.4 CODE

means the Internal Revenue Code of 1986, as amended, together with applicable regulations and other authoritative guidance issued thereunder.

1.5 PEBP

means the State of Nevada Public Employees' Benefits Program and any successor entity.

1.6 COMPONENT PLAN

means any plan or program referred to Participants in Article 6 and any other plan or program designated by PEBP as a Component Plan.

1.7 DEPENDENT

means the definition of Dependent as set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

1.8 EFFECTIVE DATE

means **July 1, 2023**.

1.9 ELECTION FORM

means the form provided by or process designated by the Administrator by which a Participant enrolls or re-enrolls in the Plan and elects Benefits in accordance with Article 3.

1.10 PARTICIPANT

means a person who is identified as eligible in the PEBP Master Plan Document for the PEBP Enrollment and Eligibility.

1.11 PEBP

means the State of Nevada Public Employees' Benefits Program.

1.12 ERISA

means the Employee Retirement Income Security Act of 1974, as amended, together with applicable regulations and other authoritative guidance issued pursuant to that Act.

1.13 INSURER

means any insurance company to which premiums are paid and which provides benefits with respect to a Participant in accordance with Article 6.

1.14 PARTICIPANT

means a Participant who becomes a Participant pursuant to Article 2.

1.15 PARTICIPANT ACCOUNT

is defined in Section 4.1.

1.16 PARTICIPATION DATE

is the first date on which a Participant may participate in the Plan (or a Component Plan, if applicable), as set forth in Section 2.1.

1.17 PLAN

means, collectively, the State of Nevada Public Employees' Benefit Program Health and Welfare Benefits Plan, as described in this document and as amended from time to time, and the Component Plans.

1.18 PLAN YEAR

means the twelve-month period beginning each July 1st and ending each June 30th.

1.19 PPACA

means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 and any subsequent legislation, together with applicable regulations and other authoritative guidance issued pursuant to that Act.

1.20 SALARY REDUCTION CONTRIBUTIONS

mean contributions made under the Plan based on an election by a Participant pursuant to Section 5.1 to have amounts withheld from the Participant's compensation on a pre-tax or after-tax basis to pay for benefits or coverage provided under a Component Plan or to contribute to a Health Savings Account.

1.21 STATUS CHANGE

means, and is limited to:

- (a) an event that changes a Participant's legal marital status, including marriage, death of spouse, or divorce;
- (b) an event that changes a Participant's number of Dependents, including the birth, adoption, placement for adoption (as defined in regulations under C.F.R. § 146.117) or death of a Dependent;
- (c) an event that changes the employment status of a Participant or the Participant's Dependent resulting in a loss or gain of coverage such as the termination or commencement of employment, Participant moving outside the HMO coverage area, the reduction or increase in hours of employment (including a switch between part-time and full-time employment, or commencement or return from an unpaid leave of absence) of the Participant and any change in

the employment status of a Participant or the Participant's Dependent that results in that person becoming (or ceasing to be) eligible under a plan sponsored by that person's employer;

(d) an event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any similar circumstance;

(e) for purposes of a Component Plan offering dependent care assistance benefits, an event that changes the number of Qualifying Individuals, as defined in Section 6.1(f)

(f) for any election that is not accomplished on a pre-tax basis, any other event that, in the Administrator's sole discretion, qualifies as a Status Change.

ARTICLE 2: ELIGIBILITY AND PARTICIPATION

2.1 PARTICIPATION.

Each Participant is eligible to participate in the Plan as set forth in the PEBP Master Plan Document for the PEBP Enrollment and Eligibility. However, individual Component Plans may impose different or additional eligibility and participation requirements as provided in each Component Plan.

Notwithstanding any other provision of this Plan, no person may participate in the Plan's Code §125 cafeteria plan feature at any time when he or she does not qualify as a Participant of the Plan (as determined by PEBP in accordance with Code §125(d)(1)(A) and other applicable guidance).

2.2 TERMINATION OF PARTICIPATION.

(a) Termination of Coverage for Participants. A Participant's participation in the Plan terminates as set forth in the PEBP Master Plan Document for the PEBP Enrollment and Eligibility.

ARTICLE 3: ELECTION OF BENEFITS

3.1 ELECTION OF BENEFITS

A Participant may elect and in accordance with the following provisions of this Article, any one or more of the Benefits available under Article 6.

3.2 ELECTION FORM.

A Participant's Election Form (electronic or paper form) shall contain such information as the Administrator may deem appropriate.

3.3 INITIAL ELECTION PERIOD.

IN GENERAL. A Participant who becomes eligible to become a Participant shall follow the guidelines as set forth in the Enrollment Processes section of the Master Plan Document for the PEBP Enrollment and Eligibility. The elections made by the Participant on this initial Election Form shall be effective, subject to Section 2.2 (Termination of Participation), for the period beginning on the Participant's Participation Date and ending on the last day of the Plan Year during which the Participant changes his or her initial elections pursuant to Section 3.4 or Section 3.5; provided, however, that a Participant's initial election of coverage under a Health Care Flexible Spending Account or Dependent Care Flexible Spending Account will expire no later than the end of the initial Plan Year for which the initial election applies.

3.4 ELECTION PERIODS AFTER INITIAL ELECTION PERIOD.

A Participant may change his or her initial elections for any subsequent Plan Year by requesting, completing, and submitting a new Election Form for the applicable Plan Year during the period preceding the applicable Plan Year that is identified by the Administrator as the Plan's annual "election period". The elections made by the Participant on each such Election Form shall be effective, subject to Sections 2.2 and 3.5, beginning on the first day of the Plan Year following the applicable election period and continuing until such elections are changed pursuant to this Section. Notwithstanding the preceding, coverage under any Component Plan for which the Participant becomes ineligible will not remain in effect beyond the date on which the Participant becomes ineligible under that Component Plan.

3.5 STATUS CHANGE ELECTIONS; SPECIAL ENROLLMENT; OTHER ELECTION CHANGES.

(a) Status Change Rules.

Within 60 days after a Status Change occurs, a Participant may, with the approval of and pursuant to guidelines established by the Administrator, change his or her election of Benefits, and any Salary Reduction Agreement referenced in Section 5.1, in a manner which is Consistent (as defined in Section 3.5(b)) with the Status Change.

With the approval of and pursuant to guidelines established by the Administrator, a Participant who is eligible to become a Participant but has failed to complete an Election Form may become a Participant and file an Election Form within 60 days after a Status Change occurs, provided that the Participant's commencement of participation and election of Benefits is Consistent (as defined in Section 3.5(b)) with the Status Change.

Elections made under this Section after being approved by the Administrator will take effect on the date specified by the Administrator and remain in effect until the earlier of (i) the end of the Plan Year in which the Participant makes an election pursuant to Section 3.4 (or, for elections relating to a Health Care Flexible Spending Account or a Dependent Care Flexible Spending Account, the end of the Plan Year in which the election is made), (ii) the date on which the Participant becomes ineligible for coverage under any Component Plan, or (iii) the date the Participant again changes his or her election in accordance with the Plan's procedures. Except for a change permitted under Section 3.5(c)(ii) because of a birth, adoption or placement for adoption, any change permitted by this Section 3.5 to a Participant's Salary Reduction Agreement under Section 5.1 may be made on a prospective basis only and may not be used to pay costs of coverage provided before the effective date of such a change.

Notwithstanding any provision of this Plan to the contrary, for any Component Plan that provides coverage through an insurance policy, elections of benefits, including any new election or change in elections that would otherwise be permitted under this Section 3.5(a) will not be permitted unless the election or change is also permitted under the terms of the applicable insurance contract.

"Consistent" Defined. Except as otherwise provided in this Section 3.5(b), an election change is "Consistent" with a Status Change only if the election change is on account of and corresponds with a Status Change that affects the Participant's or the Participant's Dependent's eligibility for coverage under an employer's plan. An election change to decrease or cancel coverage under a Component Plan is not Consistent with a Status Change because of a Participant or a Dependent becoming eligible for coverage under an employer's plan unless the Participant or Dependent elects such coverage. In determining whether an election change is Consistent for purposes of the preceding sentence, PEBP will request required documentation as outlined in the PEBP Enrollment and Eligibility Master Plan Document that alternative coverage has been or will be obtained.

An election change with respect to a Dependent Care Flexible Spending Account is also Consistent with a Status Change if the election change is on account of and corresponds with a Status Change that affects expenses covered under that Component Plan.

Notwithstanding any other provision of this Plan to the contrary, no Participant may change or initiate an election of Benefits or a Salary Reduction Agreement under the Plan regarding contributions to a Health Care Flexible Spending Account under this Plan solely because the Participant or a Dependent gains eligibility for coverage under any other employer's health plan or Health Care Flexible Spending Account plan, and no Participant may change an election of Benefits or a Salary Reduction Agreement under the Plan to stop or decrease contributions to a Health Care Flexible Spending Account under this Plan solely because of a loss of coverage for the Participant or a Dependent under any other employer's health plan or Health Care Flexible spending account plan.

If you are declining medical benefits for yourself or your eligible dependents (including your eligible spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in medical benefits provided under a PEBP-sponsored plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

If you request a change due to a special enrollment event within the 60-day timeframe, coverage will be effective the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first day of the month following the qualifying event date or the first day of the month following the date the participant notifies the plan of the qualifying event, whichever is later.

Some examples of Special Enrollment events include:

- You or your eligible dependent(s) lose eligibility for coverage under a group health plan or other insurance coverage (such as an employee and his/her dependents' loss of coverage under the spouse's plan) or when an employer terminates contributions toward health coverage;
- An individual loses coverage under a group health plan covered through COBRA continuation due to the exhaustion of the COBRA period;
- An individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption; and
- An individual loses coverage under a State Children's Health Insurance Program (CHIP) or Medicaid or becomes eligible to receive premium assistance under those programs for group health plan coverage.

Special enrollment rights are subject to certain circumstances. If you are a State or non-State retiree, special enrollment does not apply to you, but it does apply to your dependents if you are covered under the Plan. If you are a surviving spouse or surviving domestic partner, special enrollment does not apply to you or your dependents.

To request special enrollment or to obtain more information, contact PEBP at 775-684-7000 or 800-326-5496 or email mservices@peb.state.nv.us.

(b) Special Enrollment Rights.

This Section 3.5(c) applies notwithstanding any other provision of this Plan to the contrary. For purposes of the remainder of this Section 3.5(c) only, "Plan" refers only to coverage under any Component Plan that offers medical benefits that are subject to Code §9801(f) (as determined by the Administrator). This Section 3.5(c) is included in the Plan to comply with the requirements of Code §9801 and any regulations or other authoritative guidance issued pursuant to those provisions and will be construed to provide only those enrollment rights that are required by those provisions, regulations, or other authoritative guidance.

The Benefit options available to a Participant under a Component Plan during a Special Enrollment Period will be the same Benefit options that would be available to such a Participant during an initial election period or, if applicable, during an annual election period (but limited to Benefit options that are subject to C.F.R. § 146.117(f)), regardless of whether the Participant or any Dependent was enrolled in a different Benefit option or no coverage under such a Component Plan at the time of the Special Enrollment election.

Notwithstanding any provision of this Plan to the contrary, for purposes of this Section 3.5(c), “Participant” is defined as described in Section 1.10, except that “Participant” does not include any person who is not, at the applicable time, a current Participant of PEBP (as determined by PEBP).

Special Enrollment Rights Because of Loss of Alternative Coverage.

A Participant or a Dependent who is otherwise eligible for coverage under the Plan (including, for a Participant’s Dependent, any requirement that the Participant also be enrolled in the Plan) is eligible to enroll in the Plan during a Special Enrollment Period, as described in this Section 3.5(c)(i), if,

- (A) when coverage under the Plan was previously offered (e.g., during an initial enrollment period, a Special Enrollment Period or, if applicable, an open enrollment period), the Participant or Dependent had coverage under another group health plan or health insurance coverage (Alternative Coverage), and
- (B) the Participant or the Dependent satisfies one of the following conditions:
 - (1) the Alternative Coverage is not COBRA continuation coverage, and the Alternative Coverage terminates because of a “Loss of Eligibility” (as described later in this Section 3.5(c)(i));
 - (2) the Alternative Coverage is not COBRA continuation coverage and employer contributions (including contributions by any current or former employer of the Participant or Dependent) toward the Participant’s or Dependent’s Alternative Coverage terminate; or
 - (3) the Alternative Coverage is COBRA continuation coverage, and the Alternative Coverage terminates because the COBRA continuation coverage is exhausted (as described later in this Section 3.5(c)(i)).

“Loss of Eligibility” includes, but is not limited to, a loss of eligibility because of divorce, cessation of dependent status, death of a Participant, termination of employment or a reduction in the number of hours of employment. For Alternative Coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, “Loss of Eligibility” also includes a loss that occurs because the Participant or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Participant or Dependent). In addition, a “Loss of Eligibility” occurs if the Alternative Coverage no longer offers any benefits to the class of similarly situated individuals that includes the Participant or Dependent.

“Loss of Eligibility” for purposes of this Section 3.5(c)(i) does not include a loss of coverage because of a failure of the Participant or Dependent to pay for coverage on a timely basis or a loss of coverage for cause (such as for making a fraudulent claim or a misrepresentation of a material fact in connection with the Alternative Coverage).

For purposes of this Section 3.5(c)(i), exhaustion of COBRA coverage occurs when COBRA coverage ceases for any reason other than a failure of the Participant or Dependent to pay premiums on a timely basis or for cause. Exhaustion of COBRA coverage occurs when COBRA coverage ceases because an employer or

other responsible party fails to remit premiums on a timely basis. For COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, exhaustion of COBRA coverage also occurs if coverage ceases because the Participant or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available).

If a Participant loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage), the Participant (and each otherwise eligible Dependent) is eligible for Special Enrollment during the Special Enrollment Period. If a Dependent loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage), only the Participant and any Dependent who loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage) is eligible for Special Enrollment. In any case, Special Enrollment rights are subject to any Plan eligibility rules that condition Dependent eligibility on enrollment of the Participant.

A Participant or a Dependent who is eligible for a Special Enrollment under this Section 5.1 may be enrolled in the Plan, and the Participant may make a corresponding change in a salary reduction agreement under Section 5.1, if any, during the Participant's or Dependent's Special Enrollment Period. The Special Enrollment Period under this Section 3.5(c)(i) ends 60 days after the termination of the Alternative Coverage.

Following an election by a Participant under this Section 3.5(c)(i), the Participant's or Dependent's coverage will become effective no later than the first day of the first month following the month the Participant's or Dependent's loss of coverage occurred. A Special Enrollment Period election will be treated as an initial election of coverage pursuant to Section 3.3 and is subject to all Plan provisions that apply to initial elections, except that coverage begins only as described in this paragraph.

Special Enrollment Rights Following Marriage, Birth or Adoption.

Following the marriage of a Participant or a Participant, the birth of a child, or the adoption or placement for adoption of a child, the Participant, the Participant's Dependent or the Participant's Dependent, as applicable, may enroll in the Plan during a Special Enrollment Period, as follows:

1. An otherwise eligible Participant may enroll himself or herself in the Plan and make a corresponding change to a salary reduction agreement under Section 5.1, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if an individual becomes a Dependent of the Participant through marriage, birth, adoption or placement for adoption.
2. An active Participant may enroll an individual who becomes or is his or her spouse (determined under federal law) and make a corresponding change to a salary reduction agreement under Section 5.1, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if either (I) the individual becomes the Participant's spouse or (II) the individual is the Participant's spouse and a child becomes a Dependent of the Participant through birth, adoption or placement for adoption.
3. An otherwise eligible Participant may elect to enroll in the Plan the Participant and an individual who becomes or is his or her spouse (determined under federal law) and make a corresponding change to a salary reduction agreement under Section 5.1, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if (I) the Participant and the individual become married

or (II) the Participant and the individual already are married and a child becomes a Dependent of the Participant through birth, adoption or placement for adoption.

4. An active Participant may enroll an individual in the Plan and make a corresponding change to a salary reduction agreement under Section 5.1, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if the individual becomes a Dependent of the Participant through marriage, birth, adoption, or placement for adoption.
5. An otherwise eligible Participant may elect to enroll the Participant and an individual who becomes a Dependent of the Participant in the Plan and make a corresponding change to a salary reduction agreement under Section 5.1, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if the individual becomes a Dependent of the Participant through marriage, birth, adoption, or placement for adoption.

The Special Enrollment Period under this Section 3.5(c)(ii) begins on the date of the marriage, birth, adoption, or placement for adoption that gives rise to the Special Enrollment Period (or, if later, on the Participant's Participation Date) and ends 60 days after that date. Following an election during a Special Enrollment Period for coverage under the Plan, the coverage will be effective, (A) for a marriage, on a date specified by the Administrator that is no later than the first day of the first month beginning after the date the Participant submits to the Administrator an Election Form electing coverage for the Participant or Dependent under the Plan, (B) for a Dependent's birth, on the date of birth, and, (C) for a Dependent's adoption or placement for adoption, on the date of the adoption or placement for adoption. A Special Enrollment Period election will be treated as an initial election of coverage pursuant to Section 3.3 with respect to medical coverage or any other coverage that is subject to the Special Enrollment requirements of C.F.R. § 146.117(f) and is subject to all Plan provisions that apply to initial elections, except that coverage begins only as described in this paragraph.

For purposes of this Section 3.5(c)(ii), "marriage" is limited to a marriage that is recognized as a marriage for purposes of federal law.

Special Enrollment Rights Relating to Medicaid or CHIP Coverage

(see ARTICLE 11: Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)) To the extent required by C.F.R. § 146.117(f), a Participant or a Participant's Dependent who is eligible but not enrolled may enroll in the Plan by requesting enrollment during a Special Enrollment Period described in this Section 3.5(c)(iii) in either of the following situations:

1. Termination of Medicaid or CHIP Coverage. The Participant or the Participant's Dependent was covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan (CHIP) under Title XXI of the Social Security Act and coverage of the Participant or the Participant's Dependent under that Medicaid or CHIP plan is terminated as a result of loss of eligibility for that coverage.
2. Eligibility for Financial Assistance under Medicaid or CHIP. The Participant or the Participant's Dependent becomes eligible for financial assistance for coverage under the Plan, through a Medicaid plan or a state CHIP plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Special Enrollment Period described in this Section 3.5(c)(iii) is the 60-day period that begins on the date of the termination of coverage described in (A) above or the date the Participant or the Participant's

Dependent is determined by the appropriate government agency to be eligible for the financial assistance described in (B) above. Enrollment that is properly requested during that Special Enrollment Period will become effective no later than the first day of the first month following the month the Participant or the Participant's Dependent loses Medicaid or CHIP eligibility or the first day of the month the Participant or the Participant's Dependent gains eligibility for financial assistance for coverage through a Medicaid plan or a state CHIP plan. Enrollment under this Section 3.5(c)(iii) is permitted for each Participant and the Participant's Dependent who experiences an event described in (A) or (B) above. Enrollment for any person, other than the Participant or the Participant's Dependent, who has not experienced such an event will be permitted under this Section 3.5(c)(iii) only to the extent required by applicable law, as determined by PEBP.

(c) Significant Changes in Cost or Coverage.

Any election change permitted under this Section 3.5(d) must be requested, pursuant to procedures established by the Administrator, within 60 days after the date of the event giving rise to the right to make the election change (as determined by the Administrator).

Notwithstanding any provision of this Plan to the contrary, for any Component Plan that provides coverage through an insurance policy, elections of benefits, including any new election or change in elections that would otherwise be permitted under this Section 3.5(d) will be permitted unless the election or change is also permitted under the terms of the applicable insurance contract.

Significant Cost Changes.

If the cost payable by a Participant for coverage offered under a Benefit option significantly changes during a Plan Year, as determined by PEBP, the Participant may make corresponding changes to his or her election of Benefits and to a salary reduction agreement under Section 5.1. If the change is an increase in the Participant's cost of that coverage, a Participant may elect to replace his or her coverage with coverage available under another Benefit option, if any, that offers similar coverage, as determined by PEBP, or, if no other similar Benefit option is available, a Participant may drop the coverage. If the change is a decrease in the Participant's cost of coverage under a Benefit option, a Participant or a Participant who is eligible to become a Participant may revoke a current election of similar coverage and elect the coverage with the decreased cost.

For purposes of the preceding paragraph, a cost increase or decrease means an increase or decrease in the amount of the Participant's cost for a Benefit option only if the increase or decrease results from an action taken by the PEBP (or, for elections involving a Dependent Care Flexible Spending Account, from a change in costs imposed by a dependent care provider).

Notwithstanding anything else in this Section 3.5(d)(i), for any change in costs associated with a Dependent Care Flexible Spending Account, a Participant may not change a salary reduction agreement or election of Benefits if the cost change is imposed by a dependent care provider who, with respect to the Participant, is a parent, grandparent, child, grandchild, brother, sister, niece, nephew, stepparent, stepchild, stepbrother, stepsister, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law or brother-in-law.

Coverage Changes.

A) **Curtailment Without Loss of Coverage.** If a Participant experiences a significant curtailment of coverage under a Benefit option that is not a loss of coverage (under applicable law, as determined by PEBP), the Participant may elect to revoke his or her election of that Benefit option and, in lieu of that coverage, elect to receive coverage under another Benefit option, if any, that offers similar coverage, as determined by PEBP, and may make corresponding changes to a salary reduction agreement under Section 5.1. Coverage under a Benefit option is significantly curtailed only if there is an overall reduction in coverage that constitutes reduced coverage to Participants generally, as determined by PEBP.

(B) **Loss of Coverage.** If a Participant experiences a significant curtailment of coverage under a Benefit option that is a loss of coverage (under applicable law, as determined by PEBP), the Participant may elect to revoke his or her election of that Benefit option and, in lieu of that coverage, elect to receive coverage under another Benefit option, if any, that offers similar coverage, as determined by PEBP, and may make corresponding changes to a salary reduction agreement under Section 5.1. If no similar coverage is available to replace the Benefit option for which a loss of coverage occurred, a Participant may elect to drop the coverage.

For purposes of this Section 3.5(d)(ii), “loss of coverage” means a complete loss of coverage under a Benefit option and includes, for example, the elimination of a Benefit option, the loss of availability of an HMO option in the area where the Participant or Dependent resides, a Participant’s or Dependent’s loss of coverage under a health plan option because expenses exceed an annual limit and other similar events, as determined by PEBP. In addition, PEBP, in its discretion, may elect to treat as a loss of coverage any of the following: (1) a substantial decrease in the medical care providers available under the Benefit option; (2) with regard to a specific Participant or Dependent, a reduction in benefits provided under a health plan for a specific type of medical condition or treatment with respect to which the Participant or Dependent is currently in a course of treatment; or (3) any similar fundamental loss of coverage.

(C) **Addition of Option.** If PEBP adds a new Benefit option or if coverage under an existing Benefit option is significantly improved during a Plan Year, as determined by PEBP, a Participant who elected a Benefit option for the Plan Year that provides similar coverage, as determined by PEBP, may change his or her election of Benefits to replace that Benefit option with the new or improved Benefit option and may make corresponding changes to a salary reduction agreement under Section 5.1, if applicable. Any Participant, or any Participant who is eligible to become a Participant, who did not elect any Benefit option for the Plan Year that provides coverage similar to that offered under a new or improved Benefit option, as determined by PEBP, may change his or her election of Benefits to elect the new or improved Benefit option and may make corresponding changes to a salary reduction agreement under Section 5.1, if applicable.

Changes Under Another Employer’s Plan.

A Participant, or a Participant who is eligible to become a Participant, may change his or her election of Benefits and Salary Reduction Agreement under Section 5.1 on account of and corresponding to (A) an election change made under another employer-sponsored plan (including another plan of PEBP), if the change is one that is permitted under that other plan under provisions similar to the provisions in this Section 3.5, or (B) an election change made under another employer-sponsored plan (including another plan of PEBP) that corresponds to a period of coverage that is different from the Plan Year.

Loss of Other Group Health Coverage.

If a Participant or a Participant's Dependent, or a Participant who is eligible to become a Participant, or his or her Dependent loses coverage under any group health coverage sponsored by a governmental entity or educational institution, the Participant or Participant may change his or her election of Benefits and Salary Reduction Agreement under Section 5.1 to elect coverage for the affected individual.

Nothing in this Section 3.5(d) shall be construed to permit a change to a Participant's election of Benefits or Salary Reduction Agreement under Section 5.1 with respect to a Health Care Flexible Spending Account or to permit a change of election with respect to any Component Plan because of cost or coverage changes associated with a Health Care Flexible Spending Account sponsored by any employer of a Participant or a Dependent.

(d) Other Election Changes.

Any election change permitted under this Section 3.5(e) must be requested, pursuant to procedures established by the Plan Administrator, within 60 days after the date of the event giving rise to the right to make the election change (as determined by the Administrator) or as otherwise provided in this Section 3.5(e).

Notwithstanding any provision of this Plan to the contrary, for any Component Plan that provides coverage through insurance policies, elections of benefits, including any new election or change in elections that would otherwise be permitted under this Section 3.5(e) will be permitted unless the election or change is also permitted under the terms of the applicable insurance contract.

Judgment, Decree or Order.

If a Participant is subject to a judgment, decree or order (Order) resulting from a divorce, annulment, or change in legal custody (including a qualified medical child support order) for accident or health coverage for the Participant's child, the Participant, or if required by the Order, PEBP or the Administrator, may change the Participant's election of Benefits and Salary Reduction Agreement under Section 5.1, if any, to provide coverage for the child if the Order requires coverage under the Plan. If the Order requires the Participant's spouse, former spouse or another individual to provide coverage for the child, the Participant may change his or her election of Benefits and Salary Reduction Agreement under Section 5.1, if any, to cancel coverage for the child, if the Participant provides adequate proof, as determined by the Administrator, that the coverage required by the Order is actually being provided.

Medicare/Medicaid Eligibility.

If a Participant or a Participant's Dependent who is enrolled in a Component Plan that offers accident or health coverage, becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under §1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Participant may make an election change to cancel or reduce coverage of that Participant, or his or her Dependent, under the Component Plan that offers accident or health coverage, and may change a Salary Reduction Agreement under Section 5.1 accordingly. If a Participant or a Participant's Dependent, who was previously enrolled under Medicare or Medicaid as described in the previous sentence, loses eligibility for such coverage, the Participant may elect coverage for that individual under a Component Plan that offers accident and/or health coverage. A change described in this Section 3.5(e)(ii) must be requested within 60 days after the gain or loss of eligibility for Medicare or Medicaid coverage.

Family and Medical Leave Act

A Participant taking unpaid leave under the Family and Medical Leave Act of 1993 (FMLA) may revoke an existing election of group health coverage and, upon return from FMLA leave, may make other elections concerning group health coverage that are permitted by FMLA. A Participant may make corresponding changes to a Salary Reduction Agreement under Section 5.1 to reflect these special FMLA- permitted changes.

Health Savings Account Contributions

A Participant who is making Salary Reduction Contributions to a Health Savings Account under the Plan or a Participant who is eligible to make such contributions may make changes to a Salary Reduction Agreement under Section 5.1 to increase, decrease or stop such contributions on at least a monthly basis, subject to reasonable administrative rules and procedures, established by the Administrator. A Participant who ceases to be an eligible individual for purposes of Code §223 may change his or her Salary Reduction Agreement at any time to cease Health Savings Account contributions. Changes in Salary Reduction Contribution elections will become effective on a prospective basis only.

Revoking Medical Coverage to Enroll in Marketplace Coverage

A Participant who has an enrollment opportunity to enroll in a Qualified Health Plan through an exchange or marketplace established under PPACA §1311 (“Marketplace”) may change his or her election of Benefits and Salary Reduction Agreement under Section 5.1, if any, to revoke coverage under a Component Plan that provides medical coverage that qualifies as minimum essential coverage under Code §5000A(f)(1) (not including any Health Care FSA Component Plan) but only if the revocation corresponds to the intended enrollment in Marketplace coverage by the Participant and all Dependents whose coverage under this Plan is being revoked. A revocation of coverage pursuant to the preceding sentence will be treated as corresponding to enrollment in Marketplace coverage only if the Marketplace coverage (for all covered persons whose coverage would be terminated because of the revocation) is effective no later than the next day after coverage under the Plan would terminate because of the revocation of coverage under this Plan. The Plan Administrator may rely on the Participant’s reasonable representation that all covered persons whose coverage is to be revoked have enrolled in or will enroll in Marketplace coverage to be effective no later than the deadline indicated in the previous sentence. This paragraph will be interpreted to be consistent with guidance provided by the Internal Revenue Service in Notice 2014-55 and any applicable guidance, including regulations or proposed regulations that replace or supplement that guidance, as interpreted by the Plan Administrator.

Additional Permitted Election Changes for Health Coverage under Section 125 Cafeteria Plans

In accordance with [IRS Notice 2022-41](#), the plan permits an additional qualifying event that would allow dependents to opt-out of plan coverage. A participant may change their coverage tier when not under a self-only tier (other than a flexible spending arrangement (FSA)) in order to allow one or more dependents to enroll in a Qualified Health Plan (QHP) through a Health Insurance Exchange (Exchange) in the individual market. Under this notice, the employee will be able to elect self-only coverage (or family coverage including one or more already-covered related individuals) under that health plan. These changes are prospectively during a period of coverage, provided specific conditions are satisfied.

ARTICLE 4: PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS

4.1 PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS.

PEBP or Administrator shall maintain records reflecting a Participant Account for each Participant. The Participant Account shall be divided into sub-accounts (Benefit Accounts) for each Benefit elected by the Participant.

4.2 CREDITING AND ALLOCATING ACCOUNTS.

Amounts shall be credited to Participant Accounts as provided in Section 5.1 and allocated to Benefit Accounts as provided in Section 5.2.

4.3 DEBITING OF ACCOUNTS.

Benefit Accounts shall be debited as provided in Section 5.2.

4.4 ACCOUNTS AS BOOK ENTRIES ONLY.

Participant Accounts and Benefit Accounts shall be maintained by PEBP and/or the Administrator as entries on its books. No money shall be paid into any Participant Account or Benefit Account. No assets or funds shall be paid to, held in, or invested in any separate trust. No interest will be credited to or paid on amounts credited to any Participant Account or Benefit Account.

ARTICLE 5: CREDITS AND DEBITS TO ACCOUNTS

5.1 SALARY REDUCTION CONTRIBUTIONS.

During the applicable election period determined under Article 3, a Participant may enter into a Salary Reduction Agreement with PEBP which directs that the Participant's compensation for the period to which the election relates shall be reduced each payroll period and that the amount of such reduction will be credited to the Participant's Participant Account. For Participants who are eligible to participate in the Plan's Code §125 cafeteria plan feature, Salary Reduction Contributions will be made on a pre-tax basis to the extent permitted under Code §125 (as determined by PEBP) and only from compensation that would otherwise be payable to the Participant as a Participant (within the meaning of Code §125(d)(1)(A)). For certain Benefits and to the extent permitted by PEBP, a Participant may make contributions on an after-tax basis and that amount will be credited to his or her Participant Account.

Except as otherwise provided in this Plan or a Component Plan, a Participant's pre-tax Salary Reduction Contributions for any period will be limited only by the amount of compensation payable to the Participant as a Participant for that period (or the total Participant cost of pre-tax benefits elected by the Participant, if less). For purposes of the preceding sentence, "Participant" has the same meaning that applies for purposes of Code §125(d)(1)(A). Notwithstanding the preceding, the elected salary reduction, as applicable to any Participant, is subject to reduction by the Administrator to the extent deemed necessary by the Administrator to avoid the Plan being discriminatory for purposes of Code §125.

Pre-tax Salary Reduction Contributions will be deducted from a Participant's compensation on a uniform basis throughout the applicable Plan Year or other period of coverage, with deductions made for each pay period or some other interval that is specified by PEBP. Pre-tax Salary Reduction Contributions deducted from a Participant's compensation during a Plan Year may not be used to pay for coverage or benefits provided during a later Plan Year except to the extent permitted under applicable regulations issued under Code §125. As permitted by applicable regulations, in accordance with uniform and consistent administrative and payroll procedures, Salary Reduction Contributions deducted from a Participant's compensation during the last month of a Plan Year may be used to pay for health or accident coverage provided during the first month of the next Plan Year.

A Participant's elected Salary Reduction Contribution for coverage under a Component Plan is subject at all times to PEBP's right to automatically increase or decrease the amount of a Participant's contribution to correspond to a change in the amount that a Participant is required to pay for coverage under that Component Plan. Any automatic changes made based on the preceding sentence will apply prospectively only but otherwise may become effective on any date determined by PEBP. Such automatic changes will be made only on a reasonable and consistent basis.

Except as otherwise expressly permitted under the Plan and applicable law, a Participant who is not an active Participant shall make contributions on an after-tax basis. Also, any contributions made by or on behalf of a Participant to pay for coverage for any Dependent who is not a Code Section 152 dependent (as defined in Section 1.7), spouse (as determined for purposes of federal law) or child of the Participant will be made on an after-tax basis or, if PEBP in its discretion and in accordance with uniform and consistent administrative procedures, permits such contributions to be made on a pre-tax basis, will be treated as resulting in imputed income for the Participant, to the extent required under applicable law.

For purposes of the preceding sentence, “child” means any individual who qualifies as a child of the Participant under Code §152(f)(1) who will not reach age 27 before the end of the Participant’s tax year.

5.2 ALLOCATIONS TO AND DEBITING OF BENEFIT ACCOUNTS.

Amounts credited to a Participant’s Participant Account shall be allocated, on the date credited, to the Benefit Accounts of the Participant. Such allocation shall be made pursuant to the election made by the Participant in accordance with Section 6.1. However, in no event may an amount in excess of the total amount credited to a Participant’s Participant Account be credited to the Participant’s Benefit Accounts. All payments of Benefit amounts under the Plan shall be debited against the appropriate Benefit Account.

5.3 CHANGES DURING PLAN YEAR

Except as provided in Sections 3.5 or 5.1 and to the extent permitted under applicable law, a Participant shall not change (a) amounts to be credited to a Participant Account during a Plan Year pursuant to Section 5.1 or (b) the allocation of such amounts to Benefit Accounts during the Plan Year pursuant to Section 5.2.

ARTICLE 6: BENEFITS

6.1 AVAILABLE BENEFIT ELECTIONS.

The benefits available for election pursuant to Article 3 shall be those provided through the Component Plans. The Participant cost of the Benefits will be determined by PEBP and will be communicated to Participants from time to time.

Pursuant to a Participant's election of a Benefit provided under a Component Plan, the compensation of the Participant will be reduced by the amount necessary to provide that Benefit, and PEBP shall credit the amount of the salary reduction to the Component Plan on behalf of the Participant.

The Plan's Benefit options are listed below. Further details are set forth in the Master Plan Document for the PEBP Consumer Driven Health Plan for Medical, Vision and Prescription Drug Benefits.

(a) Consumer Driven Health Plan (CDHP)

Each eligible Participant may elect to have sufficient Salary Reduction Contributions made pursuant to Section 5.1 for one of the medical, dental, vision, or prescription drug coverage options designated by PEBP.

When an eligible participant to participate the program fails to make an election at initial enrollment they will be automatically enrolled on an individual basis, without coverage for dependents, in the base plan offered by the Program. The base plan is the CDHP with a Health Reimbursement Arrangement ([NRS 287.317](#)).

(b) Basic Life Insurance

Each Eligible Participant may elect to have sufficient Salary Reduction Contributions made pursuant to Section 5.1 credited to his or her Basic Life Insurance under a basic life insurance coverage option designated by PEBP.

(c) Health Savings Account

Each eligible Participant who participates in a High Deductible Health Plan (as defined in Code §223(c)(2)) offered under the Plan and who qualifies as an "eligible individual" for purposes of Code §223(c)(1) may be credited with PEBP contributions to a Health Savings Account, if any, and may elect on his or her Election Form to have sufficient Salary Reduction Contributions made pursuant to Section 5.1 credited to his or her Health Savings Account. A Participant is eligible to be credited with Employer contributions or to make Salary Reduction Contributions to a Health Savings Account only for months during which the Participant is an "eligible individual" for purposes of Code §223(c)(1). The total amount credited to a Participant's Health Savings Account through PEBP contributions or Participant Salary Reduction Contributions for a calendar year may not exceed the applicable limit that applies under Code §223. PEBP may limit contributions to a Participant's Health Savings Account as needed to ensure that the applicable limit is not exceeded, but PEBP is not responsible for monitoring contributions that are made to a Participant's Health Savings Account from outside the Plan. All contributions to a Health Savings Account become the property of the Participant in accordance with applicable law. A Participant's Health Savings Account that is funded through this Plan is not a Component Plan and is not a Participant benefit plan for purposes of ERISA or Nevada law. If PEBP elects to make contributions to Health Savings Accounts, those

contributions will be made only for individuals who are determined to be eligible individuals for purposes of Code §223(c)(1) and who, at the applicable time, are participating in the CDHP Component Plan based on an affirmative election of that coverage. No person will be eligible for PEBP contributions to an HSA for any period when that person is participating in the Health Reimbursement Arrangement based solely on an automatic election as described in Section 6.1(a) (as determined by PEBP).

(d) Flexible Spending Accounts (FSA)

Each eligible Participant may elect to have Salary Reduction Contributions made pursuant to Section 5.1 credited to his or her Health Care FSA, Dependent Care FSA, and/or Limited Purpose/Scope FSA according to guidelines established by the Administrator and set forth in the FSA Summary Plan Description, which shall set forth the amount of Salary Reduction Contributions that may be credited to a Participant's Health FSA for a Plan Year. No Participant is an eligible Participant for purposes of the Plan's Health Care FSA feature for any period when he or she is a Participant in the HSA.

(e) Buy-up Vision Plan

Each eligible Participant may elect to have sufficient Salary Reduction Contributions made pursuant to Section 5.1 credited to his or her Buy-up Vision Plan voluntary coverage option designated by PEBP.

6.2 INSURANCE CONTRACTS.

PEBP has the right to enter into contracts with one or more insurance companies for providing any Benefits under the Plan and to replace any such insurance company from time to time. If any Benefit is intended to be provided under an insurance contract, a Participant may look only to the insurance company for payment of that benefit.

Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any insurance contracts used to provide Benefits shall be the property of, and shall be retained by, PEBP, except to the extent, if any, that the Administrator determines that a portion of the payment is required to be treated as Plan assets under applicable law. To the extent that any portion of such a payment is required to be treated as Plan assets, that amount will be used to pay reasonable Plan expenses or to provide Benefits or will be used for any other purpose that is consistent with applicable law regarding the use of such assets.

6.3 SOURCE OF BENEFITS

PEBP will pay any Benefits intended to be self-funded from its general assets.

6.4 MAXIMUM CONTRIBUTIONS AND BENEFITS.

The maximum amount of contributions and Benefits made available under the Plan to any Participant in any Plan Year shall be limited as provided in the Code.

ARTICLE 7: HIPAA PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

The component Benefits of the Plan that are a ‘group health plan’ shall comply with the provisions of HIPAA, in accordance with this Article. The Component Benefits of the Plan that are not subject to HIPAA shall not be subject to this Article.

7.1 INTRODUCTION.

This Article describes the requirements under a federal law known as HIPAA that apply to health benefits for Employees and certain Retirees, and their eligible Dependents, participating in the PEBP. The confidentiality of Participant Health Information is important to the PEBP. The PEBP is committed to ensuring that the privacy of all Participants is protected and all legal requirements under HIPAA are satisfied. Accordingly, the PEBP will not use or disclose Protected Health Information other than as permitted or required by HIPAA, the HIPAA regulations, and the Article.

The PEBP provides medical, dental, vision, and prescription drug benefits, which are considered “Health Care Components” under HIPAA. The PEBP also provides other benefits that are not subject to HIPAA and some non-covered benefits. Under HIPAA, the PEBP is considered a “Hybrid Entity”. The HIPAA Privacy and Security provisions of this Article apply only to:

- (a) The Health Care Components of the PEBP and to the Health Plan, Health Care Provider, or Health Care Clearinghouse functions performed by the Health Care Component;
- (b) Protected Health Information that is created or received by or on behalf of the Health Care Component of the Plan; and
- (c) Electronic Protected Health Information created, received, maintained, or transmitted by or on behalf of the Health Care Component of the Plan.

7.2 DEFINITIONS.

The following are definitions of specific terms and words used in this section. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

“Breach” means the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted by HIPAA which compromises the security or privacy of the Protected Health Information, unless the acquisition, access, use, or disclosure is otherwise excluded in the definition of “Breach” under 45 CFR Section 164.402.

“Business Associate” has the meaning set forth in 45 CFR Section 160.103, including any third-party administrator or actuarial, legal, accounting, consulting, or similar firm that performs services involving the disclosure of Protected Health Information.

“Electronic Protected Health Information” means Protected Health Information that is transmitted by or maintained in electronic media.

“Covered Entity” means

1. A Health Plan

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2. A Health Care Clearinghouse; or
3. A Health Care Provider that transmits any Health Information in electronic form in connection with a transaction covered by HIPAA, as defined more fully in 45 CFR Section 160.103.

The plan is a covered entity.

“Genetic Information” has the meaning set forth in 45 CFR 160.103.

“Health Care” means care, services, or supplies related to the health of an Individual within the meaning of 45 CFR 160.103. Health care includes, but is not limited to, the following:

1. Preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to physical or mental condition or functional status of an Individual or that affects the structure or function of the body; and
2. Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

“Health Care Clearinghouse” has the meaning set forth in 45 CFR Section 160.103 and includes a public or private entity, including a billing service, repricing company, community health management information system or community Health Information system, and “value-added” networks and switches, that performs either of the following functions:

1. Processes or facilitates the processing of Health Information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
2. Receives a standard transaction from another entity and processes or facilitates the processing of Health Information into a nonstandard format or nonstandard data content for the receiving party.

“Health Care Component” means a Component or combination of Components of a Hybrid Entity that are designated by the Hybrid Entity in accordance with 45 CFR Section 164.105(a)(2)(iii)(D) and from whom the PEBP receives Protected Health Information subject to HIPAA. The medical, dental, vision, and prescription drug benefits offered under the Plan are Health Care Components.

“Health Care Operations” means any of the following activities of the Plan, to the extent such activities relate to the covered functions of the Plan, including, but not limited to:

1. Conducting quality assessment and improvement activities including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;
2. Patient safety activities;
3. Population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, disease management, contacting Health Care Providers and patients with information about Treatment alternatives and related functions that do not include Treatment;
4. Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner and Provider performance, rating Health Care Provider and Plan

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performance, including accreditation, certification, licensing, or credentialing activities;

5. Underwriting (subject to the prohibition in this Article 11), premium rating and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, securing or placing a contract for reinsurance of risk relating to Health Care claims, including stop-loss insurance and excess of loss insurance;
6. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
7. Business planning and development, such as conducting cost-management and planning-related analysis associated with managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
 - (1) Business management and general administrative activities of the Plan, including, but not limited to:
 - (2) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;
 - (3) Customer service, including the provision of data analysis for policyholders, Plan Sponsors, or other customers;
 - (4) Resolution of internal grievances;
 - (5) The sale, transfer, merger or consolidation of all or part of the Plan with another Covered Entity, or an entity that following such activity will become a Covered Entity, and due diligence related to such activity;
 - (6) Consistent with the applicable requirements of 45 CFR Section 164.514, creating de-identified Health Information or a limited data set, and fundraising for the benefit of the Covered Entity; and
 - (7) Any other activity that falls within the definition of the term "Health Care Operations" as set forth in 45 CFR Section 164.501.

"Health Care Provider" has the meaning set forth in 45 CFR Section 160.103 and includes a provider of medical or health services, as well as any other person or organization that furnishes, bills, or is paid for Health Care in the normal course of business.

"Health Care Treatment" means the provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party, consultation between Health Care Providers relating to a patient, or the referral of a patient for Health Care from one Health Care Provider to another, and such other activities that may be included in the definition of "Treatment" as set forth in 45 CFR Section 164.501.

"Health Information" has the meaning set forth in 45 CFR Section 160.103 and includes information (including Genetic Information), whether oral or recorded in any form or medium, including, but not limited to, verbal conversations, telephonic communications, electronic mail or messaging over computer

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networks, the Internet and intranets, as well as written documentation, photocopies, facsimiles and electronic data, that is created or received by a Health Care Provider, a Health Plan, the PEBP, a life insurer, school or university, or a Health Care Clearinghouse that relates to:

1. The past, present, or future physical or mental health or condition of an Individual;
2. The provision of Health Care to an Individual; or
3. The past, present, or future payment for the provision of Health Care to an Individual.

“Health Insurance Issuer” has the meaning set forth in 45 CFR Section 160.103 and includes an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. The term does not include a Group Health Plan (within the meaning of 45 CFR Section 160.103).

“Health Plan” means an Individual or Group Health Plan that provides or pays the cost of medical care, and includes a Group Health Plan, a Health Insurance Issuer, an HMO and such other plans or arrangements as are set forth in the definition of a “Health Plan” in 45 CFR Section 160.103, including the Plan.

“HHS” means the U.S. Department of Health and Human Services.

“HHS-Approved Technology” means:

1. With respect to data in motion, the encryption guidelines in Federal Information Processing Standard 140-2 (or successor guidelines).
2. For data at rest, HHS-Approved Technology means the encryption guidelines in National Institute of Standards and Technology (NIST) Special Publications 800-111 (or successor guidelines).
3. With respect to the destruction of data containing Protected Health Information, an HHS-Approved Technology requires the destruction of the media on which the Protected Health Information is stored such that, for paper, film, or other hard copy media, destruction requires shredding or otherwise destroying the media so that Protected Health Information cannot be read or reconstructed; for electronic media, destruction requires that the data be cleared, purged, or destroyed consistent with NIST Special Publication 800-88 (or successor guidelines) such that the information cannot be retrieved. HHS-Approved Technology may be updated from time to time based on guidance from the Secretary of HHS.

“HITECH” means the Health Information Technology for Economic and Clinical Health Act.

“Hybrid Entity” means a single legal entity that is a Covered Entity whose business activities include both covered functions and non-covered functions and that designates Health Care Components (in accordance with 45 CFR Section 164.105(a)(2)(iii)(D)) for purposes of fulfilling the Hybrid Entity requirements of HIPAA, as defined in 45 CFR Section 164.103. For purposes of this definition, “covered functions” means those functions performed by a Covered Entity that make the entity a Health Plan, Health Care Provider, or Health Care Clearinghouse. The Plan is a Hybrid Entity.

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“Individual” has the meaning set forth in 45 CFR Section 164.103 as the person who is the subject of Protected Health Information.

“Individually Identifiable Health Information” has the meaning set forth in 45 CFR Section 160.103, and includes Health Information, including demographic information, collected from an Individual and created or received by a Health Care Provider, Health Plan, employer, or Health Care Clearinghouse that identifies the Individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual involved.

“Organized Health Care Arrangement” has the meaning set forth in 45 CFR Section 160.103 and includes:

1. A Group Health Plan (within the meaning of 45 CFR Section 160.103) and a Health Insurance Issuer or HMO with respect to such Group Health Plan, but only with respect to Protected Health Information created or received by such Health Insurance Issuer or HMO that relates to Individuals who are or who have been participants or beneficiaries in such Group Health Plan;
2. A Group Health Plan and one or more other Group Health Plans each of which are maintained by the same PEBP; or
3. The Group Health Plans described in the second bullet of this definition and Health Insurance Issuers or HMOs with respect to such Group Health Plans, but only with respect to Protected Health Information created or received by such Health Insurance Issuers or HMOs that relates to Individuals who are or have been participants or beneficiaries in any of such Group Health Plans.

“PEBP Workforce” means the Executive Director, the agency staff, and the attorneys (for claim purposes).

“Plan Administration Functions” means administrative functions performed by the PEBP on behalf of the Plan, excluding functions performed by the PEBP in connection with any other benefit or benefit Plan of the PEBP.

“Plan Sponsor” means the State of Nevada. The HIPAA regulations incorporate the ERISA definition of “Plan Sponsor,” which generally means the employer that establishes or maintains the employee benefit Plan.

“Privacy Notice” means the notice of privacy practices that sets forth the uses and disclosures of Protected Health Information by the Plan that are required or permissible under HIPAA, as more fully described in 45 CFR Section 164.520.

“Privacy Official” means the person appointed by the PEBP, or its delegate, on behalf of the Plan, who is responsible for developing and implementing policies and procedures for protecting the privacy and confidentiality of Protected Health Information that is held by or on behalf of the Plan, in accordance with 45 CFR Section 164.530.

“Privacy Rule” means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

“Protected Health Information” means Individually Identifiable Health Information that is transmitted by electronic media, maintained in electronic media, transmitted, or maintained in any other form or medium, including oral or written information. Protected Health Information excludes Individually

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Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended (within the meaning of 20 USC Section 1232g), employment records held by the Covered Entity in its role as an Employer, other records described in 20 USC Section 1232g(a)(4)(B)(iv), and information regarding a person who has been deceased for more than 50 years.

“Required by Law” means

1. A mandate contained in law that compels a Covered Entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law including, but not limited to, a court order, a court-ordered warrant, subpoena, or summons issued by a court, grand jury, a governmental inspector general, or an administrative body authorized to require the production of information;
2. A civil or an authorized investigative demand;
3. Medicare conditions of participation with respect to Health Care Providers participating in the program; and
4. Statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

“Secured Protected Health Information” means Protected Health Information to the extent that the information is protected by using an HHS-Approved Technology identified by HHS for rendering Protected Health Information unusable, unreadable, or indecipherable to unauthorized Individuals.

“Security Official” means the person appointed by the PEBP on behalf of the Plan who is responsible for the development, implementation, and maintenance of the HIPAA data security policies and procedures required for the Plan in accordance with 45 CFR Section 164.308(a)(2).

“Security Standards” means the Standards for the Security of Electronic Protected Health Information, as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C.

“Subcontractor” means a person to whom a Business Associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of the Business Associate.

“Summary Health Information” has the meaning set forth in 45 CFR Section 164.504 and includes information that summarizes the claims history, claims expenses, or types of claims experienced by Individuals for whom the PEBP has provided benefits under the Plan, and from which the following information has been removed:

1. Names;
2. Geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code (if permitted under 45 CFR Section 164.514(b)(2)(i)(B));
3. All elements of dates (except year) directly relating to the Individual(s) involved (e.g., birth date) or their medical Treatment (e.g., admission, discharge date, or date of death), all ages over 89, and all elements of dates (including years) indicative of age, except that such ages and elements may be aggregated into a single category of age 90 or older);

4. Other identifying numbers, such as Social Security, telephone, fax, account or medical record numbers, e-mail or Internet addresses, URLs, or Internal Protocol (IP) address numbers, vehicle identifiers and serial numbers;
5. Facial photographs or biometric identifiers (e.g., fingerprints or voice prints);
6. Any other unique identifying number, characteristic, or code; and
7. Any information of which the PEBP has knowledge that could be used alone or in combination with other information to identify an Individual.

“Unsecured Protected Health Information” means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized Individuals using an HHS-Approved Technology.

7.3 PROVISION OF PROTECTED HEALTH INFORMATION TO THE PEBP WORKFORCE.

Certain individuals who work for the PEBP have access to the Individually Identifiable Health Information of PEBP Participants for administrative functions. These individuals are known as the PEBP Workforce. When this Health Information is provided to the PEBP Workforce, it is Protected Health Information and, if it is transmitted by or maintained in electronic media, it is Electronic Protected Health Information. This Section 7.3 describes the circumstance under which Protected Health Information may be received, used, or disclosed by the PEBP Workforce.

Permitted Disclosure of Enrollment/Disenrollment Information. A Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose to the PEBP Workforce, information on whether an Individual is participating in the PEBP or is enrolled in or has disenrolled from a Health Insurance Issuer or HMO offered by the PEBP.

Permitted Uses and Disclosure of Summary Health Information. A Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose Summary Health Information to the PEBP Workforce, provided that the PEBP Workforce requests the Summary Health Information for the purpose of:

1. Obtaining premium bids for providing Health Insurance coverage under the PEBP; or
2. Modifying, amending, or terminating the PEBP.

Summary Health Information means information that summarizes the claims history, claims expenses, or type of claims experienced by Individuals who have received health benefits under the PEBP; and from which the names and other personal identifiers described at 45 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, a Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose Protected Health Information and Electronic Protected Health Information to the PEBP Workforce, provided that the PEBP Workforce uses or discloses the Protected Health Information and Electronic Protected Health Information only for Plan administration purposes.

Plan administration purposes means administration functions performed by the PEBP Workforce, a Health Care Component of the PEBP, or a Health Insurance Issuer or HMO with respect to the PEBP. Plan

ARTICLE 7: HIPAA PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

Administration Functions include quality assurance, claims processing, auditing, and monitoring. Enrollment and disenrollment of the participants and their covered dependents (beneficiaries) is performed by the PEBP Workforce. The PEBP Workforce also performs quality assurance, auditing and monitoring in its role as the Plan Administrator. The Plan contracts with certain Health Care Components such as third-party claims administrators and HMOs to perform claims administration, auditing, and monitoring. Plan Administration Functions do not include functions performed by the employer in connection with any other benefit or benefit plan (e.g. retirement) or any employment-related actions or decisions. Employment information held by the employer is held in its capacity as an employer and is not Protected Health Information. Enrollment and disenrollment functions performed by the PEBP Workforce are performed on behalf of Participant and beneficiaries and are not Plan Administration Functions. Employment and enrollment and disenrollment information generally is not Protected Health Information.

The PEBP Workforce or any of its Health Care Components shall not use or disclose Protected Health Information or Electronic Protected Health Information in a manner that is inconsistent with 45 CFR Section 164.504(f).

With respect to any Protected Health Information, the PEBP Workforce or any of its Health Care Components shall:

1. Not use or further disclose the Protected Health Information of a Plan Participant or their covered Dependent(s) other than as permitted or required by the PEBP or as Required by Law;
2. Ensure that any agent, including a Subcontractor, to whom it provides Protected Health Information received from the PEBP Workforce agrees to the same restrictions and conditions that apply to the PEBP Workforce or any of its Health Care Components with respect to Protected Health Information;
3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the employer;
4. Report any use or disclosure of Protected Health Information in compliance with 45 CFR Section 164.400-414 of which it becomes aware that is inconsistent with the uses or disclosures;
5. Make available Protected Health Information to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;
6. Make available Protected Health Information for amendment, and incorporate any amendments to Protected Health Information, in accordance with 45 CFR Section 164.526;
7. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
8. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
9. If feasible, return or destroy all Protected Health Information that it still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible,

limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Other Uses and Disclosures of Protected Health Information. The PEBP may disclose Protected Health Information to such other persons or entities and under such circumstances as permitted under HIPAA, HITECH, and the rules, regulations, and other guidance issued by the U.S. Department of Health and Human Services under HIPAA and HITECH.

Nondisclosure of Genetic Information for Underwriting Purposes. The PEBP shall not use or disclose Protected Health Information that is Genetic Information (within the meaning of 45 CFR Section 160.103) for underwriting purposes as defined in 45 CFR Section 164.502(a)(5)(i).

Adequate Separation. The Plan shall allow the HIPAA Privacy Official, HIPAA Security Official, the PEBP Board, the Executive Officer of the PEBP, or any person under the supervision of the Executive Officer of the PEBP who receives Protected Health Information relating to payment, Health Care Treatment, or Health Care Operations of, or other matters pertaining to, the PEBP in the ordinary course of business.

No other persons shall have access to Protected Health Information. PEBP specified employees (or classes of employees) shall only have access to and use of Protected Health Information to the extent necessary to perform the Plan Administration Functions of the Plan. If a specified employee does not comply with the provisions of this Article, the employee shall be subject to disciplinary action by the PEBP for non-compliance pursuant to the PEBP's employee discipline and termination procedures.

The PEBP shall ensure that the provisions of this Article are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic Protected Health Information on behalf of the PEBP.

Organized Health Care Arrangement. The Plan (including the Component Benefits), and the other fully insured and self-insured medical options offered or maintained by the PEBP, shall be deemed part of an Organized Health Care Arrangement, to the fullest extent permitted under the Privacy Rule.

Interpretation. The Plan and this Section shall be interpreted and administered in accordance with the Privacy Rule, any applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Privacy Rule, statute, regulation, or guidance, such Privacy Rule, statute, regulation, or guidance shall govern.

7.4 HIPAA SECURITY RULES.

PEBP Security Practices. By law, PEBP is required to:

1. Put in place administrative, physical, and technical safety measures to reasonably and appropriately protect the confidentiality, integrity, and availability of Participant personal medical information that is stored electronically, consistent with the requirements of the Security Standards;
2. Make sure there are reasonable and appropriate security measures in place to protect and separate Participant personal medical information that is stored electronically from other agencies, Employees, or Employers who do not need access to it, consistent with the requirements of the Security Standards;

ARTICLE 7: HIPAA PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

3. Make sure that any agents, including a subcontractor, or vendors who help PEBP with its operations also have in place reasonable and appropriate security measures to protect PEBP personal medical information; and
4. Report to the PEBP Security Officer any security problems or incidences resulting from unauthorized access, use or interference of systems operations in a system containing PEBP personal medical information, known by PEBP or any agent or vendor.

Interpretation. The plan and this Section shall be interpreted and administered in accordance with the Security Standards, any applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Security Standards, statute, regulation, or guidance, such Security Standards, statute, regulation, or guidance shall govern. The Plan shall adopt written policies and procedures to implement the provisions of this Section.

7.5 HIPAA BREACH NOTIFICATION STANDARDS.

PEBP shall comply with the breach of unsecured protected health information notification provisions as set forth in HITECH and addressed under Notification in the Case of Breach of Unsecured Protected Health Information at 45 CFR Part 164, Subpart D.

7.6 CERTIFICATION.

The Plan Sponsor certifies that this Article incorporates the provisions set forth in 45 CFR 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii).

7.7 AMENDMENT.

The Plan Administrator may amend the PEBP Workforce to add or remove a PEBP position, access, or access level, or to update the Privacy Official, Security Official, and HIPAA contact office information. Any such modification shall not necessitate a formal amendment to this Plan document.

ARTICLE 8: ADMINISTRATION

8.1 THE ADMINISTRATOR.

Except as to those functions reserved within the Plan or a Component Plan to PEBP, or an Insurer, the Administrator controls and manages the operation and administration of the Plan. The Administrator is PEBP or any other person or committee appointed by PEBP to administer the Plan. The Administrator or any person who is a member of a committee that is appointed to be the Administrator may or may not be a Participant in the Plan.

8.2 ADMINISTRATIVE RULES AND DETERMINATIONS.

Subject to the limitations of the Plan, the Administrator shall establish rules for the administration of the Plan and the transaction of its business. The Administrator has the exclusive right (except as to matters reserved to PEBP or an Insurer by the Plan or a Component Plan) to interpret the Plan and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Administrator or PEBP in respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator has the following powers and duties:

1. To require any person to furnish such information, including, but not limited to, the execution of any agreements, as the Administrator may request for the purpose of the proper administration of the Plan as a condition to receiving any Benefits under the Plan;
2. To make and enforce such rules and regulations and prescribe the use of such forms as the Administrator deems necessary for the efficient administration of the Plan;
3. To decide on questions concerning the Plan and the eligibility of any Participant to participate in the Plan, in accordance with the provisions of the Plan; and
4. To determine the amount of Benefits which shall be payable to any person in accordance with the provisions of the Plan, to inform PEBP of the amount of such Benefits and to provide a full and fair review to any Participant whose claim for Benefits has been denied in whole or in part.

In carrying out its duties herein, the Administrator shall have discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it, and its determinations shall be given deference and shall be final and binding on all interested parties.

Benefits under the Plan will be paid only if the Administrator decides in its discretion that the applicant is entitled to them. Because of this reservation of discretionary power to Plan fiduciaries, any judicial review of a Plan fiduciary's decision would not be made on a "de novo" basis but would be made under the deferential "arbitrary and "capricious" standard of review.

8.3 DELEGATION AND RELIANCE.

The Administrator, subject to approval of PEBP, may employ the services of such firms or persons as it may deem necessary or desirable in connection with the Plan. The Administrator may delegate any of its powers or duties to another person or persons. Without limiting the generality of the preceding sentence, the Administrator shall specifically have the power to delegate to any Insurer the power and responsibility to determine claims and benefits under any policy issued by such Insurer, and the Administrator shall be

protected in relying upon such Insurer's determinations. The Administrator and PEBP (and any person to whom the Administrator may delegate any duty or power in connection with the administration of the Plan) and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant (including Participants of PEBP who are actuaries or accountants) or legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive upon all persons.

8.4 INDEMNIFICATION AND INSURANCE.

To the extent permitted by law, neither the Administrator, nor any other person performing duties hereunder, shall incur any liability for any act done, determination made or failure to act, if in good faith, and PEBP shall indemnify the Administrator, its members and such other persons against any and all liability which is incurred as a result of the good faith performance or non-performance of their duties hereunder. Nothing in this Plan shall preclude PEBP from purchasing liability insurance to protect such persons with respect to their duties under this Plan.

8.5 COMPENSATION, EXPENSES AND BOND.

Unless otherwise agreed to by PEBP, the Administrator shall serve without compensation for its services as such, but all reasonable expenses incurred in the performance of its duties shall be paid by PEBP. Unless otherwise determined by PEBP or unless required by any federal or state law, the Administrator shall not be required to give any bond or other security in any jurisdiction.

8.6 ADMINISTRATIVE EXPENSES PAID BY EMPLOYER.

All administrative expenses incurred in connection with the Plan, including but not limited to administrative expenses and compensation and other expenses and charges of any actuary, counsel, accountant, specialist or other person who shall be employed by the Administrator in connection with the Plan, shall be paid by PEBP or from Participant contributions, as determined by PEBP.

ARTICLE 9: AMENDMENT OR TERMINATION OF PLAN

9.1 AMENDMENT.

PEBP reserves the power at any time and from time to time, and retroactively if deemed necessary or appropriate, to modify or amend, in whole or in part, any or all of the provisions of the Plan or the insurance contracts maintained to provide Benefits under the Plan. All amendments to the Plan will be in writing.

Notwithstanding the preceding, to the extent that any amendment affects the Plan's Code §125 cafeteria plan feature, the amendment will be effective no earlier than the date the written amendment is adopted by PEBP, except to the extent an earlier effective date is permitted under applicable guidance from the Internal Revenue Service or the Department of the Treasury. For any amendment that adds a new Component Plan or a new benefit under an existing Component Plan to the Plan, to the extent that the new benefit is made available under the Plan's cafeteria plan feature, the Plan will not pay or reimburse any expenses relating to that benefit, unless the expenses were incurred after the later of the amendment's adoption date or effective date.

9.2 TERMINATION.

PEBP reserves the power to discontinue or terminate the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of PEBP, the Plan shall terminate unless it is continued by a successor to PEBP.

9.3 REDUCTION OR TERMINATION OF BENEFITS.

Participants in the Plan, including future retirees and retirees who have already retired, if any, have no right to Plan Benefits after a Plan termination or a partial Plan termination affecting them, and have no right to Plan Benefits to the extent that they are eliminated or reduced by a Plan amendment, except that such Participants are entitled to Benefits with respect to covered events giving rise to Benefits and occurring before the effective date of the Plan termination or applicable Plan amendment.

9.4 EFFECTIVE DATES.

Any such amendment or termination shall be effective at such date as PEBP shall determine.

9.5 PROCEDURE.

An amendment or termination under this Article shall be valid only if it is approved by PEBP's Board of Directors at a duly called meeting at which a quorum thereof is present or by written consent of the members of PEBP's Board of Directors executed in accordance with applicable state law. Notwithstanding the preceding, the Board of Directors, in its discretion, may designate an officer of PEBP or other individual to approve an amendment or termination under this Article. If so, an amendment or termination will be valid if it is approved by the authorized designee of the Board in writing, provided the designee is operating within the scope of his or her authority in approving the amendment or termination.

ARTICLE 10: GENERAL PROVISIONS

10.1 NO EMPLOYMENT CONTRACT.

Nothing contained in this Plan shall be construed as a contract of employment between PEBP and any Participant, or as a right of any Participant to be continued in the employment of PEBP, or as a limitation of the right of PEBP to discharge any of its Participants with or without cause.

10.2 APPLICABLE LAW.

The provisions of the Plan shall be construed, administered, and enforced according to the laws of the State of Nevada. The Plan is not established under and/or subject to the federal law known as the Employee Retirement Income Security Act of 1974, as amended (ERISA).

10.3 NON-ALIENATION PROVISIONS.

No Benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No Benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order (QMCSO) which provides for Plan coverage for an Alternate Recipient the Plan's QMCSO Procedures.

10.4 PAYMENTS TO INCOMPETENTS.

If the Administrator knows that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, age or some other cause, it may cause all payments thereafter becoming due to such person to be made to the person's legal guardian for the person's benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Administrator and PEBP.

10.5 EFFECT OF MISTAKE.

In case of a mistake as to the eligibility or participation of any person in the Plan, or the allocations made to the Benefit Account of any Participant, or Benefits paid or provided for a Participant, Dependent or any other person, the Administrator may, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to the Participant or other person the credits to the account or distributions to which he or she is entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or PEBP from compensation payable by PEBP, to the extent permitted under applicable law.

10.6 INABILITY TO LOCATE RECIPIENT.

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of PEBP), such payment and all subsequent payments otherwise due to such Participant or

other person shall be forfeited 18 months after the date such payment first became due or after such period as is provided in the applicable insurance contract.

10.7 PLAN COMMUNICATIONS.

All communications in connection with the Plan made by a Participant will become effective only when duly executed on forms provided by and filed with the Administrator.

10.8 SOURCE OF BENEFITS.

PEBP (and any insurance contracts purchased or held by PEBP) shall be the sole source of Benefits under the Plan. No Participant or other person shall have any right to, or interest in, any assets of PEBP upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Participant or other person.

10.9 INTERPRETATION.

This Plan is to be interpreted so as to be consistent in all respects with the requirements of the Code and the laws of the State of Nevada.

10.10 MEDICARE, MEDICAID, AND TRICARE SECONDARY PAYER RULES.

The Plan at all times will be operated in accordance with any applicable Medicare and Medicaid secondary payer and non-discrimination rules, including, but not limited to the rules of §1144(a) of the Social Security Act. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active Participants age 65 or over, and rules concerning working disabled individuals. In addition, the Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

10.11 HEALTH CARE CONTINUATION COVERAGE RULES.

Notwithstanding any provision of the Plan to the contrary, PEBP shall provide Participants and Dependents with all health care continuation coverage rights to which they are entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any other similar, applicable state law.

10.12 HIPAA RULES.

Notwithstanding any provision of the Plan to the contrary, the Plan shall always be administered in accordance with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

10.13 STATUTE OF LIMITATIONS.

Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than 12 months after the final review decision by the Administrator has been rendered (or deemed rendered).

10.14 COORDINATION OF BENEFITS.

The coordination of benefits provisions specified in the Master Plan Document for the PEBP Consumer Driven Health Plan for Medical, Vision, and Prescription Drug benefits, as interpreted by the Administrator in its discretion, shall control coordination of benefits situations involving the Plan and other payers.

Notwithstanding any provision of this Plan to the contrary, in any case where a claimant receives benefits under a Component Plan that could have been paid in part under another plan, the Administrator has the right to seek reimbursement from that other plan.

10.15 CLAIMS SUBSTANTIATION REQUIREMENT.

All claims for Benefits offered through the Plan's Code §125 cafeteria plan feature must be substantiated by information provided by an independent third party in accordance with applicable regulations before benefits may be paid. However, the Plan is not responsible for substantiating claims for reimbursement from a Participant's Health Savings Account.

10.16 MENTAL HEALTH PARITY.

Notwithstanding any provision of the Plan to the contrary, mental health and substance abuse benefits provided under any Component Plan will comply in all respects with all applicable requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

10.17 GINA.

Notwithstanding any provision of the Plan to the contrary, the Plan, including all Component Plans, will comply with the applicable requirements of the Genetic Information Nondiscrimination Act of 2008.

10.18 HEALTH CARE REFORM.

Notwithstanding any provision of the Plan to the contrary, the Plan, including all Component Plans, will comply with any applicable requirement of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 beginning on the applicable effective date.

10.19 RESCISSION OF COVERAGE.

Notwithstanding any provision of the Plan to the contrary, the Plan may rescind coverage under any Component Plan for any individual (or a Participant or Dependent covered under the same coverage as that individual) who engages in fraud with respect to the Plan, or who makes an intentional misrepresentation of material fact. Except as otherwise prohibited by law, the Plan may rescind coverage under a Component Plan for other reasons in accordance with the terms of the applicable Component Plan.

The Plan will not rescind coverage under any Component Plan that is subject to PPACA, for any individual covered under that Component Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In cases where rescission is permitted, the Plan will provide at least thirty days advance written notice to each Participant or Dependent who would be affected before coverage will be rescinded under this Section. This paragraph is included in the Plan to comply with the requirements of PPACA and applicable regulations, including Treasury Regulations §54.9815-2712T (and any subsequent regulations that amend or replace those regulations) and shall be interpreted to be consistent with such regulations and to permit rescissions to the extent permitted under those regulations.

For purposes of this Section, a rescission is a cancellation or discontinuance of coverage under a Component Plan that has retroactive effect. A cancellation or discontinuance of coverage is not a

rescission if (i) it is effective retroactively only to the extent it is attributable to a failure to timely pay required Participant contributions towards the cost of coverage or (ii) the Administrator determines the Plan is not required by law to treat the retroactive termination as a rescission under applicable law.

ARTICLE 11: PREMIUM ASSISTANCE

UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB

under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)