State of Nevada
Public Employees' Benefits Program

Biennial Compliance Review

November 2026

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Segal

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Section 1. Introduction

NRS 287.0425(2)(b) requires an independent biennial review of Public Employees' Benefits Program (PEBP) to determine whether the Program complies with federal and state laws relating to taxes and employee benefits. At the request of the Public Employees' Benefits Program (PEBP), Segal performed a review of certain plan documents and administration processes provided by PEBP to enable PEBP to comply with applicable federal and state laws. Segal worked with PEBP to confirm the scope of review and identify the applicable State statutes subject to review.

Our compliance review is based on documents received, statutes, and regulations as existing and in effect for PEBP's July 1, 2026 – June 30, 2027, plan year (PY 2027). We requested from PEBP staff members certain documents and answers to specific questions relevant to PEBP. We did not attempt to verify actual administration of PEBP through sampling techniques, discussions with third party vendors/administrators, or otherwise. In addition, we did not perform any claim audits related to PEBP, or consider issues related to payroll practices, workers' compensation, unemployment compensation, classification of employees, or other non-benefits-related aspects of any federal or state law.

Although we identified certain compliance issues relating to PEBP, our report should not be relied upon to identify all possible weaknesses in internal controls, errors, irregularities, or illegal acts, or to identify all possible violations of the Nevada Revised Statutes (NRS), Nevada Administrative Code (NAC), the Internal Revenue Code (the Code), Public Health Service Act (PHSA), the Employee Retirement Income Security Act of 1974 as amended (ERISA) (in relevant part as made applicable through the PHSA), Internal Revenue Service (IRS), regulations, or other technical pronouncements as we did not perform a transactional operational compliance review of PEBP. We interpreted compliance requirements in a manner we believe to be reasonable. However, we cannot guarantee that government agencies, courts, or participants will agree with our interpretation, or that PEBP would be in compliance with all applicable laws, regulations, rules, or other governmental pronouncements if PEBP implemented all of our recommendations.

This report outlines the results of Segal's review and summarizes our findings and recommendations to address certain document compliance issues that we have identified as a result of our compliance review. Any consulting advice we provide is intended to assist PEBP in determining how best to comply with applicable requirements relating to PEBP's compliance with federal and state laws. Nevertheless, Segal does not engage in the practice of law, and the consulting advice we provide is not, and is not intended to be, legal advice. Accordingly, this report should be reviewed with PEBP's legal counsel.

Section 2. Summary of Findings

The following highlights key findings. Please reference Section 3 and Section 4 for detailed information about federal and state requirements, PEBP's coverage and processes, and recommended actions. Our recommendations in the report consider interactions between state and federal regulations, new or ongoing federal guidance and updated Nevada statutes.

For ease of reference, we use the following acronyms in the report: CDHP for the Consumer Driven Health Plan, LD PPO for the Low-Deductible PPO Plan, and EPO for the Exclusive Provider Organization Plan.

Federal findings

Consistency in description of benefits

During review, certain language inconsistencies between plan documents, as well as between Master Plan Documents (MPDs) and Summary of Benefits and Coverage (SBCs) were identified. PEBP should review its vision benefit schedule of benefits and physician references throughout the documents and clarify and/or update these sections, as necessary. We have provided clarifications regarding coverage of vision benefits and the exclusion of maternity benefits for dependent daughters.

Notices

Segal reviewed PEBP's compliance with federal notices required by the ACA, COBRA, HIPAA, No Surprises Act, and other federal regulations. Based on the review of plan documents and responses, Segal identified notices that PEBP should revise in order to comply with best practices. PEBP should continue the practice of distributing a new hire packet with mandatory notices in addition to annual distribution of notices.

Children's Health Insurance Program Reauthorization Act (CHIPRA) notice

CHIPRA statutory obligations apply to all group health plans regardless of ERISA exemption, and the DOL model provides a safe harbor of accurate state listings with specific contacts. DOL updated the CHIPRA notice in July 2026. PEBP should revise its CHIPRA notice using the most current DOL model.

Qualified Medical Child Support notice

PEBP describes the Qualified Medical Child Support Order (QMCSO) in its MPDs. PEBP should consider amending language in the MPDs to clarify that a copy of the QMCSO procedures is provided free of charge upon request.

Disease management programs

PEBP offers disease management programs, including the Obesity Care Management (OCM) program, the Diabetes Care Management (DCM) Program, and Real Appeal, that are voluntary and provide additional benefits to individuals with certain health conditions or risks. We recommend PEBP to verify that to any extent the programs overlap with the EEOC, HIPAA nondiscrimination or wellness program rules and/or the Genetic Information Nondiscrimination Act, the employers and service providers issue the required authorization and notices, to the extent applicable.

Clinical trials

Under the Affordable Care Act, non-grandfathered plans must cover routine patient costs for items and services furnished in connection with participation in an approved clinical trial for cancer or other life-threatening conditions.

MPDs for CDHP, LD PPO, and EPO state “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.” While this language is consistent with the relevant Nevada statute, it omits the federal requirement for non-grandfathered plans to cover routine costs for items and services in an approved clinical trial for life-threatening conditions. We recommend clarifying that clinical trials for life-threatening conditions are covered as required under the ACA.

Plan document language on HIPAA special enrollment rights

PEBP’s Enrollment and Eligibility MPD states under special enrollment due to birth, adoption, or placement for adoption of a child that while coverage for the child is effective on the date of the event (birth, adoption, or placement for adoption), "coverage for other dependents are effective on the first of the month concurrent with or following notification.”

While PEBP has confirmed that administratively, coverage for anyone special enrolling due to birth, adoption, or placement for adoption takes effect as of the date of the event, we recommend that the MPD language be revised for consistency with its administrative practice and for compliance with federal HIPAA special enrollment rules which require coverage to be retroactive to the date of birth for the employee, spouse and new dependent. Additionally, PEBP should consider clarifying in the MPDs that members are allowed to change plan options during a HIPAA special enrollment event.

Training materials regarding HIPAA privacy protections

On April 22, 2024, the Department of Health and Human Services (HHS) issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare and substance use disorder records. While the reproductive health information portion of the 2024 final rules related to protection of PHI was invalidated, the final rule’s new HIPAA privacy notice requirements related to substance use disorder (SUD) patient records remain intact. These protections are noted in

PEBP's current HIPAA privacy notice; however, they do not seem to be discussed in its HIPAA training materials. PEBP should review its HIPAA privacy training materials and update provisions to include protection of substance use disorder patient records.

Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

Federal mental health parity rules and guidance related to compliance with these rules continue to evolve. In September 2026, the Departments of HHS, the Treasury, and DOL issued a MHPAEA guidance tool for plan sponsors with operational red flags and best practices for MHPAEA compliance. An example focused on age limits for autism spectrum disorder treatments.

MPDs for CDHP, LD PPO, and EPO state that autism treatment is covered until age 22. While this age restriction seems to comply with the Nevada statute, this restriction poses a compliance risk under federal MHPAEA regulations. PEBP should consider removing the age limit considering the most recent federal guidance for the federal mental health parity rules. PEBP should also review the September 2026 guidance and best practices for monitoring operational compliance with federal rules.

HIPAA nondiscrimination

Under the federal HIPAA nondiscrimination rules, a health plan cannot use an "illegal acts" exclusion to deny a claim if the injury resulted from a physical or mental health condition or domestic violence. In addition, Nevada statute NRS 695G.405 prohibits health plans from denying coverage solely because insured was intoxicated or under the influence of controlled substance.

The MPDs, under Benefits Limitations and Exclusions, contain a coverage exclusion related to illegal acts, stating that "injuries sustained during the course/because of committing illegal acts is not covered." PEBP should consider revising this language in the MPDs for consistency with HIPAA nondiscrimination rules and NRS 695G.405.

Pre-existing condition exclusion

The CDHP, LD PPO, and EPO MPDs state that the Plan covers injury to sound and natural teeth under the medical plan to a maximum of two (2) years following the date of injury. This appears to be a hidden pre-existing condition exclusion as coverage would be denied on teeth that have had previous work done (such as fillings or crowns). PEBP should consider removing the reference to "sound and natural" teeth and instead state "injury to teeth." We also recommend adding language to clarify that this plan provision is applied without respect to when the individual is enrolled in the plan.

The No Surprises Act (NSA)

The No Surprises Act protects patients from balance billing if they receive Emergency Services at a Hospital or at an Independent Freestanding Emergency Department, or if they use air ambulance services. The Act also protects patients who receive certain non-emergency services from an out-of-network provider at an in-network facility, limiting patients' responsibility to an in-network rate. In

addition, the *No Surprises Act* has some other patient protection provisions concerning continuity of care, provider directories, and access to external review for denials related to surprise billing protections.

MPDs for CDHP, LD PPO, and EPO state that all inter-facility air ambulance transport services require prior authorization. This requirement conflicts with the No Surprises Act if it is applied to an emergency inter-facility transfer. We suggest clarifying in the MPDs that prior authorization does not apply to emergency inter-facility air ambulance transfers. Additionally, PEBP should include language in the CDHP MPD about No Surprises Act protection for continuing care patients when the Plan terminates its PPO contract with a Network Provider or Network Facility or Hospital.

Claims and appeals procedures

PEBP has indicated that healthcare claims, including disability-related claim are administered according to the PEBP MPDs and Nevada state regulations, with UnitedHealthcare serving as the third-party administrator. PEBP should consider stating in the MPDs that the claims and appeals procedures for post-service claims discussed in the MPDs also apply to disability-related claims and identify any differences in the claims and appeals procedures for disability-related claims.

PEBP should also consider clarifying in the MPDs how expedited reviews are processed. Segal provided suggested language for clarifications in the MPDs.

Flexible spending accounts (FSAs)

Segal suggests minor revisions to clarify eligibility for the dependent care FSA, payments to related persons, and the use of debit cards.

State findings

NRS 287.04335 directs that compliance with certain provisions in NRS and NAC is required to provide health insurance through a plan of self-insurance. Segal worked with PEBP to confirm the scope of review and identify the applicable State statutes subject to review. NRS 287.04335 was amended in the 2025 Nevada Legislature and made several changes applicable to PEBP.

PEBP should review the benefit requirements and new updates and make updates to the Master Plan Documents (MPDs) as necessary. PEBP should also confirm with UMR that it is administering the benefits according to the amendments made to NRS 287.04335. The following statutes were identified as areas PEBP may wish to clarify.

Telehealth

NRS 695G.162 requires plans to cover telehealth services to the same extent as though provided in person and by other means. Additionally, the statute allows for counseling or treatment relating to a mental health condition or a substance use disorder when such counseling or treatment is provided through audio-only interaction.

The MPDs indicate that telemedicine only involves audio-visual (video) communication technology and does not include communication through telephone, facsimile, or email. PEBP should clarify in MPDs that audio-only (telephone) interactions involving counseling and treatment of mental health or substance use disorder conditions are covered under telemedicine services in compliance with NRS 695G.162(2)(b).

Plan document language clarification regarding coverage for prevention, testing, and treatment of human immunodeficiency virus and hepatitis C

NRS 695G.1705 mandates coverage for laboratory testing that is necessary for therapy that uses a drug to prevent the acquisition of human immunodeficiency virus (HIV) and any service to test for, prevent, or treat HIV or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist. The MPDs state that the Plan provide coverage for testing for HIV and hepatitis C and coverage for hepatitis C drugs. PEBP should clarify coverage for drugs used for prevention and treatment of HIV, including all medications approved by the U.S. FDA.

Plan document language clarification regarding coverage for testing, treatment, and prevention of sexually transmitted diseases

NRS 695G.1714 mandates that plans provide coverage for examination of a pregnant person for certain diseases, including sexually transmitted diseases. Additionally, NRS 695G.1707 mandates that plans include coverage for testing for, treatment of and prevention of sexually transmitted diseases. The statute also mandates unrestricted coverage of condoms for insureds who are 13 years of age or older.

The MPDs state that the Plans provide coverage for screening and testing of sexually transmitted diseases and ACA mandated preventive care services. The Nevada statutes related to screening and testing appear to mandate coverage above what the ACA preventive services mandate and do not contain any age limitations.

PEBP should consider clarifying in the MPDs that all coverage mandated by NRS 695G.1707 and NRS 695G.1714 is included. This clarification should note that coverage is provided for testing of diseases referenced in NRS 695G.1714 as part of maternity coverage, without requiring prior authorization and without age restrictions. Additionally, PEBP should refer to comments in the MPDs to clarify coverage of female condoms in coordination with federal preventive services rules.

Coverage of certain prescription drugs

Substance use and opioid disorder drugs:

NRS 695G.1719 requires that plans include in the plan coverage for: (a) All drugs approved by the United States Food and Drug Administration to support safe withdrawal from substance use disorder, including, without limitation, lofexidine. (b) 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. The statute further requires that these drugs are not subjected to medication management techniques, other than step therapy. PEBP should consider clarifying in the MPDs that the Plan provides benefits for substance use disorder for all drugs approved by FDA to support safe withdrawal from substance use disorder, including, without limitation, lofexidine. PEBP should clarify that the Plan does not subject these benefits to medical management techniques, other than step therapy.

Step therapy cancer protocols:

NRS 695G.1675 require health plans that provide coverage of a prescription drug for the treatment of cancer or any symptom of cancer that is part of a step therapy protocol to allow an insured who has been diagnosed with stage 3 or 4 cancer to apply for an exemption from the step therapy protocol. PEBP should consider clarifying step therapy exemption procedures in the MPDs, consistent with NRS 695G.1675.

Emergency prescription coverage during an emergency or disaster declaration:

NRS 695G.1635 mandates emergency prescription coverage during an emergency or disaster declaration. PEBP should consider adding language in the MPDs to explain the procedure to obtain emergency prescription coverage during emergency or disaster declaration, and any geographic limitations to this benefit.

Prescription drugs irregularly dispensed for synchronization of chronic medications:

NRS 695G.1665 requires health plans and insurers to cover and pay for an irregular or less-than-30-day supply of a medication if a doctor or pharmacist determines it is necessary to synchronize the patient's refills for chronic medications otherwise approved for coverage. Additionally, unless stated otherwise in a contract, the health plan is prohibited from prorating the pharmacy's dispensing fees for handling these synchronized partial refills. PEBP should consider adding language in the MPDs concerning coverage of irregularly dispensed prescription drugs for the synchronization of chronic medications in compliance with NRS 695G.1665. Additionally, unless it is stated otherwise in its network contract, PEBP should confirm that pharmacy dispensing fees are not prorated for handling synchronized partial refills.

Early refills of topical ophthalmic products:

NRS 695G.172 prohibits denial of coverage for early refill of topical ophthalmic medications covered under the Plan's formulary. PEBP should consider explicitly including these early refill provisions for topical ophthalmic products in the MPDs.

Section 3. Federal Findings in Detail

IRS requirements

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Form W-2	Employers must report the cost of health coverage and Dependent Care Assistance Program and Health Flexible Spending Arrangement (FSA) benefits on an annual Form W-2, along with other information.	PEBP's Eligibility and Enrollment vendor TELUS Health/Lifeworks sends the necessary data for reporting on individual employee W-2s to the applicable state employers. PEBP has stated that neither PEBP nor Central Payroll have any concerns. No concerns noted during review.	No action required.

Patient Protection and Affordable Care Act (ACA) requirements

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Summary of Benefits and Coverage	Plans must provide a Summary of Benefits and Coverage (SBC) that accurately summarize key features of the plan, such as covered benefits, cost-sharing provisions and coverage limitations.	PY2027 SBCs provided: • PY2027 CDHP SBC Employee Family • PY2027 EPO SBC Individual Family • PY2027 LD PPO SBC Employee Family SBCs are posted on the PEBP website. SBCs are referenced in the annual Benefits Guide with a statement that the SBCs "are available by logging on to your E-PEBP Portal at www.pebp.state.nv.us or by calling PEBP and requesting a copy be mailed to you." No concerns with PEBP's distribution of SBCs were noted.	Recommended Action: Clarifications are provided regarding the consistency between the SBCs and the MPDs regarding coverage of vision benefits and excluding maternity benefits for dependent daughters.
Patient-Centered Outcomes Research Institute (PCORI) Fee	Plans and insurers pay fees to fund PCORI, which funds evidence-based research projects with the goal to advance quality of care. Fee is filed with IRS on Form 720. Payment is due 7/31 of calendar year immediately following last day of plan year to which fees apply. Applies through plan years ending before 10/01/29.	PEBP states it has paid its PCORI fee for 2025-2026 in July 2026. PEBP is in compliance with the PCORI fee.	No action required.
Coverage for children up to age 26	Health plans that provide coverage of dependent children must make coverage available for adult children up to age 26, regardless of the child's student or marital status. Coverage must be provided through the end of the month in which the child turns	Per the Eligibility MPD, Dependent children are covered through the end of the month in which they turn 26. With respect to coverage beyond the required children, foster	Recommended Action: As student status may be requested for dependent children under legal guardianship, PEBP should consider updating the Eligibility MPD to include Michelle's law continuation.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	26 to meet employer penalty rules. The age 26 mandate requirements do not apply to children who are outside the scope of the definition in Internal Revenue Code section 152(f)(1).	children are not eligible for dependent coverage. Unmarried children under age 19 who are under a legal permanent guardianship may be enrolled as a dependent. 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 certain conditions 1. 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 2. Dependent is a grandchild, brother, sister, stepbrother, step-sister, or descendent of such relative. 3. Children covered under legal guardianship are not eligible to continue benefits under the provision of a disabled dependent. No concerns noted with PEBP's coverage of dependent children.	
90-Day Waiting Period Rule	Plans must cover employees within 90 days of the date on which an employee is otherwise eligible.	Eligibility MPD states new hire employees are eligible for coverage on the first day of the month concurrent with or following the date of hire. PEBP is in compliance with the 90-day waiting period rule.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
No Rescission	Plans may not rescind coverage retroactively (with limited exceptions).	MPD discusses no retroactive rescission with limited exceptions. No concerns noted.	No action required.
Preexisting Condition Exclusions	Plans may not have preexisting condition exclusions or limitations. Hidden pre-existing conditions are also prohibited.	The Health & Welfare Wrap MPD states that PPACA group market (insurance) reforms that apply to all 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, including prohibition of preexisting condition exclusions under PHSA 2704. The CDHP, LD PPO, and EPO MPDs state that the Plan covers injury to sound and natural teeth under the medical plan to a maximum of two (2) years following the date of injury. This appears to be a hidden pre-existing condition exclusion.	Recommended Action: Consider removing the reference to “sound and natural” teeth and just state “injury to teeth.” We also recommend adding language to the 2 years following the date of injury to state “applied without respect to when the individual is enrolled in the plan.”
No annual or lifetime dollar limits on Essential Health Benefits (EHBs)	Plans may not impose an annual or lifetime dollar limitation on EHBs. Plans may adopt a benchmark that excludes a benefit from EHB and have dollar limit on those benefits. One of the EHBs categories include pediatric vision services.	It does not appear that the PEBP plan imposes annual or lifetime dollar limitations on EHBs in the medical plan.	No action required.
Preventive Care	Non-grandfathered group health plans must provide certain specified preventive health services without cost sharing.	Per the MPD: “Preventive Care/Wellness Benefits are covered 100% in-network not subject to the deductible.”	Recommended Action: Clarifications are noted in the MPDs.
Cost-Sharing Rules Out-of-Pocket Maximums	Non-grandfathered plans must have limits on out-of-pocket cost sharing. The cost sharing limits only apply to a plan's essential health benefits (EHB). 2027 limits:	Per the SBCs: • 2026-2027 OOP maximums: • Low PPO - $5,000/$10,000 (in-network)	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	$12,000 for an individual plan and $24,000 for a family plan before marketplace subsidies.	• EPO - $4,000/$8,000 (in-network) • CDHP - $5,000/$10,000 (in-network)	
Clinical Trials	Non-grandfathered plans must cover routine patient costs for items and services furnished in connection with participation in an approved clinical trial for cancer or other life-threatening conditions.	The Active Health and Welfare Wrap MPD has reference to clinical trials under PHSA 2709 in the Compliance with Federal Group Health Plan Benefits and Coverage Mandates section. Additionally, per the MPD: "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 MPD sets out preauthorization requirements for clinical trials and defines approved clinical trials.	Recommended Action: Consider clarifying that clinical trials for life-threatening conditions are covered as required under the ACA.
Provider Nondiscrimination	Plans cannot discriminate against a health care provider acting within the scope of his or her license.	The Active Health and Welfare Wrap MPD has reference to provider non-discrimination under PHSA 2706 in the Compliance with Federal Group Health Plan Benefits and Coverage Mandates section. The CDHP, LD PPO, and EPO MPDs refer to specific providers rather than licensed providers who are practicing within the scope of their license. ACA nondiscrimination rules allow services to be performed by a licensed provider who is practicing within the scope of their license.	Recommended Action: Segal provided suggested language as comments within the MPDs.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Excepted Benefits	Excepted benefits are exempt from numerous provisions in the Affordable Care Act (ACA), including its market reforms (e.g., restrictions on annual limits, age 26 rule, first-dollar preventive care), the research effectiveness (PCORI) fee, the requirement to provide a Uniform Summary of Benefits and Coverage (SBC), and the requirement to report the cost of the benefits on the employee's W-2. Additionally, excepted benefits are exempt from the HIPAA portability rules.	Dental and Vision coverage appear to be excepted benefits.	No action required.
Employer Shared Responsibility Penalty I.R.C. Sections 4980H(a) and 4980H(b).	Employer is responsible for counting hours and determining who is a full-time employee eligible for coverage. Medical coverage offered must meet the minimum value standard and be affordable (monthly contribution amount for employee-only coverage in the lowest cost plan is below Federal Poverty Line) Employers classified as applicable large employers (ALEs) —generally those with 50 or more full-time employees and full-time equivalent employees— may face excise tax penalties if they do not offer health coverage or do not offer coverage that meets certain minimum value and affordability standards.	Employees working 80 hours a month (NAC 287.150) or an average of at least 130 hours per month as defined by the IRS are defined as full-time. The employers may have received the Employer Shared Responsibility Payment notice from the IRS. No concerns identified.	No action required.
Minimum Value	Coverage must meet minimum value standard (60 percent).	SBCs state the plans meet minimum value.	No action required.
Affordability	Employer-offered coverage is considered affordable for an employee if the employee's	PEBP uses the state of Nevada minimum wage for affordability. (Rate of Pay).	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	required premium contribution (if any) is no more than 9.5% of that employee's household income (indexed annually) (9.02% for 2025, and 9.96% for 2026). For this test, look at the employee's cost of enrolling in the least expensive self-only coverage offered by the employer that provides minimum value, even if the employee elects more expensive coverage or coverage that does not provide minimum value. For the rate of pay safe harbor, for an hourly employee, the employer uses an assumed rate of 130 hours per calendar month multiplied by an hourly employee's rate of pay, regardless of whether the employee actually works more or less than 130 hours during a calendar month. An offer of coverage to a non-hourly employee is treated as affordable for a calendar month if the employee's required contribution for the calendar month for the lowest-cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed) of the employee's monthly salary, as of the first day of the coverage period (instead of 130 multiplied by the hourly rate of pay); provided that if the monthly salary is reduced, including due to a reduction in work hours, the safe harbor is not available.	Nevada minimum wage: $12.00 regardless of whether employer provides qualifying health coverage $12.00 x 130 hours = 1,560 $1,560 x 9.96% = $155.38 The lowest cost employee only contributions per month is $55.26 for the CDHP plan. PEBP meets the affordability standard.	

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Form 1095-B and Form 1094-B	Group health plans as well as employers that are not large employers, that offer self-insured minimum essential coverage must provide participants with Form 1095-B, documenting enrollment in plan coverage, and file all such forms with IRS (along with Form 1094-B transmittal). Forms for the previous reporting year are generally due to participants by 3/1 and filed with IRS by 3/31 if filed electronically (by 2/28 for paper filing). Employers filing more than 250 reporting forms are required to file electronically. Employers can use IRS Form 8809 for an automatic 30-day extension.	PEBP works with its Benefit Administration System vendor, Telus Health, to send the data to extract to SOVOS to file with the IRS and generate applicable forms per members' request. No concerns reported.	No action required.
Form 1095-C and Form 1094-C	Large employers (50 or more full-time employees, including equivalents), must provide full-time employees with Form 1095-C, documenting offer of coverage, and file all such forms with IRS (along with Form 1094-C transmittal). Forms for the previous reporting year are generally due to employees by 3/1 and filed with IRS by 3/31 if filed electronically (or 2/28 for paper filing). Employers filing more than 250 reporting forms are required to file electronically. Employers use IRS Form 8809 for an automatic 30-day extension of time.	PEBP works with its Benefit Administration System vendor, Telus Health, to send the data to extract to SOVOS to file with the IRS and generate applicable forms per members' request. No concerns reported.	No action required.
Notice of Choice of Providers (Patient Protection)	Group health plans that require a designation of a primary care provider (PCP) must provide the	The Plan does not require a designation of a primary care physician.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	following disclosure: notice of the right to choose a PCP, pediatrician, or ob/gyn in SPD or other descriptions of benefits. Effective for plan years beginning on and after January 1, 2022, the No Surprises Act recodified the patient protections regarding choice of health care professional and extended to grandfathered health plans.		
Notice of Coverage Options in the ACA Marketplace	Employer subject to the Fair Labor Standards Act required to provide new employees within 14 days of hire with notice about health insurance marketplaces, their options for health coverage, and information about premium tax credits, regardless of the employee's plan enrollment status or of part-time or full-time status. Note – this is an employer requirement, not a health plan requirement.	This is an employer requirement, however PEBP does include this notice on its website.	No action required.
Notice of Grandfathered Status	A grandfathered plan must include a statement to that effect in any and all materials describing benefits under the plan.	The plan is not grandfathered.	Not applicable.
Notice of Rescission	Advance written notice of retroactive termination of coverage due to fraud or intentional misrepresentation of material facts by participant must be provided to the participant at least 30 days before coverage may be retroactively terminated.	The MPD defines rescission, and the Plan has not rescinded coverage retroactively.	No action required.
Section 1557 Notice (or Statement) of Nondiscrimination with Taglines	ACA §1557 prohibits discrimination on the basis of race, color, national origin, disability, age, and sex in health	This requirement is no longer mandated under the 2024 final	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	plans that receive federal financial assistance or are administered by HHS such as Medicare Part D. Covered entities must provide participants/beneficiaries with a notice conveying information about §1557 nondiscrimination requirements in significant publications, communications, websites, and physical locations.	rules. PEBP is not required but may choose to include this notice.	

COBRA

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Initial or General Rights Notice	Provides basic information regarding COBRA and the rights and responsibilities of qualified beneficiaries to ensure they have the information they need before the occurrence of a qualifying event.	General notice provided. Notice is mailed to all new enrollees by eligibility unit.	No action required.
COBRA Continuation Coverage Election Notice	Plans must send notices to qualified beneficiaries after a qualifying event. Employers have to alert the COBRA administrator within 30 days of terminating a worker. Once the COBRA administrator is notified, it has 14 days to send a notice to qualified beneficiary(ies). However, if the employer administers COBRA, the deadline to send the notice is 14 days.	Election notice provided.	No action required.
Notice of Unavailability of COBRA	Individuals who have sent the plan a qualifying event notice must be notified about why COBRA is not available. The notice must be provided within 14 days after the plan administrator is notified of the qualifying event.	Notice of Unavailability provided. PEBP stated it provides this notice as required.	No action required.
Notice of Termination of COBRA	Qualified beneficiaries must be notified about early termination of COBRA. The notice is required as soon as practicable after the plan's determination that COBRA can be terminated prior to the applicable 18-, 36-, or 29-month period.	Notice of Termination example provided. PEBP states it provides this notice as required.	No action required.
Notice of Insufficient Payment of COBRA Premium	Qualified beneficiaries must be notified that a COBRA payment was less than the correct amount	Notice of Late payment provided. PEBP states it provides this notice as required.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	required before terminating COBRA. Plan must provide a reasonable period to cure the deficiency before terminating COBRA. A 30-day grace period is considered to be a reasonable period.	A premium payment shortfall is insignificant if it is less than or equal to the lesser of (a) $50; or (b) 10% of the COBRA premium required by the plan. Payment of such an amount will be deemed to satisfy the COBRA payment requirement unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency.	

Health Insurance Portability and Accountability Act (HIPAA)

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
HIPAA Notice of Special Enrollment Rights	HIPAA requires group health plans to provide notice of special enrollment opportunities outside of the plans' regular enrollment periods in the following situations: • A loss of eligibility for other health coverage. • Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) • The acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption; and • Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP. Notice must be provided on or before the date the participant is offered the opportunity to enroll in the plan.	Provided in Enrollment and Eligibility MPD under HIPAA Special Enrollment Notice and within Annual Notices. The Annual Notices were emailed to all Active and Retired PEBP members July 2026.	No action required.
HIPAA Prohibition Against Discrimination on account of Health Factor	HIPAA also prohibits discrimination against employees and their dependents based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information. Cannot be denied eligibility or ongoing eligibility to enroll in the plan because of a health factor; Cannot be charged a greater amount for coverage than an individual in a similar situation on account of any health factor.	Active Health and Welfare Wrap MPD states PPACA group market (insurance) reforms that apply to all 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 including: • Prohibiting discrimination against Participants and beneficiaries based on a health factor under PHSA 2705.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Wellness Incentives	Plans that provide wellness incentives must meet 5-factor test, including 30 percent test and reasonable accommodations standards.	PEBP offers disease management programs that are voluntary and provide additional benefits to individuals with certain health conditions or risks.	Recommended Action: Segal recommends PEBP to verify that to any extent the programs overlap with the EEOC, HIPAA nondiscrimination or wellness program rules and/or the Genetic Information Nondiscrimination Act, the employers and service providers issue the required authorization and notices.
Plan Sponsor Certification of Group Health Plan HIPAA Compliance	HIPAA requires plan sponsor to certify understanding of and compliance with certain HIPAA requirements before the plan may disclose PHI to the plan sponsor or its authorized representatives.	Section 7 of the Section 125 H&W Benefits Plan Document. HIPAA Privacy and Security of Protected Health Information. "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)."	No action required.
HIPAA Notice of Privacy Practices (NPP)	A notice to participants describing their rights, plan's legal duties with respect to Protected Health Information (PHI) and the plan's uses and disclosures of PHI must be included on the plan's website and provided upon enrollment. In general, any material revision to the notice must be provided within 60 days of the revisions. If a plan posts the revision on its website by the revision's effective date, then individual notices can be sent at the time of the next annual mailing. The notice must also be provided upon request. The Department of Health and Human Services (HHS) issued a	The Privacy Notice – Disclosure and Access to Medical Information is located on the PEBP website (Mandatory Notices (state.nv.us) The Privacy notice was last updated July 2026. PEBP confirmed that the privacy notice is provided upon enrollment.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	final rule in 2024 that strengthens privacy protections for Protected Health Information (PHI) related to substance use disorder records. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes.		
HIPAA Notice of Privacy Practices Reminder	Covered individuals must be notified at least once every three years of the availability of the NPP. Not required if the NPP is provided annually.	The Privacy Notice – Disclosure and Access to Medical Information is located on the PEBP website (Mandatory Notices (state.nv.us). The reminder notice is included in the Annual Notices emailed to all Active and Retired PEBP members July 2026.	No action required.
HIPAA Privacy Policy and Procedures	A covered entity must develop and implement written privacy policies and procedures that are consistent with the HIPAA Privacy Rule. In 2024, the Department of Health and Human Services (HHS) issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to substance use disorder patient records. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes.	Privacy and Security of Protected Health Information (PHI) policy – updated 08/10/2021 The HIPAA privacy notice on PEBP's website includes a discussion of requirements related to confidentiality of substance use disorder patient records.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
HIPAA Security Policy and Procedures	A covered entity must adopt reasonable and appropriate policies and procedures to comply with the provisions of the Security Rule.	Privacy and Security of Protected Health Information (PHI) policy – updated 08/10/2021.	No action required.
HIPAA Security Risk Analysis	HIPAA Security Rule requires covered entities to perform risk analysis as part of their security management processes, risk analysis should be an ongoing process, in which a covered entity regularly reviews its records to track access to e-PHI and detect security incidents, periodically evaluates the effectiveness of security measures put in place, and regularly reevaluates potential risks to e-PHI.	PEBP has conducted a security risk assessment through the use of the Security Risk Assessment Tool as provided through healthit.gov on September 11, 2024.	Recommended Action: PEBP should consider supplementing this assessment with an additional review addressing issues such as how information is identified as PHI, when PHI is encrypted or destroyed for purposes of rendering it secure under the HITECH Act, and providing details about items such as reporting events, training, and how the plan assures business associate contracts are in place.
HIPAA Training	A covered entity must train all workforce members on its privacy and security policies and procedures, including the new rules regarding substance use disorder records.	HIPAA Privacy and Data Security Training – conducted annually. PEBP keeps attestation of trainings on file.	Recommended Action: PEBP should review HIPAA training materials and update provisions to include protection of substance use disorder patient records.
Breach of Unsecured PHI	Plan must file notice with HHS (and prominent media outlets) within 60 days of discovery if the breach affects 500 or more individuals. Plan must file annually with HHS if the breach affects fewer than 500 individuals, no later than 60 days after the end of calendar year.	Privacy and Security of Protected Health Information (PHI) policy – updated 8/10/2021. PEBP confirmed no breaches of PHI within this review period.	No action required.
Business Associate Agreements (BAA)	A BAA is a required agreement between the covered entity (i.e., the plan) and a vendor, TPA, or individual that performs functions or activities on behalf of, or	PEBP should continue to inventory current BAAs.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	provides a service to, the plan that involves access to Protected Health Information (PHI) under the plan.		

Medicare

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Medicare Part D Notices	Participants and beneficiaries eligible for Part D must be notified in writing, prior to the beginning of the annual Medicare's open enrollment period which occurs on October 15 through December 7 of each year, whether a plan's prescription drug coverage is, on average, at least as good as standard coverage under Medicare Part D.	PEBP mailed and emailed the Medicare Part D notices July and August 2026.	No action required.
Creditable Coverage Disclosure to CMS	Provide written disclosure to CMS stating whether the plan's prescription drug coverage is, on average, at least as good as standard Medicare Part D coverage is due 60 days after beginning of the plan year (generally March 1 for a calendar year plan). Plan must also provide within 30 days of the plan's termination of drug coverage or change in creditable status of the plan. No penalty.	PEBP submits on CMS website every year. PEBP confirmed submission for PY 2026 and PY 2027.	No action required.
Retiree Drug Subsidy Application	RDS application (along with retiree list and attestation) is due at least 90 days prior to the start of the plan year (typically October 3 for a calendar year plan, unless extended for 30 days until November 2). Reconciliation must be completed within 15 months after the end of the applicable plan year, unless 30-day extension.	The RDS is performed annually by PEBP. Data files are downloaded from TELUS and requested from ESI and HPN and reconciled with each other, then the reporting is completed on the CMS website and payment is requested.	No action required.
Medicare Secondary Payer (MSP) Data Reporting	Plans (including HRAs with annual benefit levels of $5,000 or more as of the beginning of the	Both UMR and ESI confirm they follow Section 111 guidelines.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	plan year) must report to CMS medical and prescription drug coverage (since 2020) information about participants and beneficiaries who are also Medicare enrollees. Plans should be registered with CMS and reporting electronically on a quarterly basis.		

Transparency – No Surprises Act

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Disclosure Notice Regarding Patient Protections Against Surprise Billing	Effective for plan years beginning on or after January 1, 2022, Section 104 of the No Surprises Act requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer and include on each explanation of benefits for an item or service with respect to which the requirements of the No Surprises Act apply.	PEBP has posted this notice on its website.	No action required.
Notice of Right to Continue Care	Under the No Surprises Act, group health plans must notify each individual who is a continuing care patient at the time of a provider or facility network contract termination and permit the individual to continue transitional care from the provider or facility at in-network rates.	UMR confirmed that provider termination notices are sent to members. Patients under care are allowed to elect to continue benefits under the plan, with the treating provider and under the same terms and conditions for a period of 90 days (from date of notice) or earlier with the ending of continuing care from the provider. UMR has confirmed that notices are sent to members. Continuity of Care Forms can also be found on the PEBP website. The LD PPO and EPO MPDs contain the continuing care requirements of the No Surprises Act.	Recommended Action: PEBP should consider including language in the CDHP MPD about No Surprises Act protection for continuing care patients when the Plan terminates its PPO contract with a Network Provider or Network Facility or Hospital.
Group Health Plan Transparency Rule for Public Disclosure (Machine-Readable Files)	Effective 1/1/2022, non-grandfathered plans must post on public website the following information online using three machine-readable files, which must be updated monthly: 1. In-network rates	Provided on website: https://pebp.state.nv.us/plans/mandatory-notices/ including the link to the machine-readable files provided by URL: https://transparency-in-coverage.uhc.com	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	2. Out-of-network allowed amounts and 3. Prescription drug negotiated rates Enforcement delayed until future rulemaking for prescription drug negotiated rate file.		
Insurance Identification Cards	For plan years beginning on and after 1/1/2022, Plans must include plan deductibles, out-of-pocket (OOP) maximums and consumer assistance contact information (phone number and website) in clear writing on any physical or electronic plan or insurance identification card.	PEBP has confirmed that UMR has updated the identification cards. PEBP reported that the insurance identification cards include plan deductibles, out-of-pocket (OOP) maximum limits, and customer service contact information including phone numbers and website details for the specific plan administrator, member ID, group, number, and prescription benefit data.	No action required.
Prescription Drug Reporting (RxDC Report)	Under Section 204 (of Title II, Division BB) of the Consolidated Appropriations Act, 2021 (CAA), insurance companies and employer-based health plans must submit information about prescription drugs and health care spending.	PEBP response: ESI reports the Dental and UMR reports the medical side. It goes directly to the PEBP CFO and CMS annually. PEBP should continue to coordinate with its medical and PBM vendors to confirm filing status.	No action required.
Gag Clause Attestation	Group health plans and health insurance issuers may not enter into an agreement with a provider, network, TPA or other service provider that would directly or indirectly restrict the plan or issuer from providing provider-specific cost or quality information to referring providers, the plan sponsor, participants/ beneficiaries (or	PEBP has stated they have worked with vendors for submission and will submit the new attestation by the required date.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	people eligible for coverage under the plan). Plans must provide by 12/31 an annual attestation to the government that they are in compliance with this section.		
No Surprises Act: Emergency Services	Effective for plan years beginning 1/1/2022, Plans must cover emergency services at non-participating facility, services/items provided by non-participating provider at a participating facility, or non-participating provider air ambulance services with the same participant cost-sharing whether the services are from a participating or non-participating provider or facility. Providers and facilities are banned from balance billing.	Per nv.doi.gov: The federal Surprise Billing law covers everything protected under current Nevada state law and more. In situations where the state has stricter statutes to protect consumers, or rules in place determining the rate of compensation due to the out-of-network providers, the federal law defers to the state law. This would be the case for out-of-network providers that were previously in-network within the last 24 months. In this situation Nevada law specifies the formula for computing the rate of compensation. PEBP has included language in its MPD to highlight when balance billing is not permitted under the No Surprises Act. MPDs state that all inter-facility air ambulance transport services require prior authorization. This requirement conflicts with the No Surprises Act if it is applied to an emergency inter-facility transfer. Additionally, the CDHP MPD does not include language about No Surprises Act protection for continuing care patients when the Plan terminates its PPO contract with a Network Provider or Network Facility or Hospital.	Recommended Action: We suggest clarifying in the MPDs that prior authorization does not apply to emergency inter-facility air ambulance transfers and include language in the MPDs about No Surprises Act protection for continuing care patients. Clarifications are provided regarding No Surprises Act as comments in the MPDs.
Group Health Plan Transparency Rule (Internet-Based Price Comparison Tool)	For plan years beginning on or after 1/1/2023, for 500 items and services (on or after 1/1/2024 for all covered items	PEBP Response: UMR complies with the federal Transparency in Coverage Rule by providing a member-facing cost	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	and services) non-grandfathered plans must provide cost-sharing information and rate information that is accurate at the time of the request to participants on a searchable, internet-based, self-service tool; and must provide a notice when the tool is used.	comparison tool, publishing monthly machine-readable files with in-network negotiated rates and historical out-of-network charges, and offering personalized cost estimates for care prescriptions. UMR meets these requirements by hosting the Transparency in Coverage MRFs at transparency-incoverage-uhc.com. They also publish the MRFs for both in-network and out-of-network data, as required by CMS.	

Other laws affecting group health plans

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Age Discrimination in Employment Act of 1967	The Older Workers Benefit Protection Act of 1990 (OWBPA) amended the ADEA to specifically prohibit employers from denying benefits to older employees. Only in limited circumstances (e.g., life insurance), an employer may be permitted to reduce benefits based on age, as long as the cost of providing the reduced benefits to older workers is the same as the cost of providing benefits to younger workers. Employers are permitted to coordinate retiree health benefit plans with eligibility for Medicare or a comparable state-sponsored health benefit.	PEBP does not reduce benefits based on age.	No action required.
Americans with Disabilities Act of 1990, as amended (ADA)	Under the ADA, workers with disabilities must have equal access to all benefits and privileges of employment that are available to similarly situated employees without disabilities. Prohibits exclusion from participation or denial of benefits in "services, programs or activities of a public entity." Website accessibility is a current litigation risk under the ADA.	Per the Health and Welfare Active MPD: "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." Website pages regarding ADA accessibility: • Americans With Disabilities Act (adahelp.anv.gov) • Accessibility Information (adahelp.nv.gov)	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Family and Medical Leave Act of 1993 (FMLA)	Employers must continue an employee's insurance coverage under the company's group health plan during FMLA leave, just as if the employee had worked continuously rather than out on leave. The employer may require employees on FMLA leave to pay their share of premium payments in any of the following ways: (1) Due at the same time as it would be made if by payroll deduction; (2) Due on the same schedule as payments are made under COBRA; (3) Prepaid pursuant to a cafeteria plan at the employee's option; (4) Using employer's existing rules for payment by employees on leave without pay provided that such rules do not require payment prior to the commencement of the leave of the premiums that will become due during a period of unpaid FMLA leave or payment of higher premiums than if the employee had continued to work instead of taking leave; or, (5) Another system voluntarily agreed to between the employer and the employee, which may include prepayment of premiums (e.g., through increased payroll deductions when the need for the FMLA leave is foreseeable).	Per the Eligibility and Enrollment MPD: "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." Per the Active Wrap plan document: "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."	No action required.
Genetic Information Nondiscrimination Act of 2008 (GINA)	• Group health plans cannot adjust premiums or contribution amounts for a plan, or a group of similarly situated individuals under the plan, based on	Per the Active Wrap plan document: "Genetic Information Non-discrimination Act of 2008 (GINA). The Plan shall comply	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	genetic information of one or more individuals in the group. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.) • Prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. A plan or issuer may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. Also, a research exception. • Prohibits plans from collecting genetic information (including family medical history) from an individual prior to or in connection with enrollment in the plan, or at any time for underwriting purposes. Plans and issuers are generally prohibited from offering rewards in return for the provision of genetic information, including family medical history information collected as part of a Health Risk Assessment.	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."	
Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART)	Heart Act allows – but doesn't require – a health FSA to permit reservists called to active duty for 180 days or more to withdraw all	Per the FSA MPD: "Under the Heroes Earnings Assistance & Relief Tax Act of 2008, employees called to active	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	or a portion of any unused money (notwithstanding the normal use or lose rule). The distribution of these funds must be made during the period from the date of call-up until the last day the benefits could normally be reimbursed for the plan year.	military duty for a period of at least six months can receive a taxable distribution of the HCFSA funds to avoid forfeiture."	
Newborns and Mothers' Health Protection Act	Plans may not restrict hospital stays in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a caesarean delivery.	Per the MPDs: "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)."	No action required.
Pregnancy Discrimination Act (PDA)	Any health insurance provided by an employer must cover and reimburse expenses for pregnancy-related conditions on the same basis as expenses for other medical conditions. Insurance coverage for expenses arising from abortion is not required, except where the life of	Per the MPDs: "Prenatal care 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	Recommended Action: For dependent children maternity coverage, in addition to noting the exception for pregnancy complications, consider including an exception for emergency services under NSA.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	the mother is endangered, or medical complications arise from an abortion. The amounts payable by the insurance provider can be limited only to the same extent as costs for other conditions. No additional or larger deductible can be imposed.	complications of pregnancy for the dependent child." Prenatal care for covered dependent children. Delivery is not covered unless it is related to a complication of pregnancy. "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."	
Title VII of the Civil Rights Act of 1964	• Supreme Court held in Bostock v. Clayton County (2020) that Title VII of the Civil Rights Act of 1964 protects transgender, gay and lesbian employees (and prospective employees) from workplace discrimination based on sex. Bostock. This protective authority of Title VII generally extends to employer-sponsored healthcare benefits. • Supreme Court held in Newport News Shipbuilding Co. v. EEOC (1983) that Title VII requires equally comprehensive coverage to both male and female employees, mandating that employer-provided health plans may not discriminate on sex-based characteristics (e.g., employer-provided health plans must cover pregnancy, childbirth and related medical conditions).	MPDs state that the Plan provides benefits for treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment.	No action required.
Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)	• Reemployed service members are entitled to the seniority and all rights and benefits based on	Per the Enrollment and Eligibility MPD:	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	seniority that they would have attained with reasonable certainty had they remained continuously employed. • During a period of service, the employees must be treated as if they are on a leave of absence and are entitled to participate in any rights and benefits not based on seniority that are available to employees on comparable. nonmilitary leaves of absence, whether paid or unpaid. If there is a variation in benefits among different types of nonmilitary leaves of absence, the service member is entitled to the most favorable treatment so long as the nonmilitary leave is comparable. • Service member entitled to benefits that become effective during their service and that are provided to similarly situated employees on furlough or leave of absence. • Service members may be required to pay the employee cost, if any, of any funded benefit to the extent that other employees on leave of absence are so required.	"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."	
Women's Health and Cancer Rights Act	Plans that cover mastectomies must cover certain reconstructive surgery and services.	Per the MPD: "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	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
		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."	

Certain required notices

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Women's Health and Cancer Rights Act (WHCRA) Notice	Plans must provide a description of benefits under WHCRA both upon enrollment and annually thereafter.	PEBP's Annual Notices document includes Women's Health and Cancer Rights Act. The Annual Notices were emailed to all Active and Retired PEBP members July 2026. WHCRA language is included in the MPDs.	No action required.
Children's Health Insurance Program Reauthorization Act (CHIPRA) Notice	Employers in states with Medicaid or CHIP premium assistance programs must annually notify employees of these opportunities by the first day of the plan year. Frequently provided in open enrollment materials. Model notice updated 7/31/2026. https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra	PEBP's Annual Notices document includes CHIP Notice– Medicaid and Children's Health Insurance. The Annual Notices were emailed to all Active and Retired PEBP members July 2026.	Recommended Action: PEBP should update its CHIPRA notice using the most current 7/31/2026 model notice.
Section 125 Cafeteria Plan	While there is no reporting or disclosure requirement for the Section 125 plan, employers typically make the plan document available to employees on a website or upon request.	The PEBP Section 125 Health and Welfare Plan Document is accessible on the PEBP website.	No action required.
Change in Status Events	Employers typically make information available in the SPD about mid-year change in status events, including forms for changing enrollment elections.	The PEBP Section 125 Health and Welfare Plan Document include a section of the mid-year change events and is accessible on the PEBP website. PEBP's Enrollment and Eligibility MPD states under special enrollment due to birth, adoption, or placement for adoption of a child that while coverage for the child is effective on the date of the	Recommended action: PEBP should revise the enrollment and eligibility MPD language related to special enrollment of a newborn, adoption of a child, and placement for adoption of a child placed for adoption for consistency with its administrative practice and for compliance with federal HIPAA special enrollment rules.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
		event (birth, adoption, or placement for adoption), "coverage for other dependents are effective on the first of the month concurrent with or following notification." PEBP reported that administratively, coverage for anyone special enrolling due to birth, adoption, or placement for adoption takes effect as the date of the event. Additionally, PEBP confirmed that during a HIPAA special enrollment event, members are allowed to change plan options.	PEBP should consider including in the MPD that members are allowed to change plan options during a HIPAA special enrollment event.
Wellness Program Notice of Reasonable Alternative	Plans must disclose availability of a reasonable alternative standard to qualify for the wellness program's reward in all plan materials that describe health-contingent wellness programs. Also, must provide contact information for obtaining the alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. The information must be included in the SPD, enrollment materials and other materials discussing wellness.	The plan includes disease management programs that are voluntary and provide enhanced benefits.	Recommended Action: PEBP should verify that to any extent the wellness/disease management programs overlap with the EEOC, HIPAA nondiscrimination or GINA wellness program rules, the employers or service providers issue the required notices.
Wellness Notice (required by EEOC)	If wellness program includes disability-related inquiries, genetic information, or medical examinations, the plan sponsor must provide participants with a notice describing what medical information will be obtained, how it will be used and how it will be protected from improper disclosure. Programs that permit spouses to participate must provide similar notice and obtain the spouse's	The plan includes disease management programs that are voluntary and provide enhanced benefits.	Recommended Action: As noted above, PEBP should verify that to any extent the wellness/disease management programs overlap with the EEOC, HIPAA nondiscrimination or GINA wellness program rules, the employers or service providers issue the required notices.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	authorization if genetic information is being requested. Notice must be provided before the participant is asked to answer disability-related questions or undergo a medical exam.		
Newborns and Mothers' Notice	Plans must provide notice describing requirements for minimum length of hospital stay in connection with childbirth required within SPD time frame.	PEBP's Annual Notices document includes Newborns' and Mothers' Health Protection Act; and is referenced within the MPD. The Annual Notices were emailed to all Active and Retired PEBP members July 2026.	No action required.
Michelle's Law Notice	Only if coverage provided based on student status (age 26 or older), plans must provide notice regarding ability to extend coverage for post-secondary students on medical leave.	Per the Active Employee Wrap Plan Document: "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	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
		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."	
Qualified Medical Child Support Notice	Plans must acknowledge receipt of medical child support order and notify participants that its Qualified Medical Child Support Order (QMCSO) procedures for determining whether the order is qualified are available free of charge. Within a reasonable time after its receipt, the plan must also issue notice of whether the order is qualified. QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce.	The Plan provides benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO), including a National Medical Support Notice (NMSN), as set forth in PEBP's Enrollment and Eligibility MPD. 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	Recommended Action: Segal suggests adding the following language to the MPD: "You and the affected child will be notified if an order is received, and a copy of the procedures is available free of charge upon request."

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
		• 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.	

Cafeteria plan, FSAs, HSA/HDHPs, HRAs

Cafeteria plan

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Plan year requirement	A cafeteria plan year must continue for 12 consecutive months, as established by the plan document. A plan year of less than 12 months is only allowed for a valid business purpose, e.g., first plan year, last plan year.	Plan year is defined as the 12-month period beginning each July 1st and ending each June 30th.	No action required.
Written plan document	Section 125 requires a written plan document. While there is no reporting or disclosure requirement, employers typically make the plan document available to employees on a website or upon request.	PEBP has a written Section 125 Health and Welfare Benefits Plan Document.	No action required.
Salary reduction agreement	Required for participant to pay for benefits on a pre-tax basis	Defined and referenced throughout Section 125 plan document.	No action required.
Annual participation and contribution elections generally must be irrevocable for the plan year	Exceptions: • Contributions to HSAs • Status or cost/coverage changes as adopted under the plan • To comply with HIPAA special enrollment rights • To comply with a judgment, decree, or order to provide coverage for a dependent child in connection with a change in marital status or custody • To reflect a change in entitlement to Medicare or Medicaid	Permitted mid-year events referenced in Status Change Elections; Special Enrollment; Other Election Changes section of the Section 125 plan document.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	• The Family and Medical Leave Act grants employees on FMLA leave the right to revoke or change an existing election for accident or health plan coverage. • Limited exception for administrative error: Although the election change regulations do not address mistakes, based on the informal IRS doctrine of mistakes an election may be corrected when there is clear and convincing evidence a mistake has been made. For example, if an employee with no eligible dependents makes a dependent care election, rather than a health FSA election, there is clearly an error. If there is evidence that an individual has made a mistake in an election, or that the employer has made an administrative mistake in recording that election, then the election can be undone, even retroactively, to correct the mistake.		
Participants limited to current or former employees	Individuals who are self-employed, such as sole proprietors or partners in a partnership, and individuals who are 2% shareholders in an S corporation, are not employees for this purpose. Though only employees may participate, spouses and dependents may benefit from the plan.	Active Legislators pay 100% of their own contributions after tax. There are no subsidies.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Paid Time Off (PTO)	A cafeteria plan can offer elective PTO (i.e., PTO that can be purchased or sold under the cafeteria plan) as a permitted taxable benefit, including through the application of flex-credits.	Not applicable: The cafeteria plan does not offer PTO that can be purchased or sold.	No action required.
Non-elective Employer Contributions (flex credits)	The employer may make contributions on behalf of participants to be used for non-taxable qualified benefits. The contribution amount (or maximum) must be specified in the cafeteria plan document, as either a fixed amount or a percentage of compensation. Participants can allocate these employer contributions among different qualified and/or taxable benefits offered through the plan.	Not applicable: No flex credits	No action required.

Health flexible spending account (FSA)

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Maximum annual employee contribution election	For 2026: $3,400	The limit for calendar year 2026 is $3,400 for the medical FSA or the Limited Purpose FSA.	No action required.
Employer contribution	An employer may match up to $500, regardless of whether or not the employee contributes to a health FSA themselves. Above $500, employers may only make a dollar-for-dollar match to the employee's contribution. But see rules for Excepted Benefit FSA below.	Not applicable: No employer contributions to health FSA.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Uniform coverage rule	The full amount of reimbursement available under a health FSA (less amounts previously reimbursed for the plan year) must be available throughout the plan year. This rule does not apply to DCFSA.	Per the FSA MPD: "The amount of reimbursement will either be the full approved amount of the claim or the balance of your annual election, whichever is less. Payment under the medical FSA is not limited to the amount in your account at the time of your claim, as monthly contributions will continue for the remainder of the Plan Year."	No action required.
Grace period (optional)	Cannot have both a grace period and a carryover. Allows costs to be incurred up to 2½ months after the end of the plan year.	Not applicable: The Plan does not permit a grace period.	No action required.
Carryover (optional)	Cannot have both a grace period and a carryover. Maximum carryover amount indexed to 20 percent of the annual maximum election. For 2026 ($660); For 2027 ($680). Not applicable to DCFSA.	The Health Care FSA and Limited Purpose FSA permit a carryover of up to $680.	No action required.
Run-out period (optional)	A predetermined amount of time (generally set by the employer) that allows reimbursement after the plan year ends. Most run-out periods are 90 days, starting the day after the plan year ends.	Per the FSA MPD: Allowable expenses must be incurred during the current Plan Year, and claims must be submitted to the TPA by October 31st following the end of the Plan Year.	No action required.
Significant cost or coverage changes	Does not apply to an election change with respect to a health FSA (or on account of a change in cost or coverage under a health FSA).	FSA MPD confirms this does not apply to the health FSA or limited purposes states the change applies when the cost charged to employees for a benefits package option significantly increases or decreases.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Qualified medical expenses	Qualified medical expenses are those specified in the plan that are paid for care as described in Section 213 (d) of the Internal Revenue Code that are not otherwise reimbursed. See Pub. 502. Expenses incurred after December 31, 2019, for over-the-counter medicine (whether or not prescribed) and menstrual care products are considered medical care and are considered a covered expense.	Per the FSA MPD: "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 all insurance premiums and long-term care expenses."	No action required.
Substantiation	An independent third party must substantiate medical expenses paid or reimbursed from a health FSA. Substantiation for health care expenses includes information describing the service or product; the date of service or sale; and the amount of the expense.	Per the FSA MPD: The Third-Party Administrator (TPA) will review claims and all supporting documentation. Per Section 125 MPD: 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.	No action required.
Limited Purpose Health FSA (LPFSA)	Qualified medical expenses are limited to eligible dental and vision costs.	The LPFSA is set up to reimburse only eligible FSA dental and vision expenses.	No action required.
Excepted Benefit FSA	Employer contributions should not exceed $500 per plan year for a health care FSA to maintain excepted benefit status, which avoids making it subject to certain ACA and HIPAA requirements.	Not applicable: No employer contributions to health FSA.	No action required.
Integration with HSA	Employees with an HSA can only have a Limited Purpose FSA.	Per the FSA MPD: IRS provisions do not permit contributions to an HSA and an	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
		HCFSA since both the HSA and the HCFSA 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.	
COBRA Special Exception (not required to offer COBRA to qualified beneficiaries who have overspent their FSA amounts)	An employer determines whether a participant has overspent or underspent his or her health FSA account by looking at: (1) the participant's maximum benefit for the plan year; (2) the amount of reimbursable claims submitted to the FSA for the plan year before the qualifying event; and (3) the maximum amount that the employer is permitted to charge for COBRA coverage under the health FSA for the remainder of the plan year.	Per the MPD: "COBRA FSA benefits will end on the earlier of: • When a participant stops paying the monthly administration fee. • The 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."	No action required.
COBRA Premium	IRS regulations indicate that the maximum COBRA premium for FSA coverage is based on the annual coverage amount under the FSA, which includes both employee and employer contributions (and any carryover).	PEBP does not charge a COBRA premium for the health FSA.	No action required.

Dependent care FSA

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Eligibility	• Both parents working: • One spouse not working: generally, can qualify if (i) Job-related: the spending must enable participant and spouse to work or look for a new job and (ii) Earned income: Spouse must make money through employment during the year to exceed the DCFSA contribution • Spouse disabled: can use a DCFSA when only one parent is working, when one spouse is physically or mentally incapable of self-care or disabled (person is physically or mentally incapable of performing regular job duties) • Full-time student: One parent is working when the other is a full-time student attending classes at an authorized school. IRS rules define when they impute earned income during the month. • Full-time definition: enrolled in classes for at least five calendar months, with enough credit hours to exceed the school-defined part-time definition • Authorized institutions: high schools, colleges, universities, plus technical, trades, and mechanical schools	Per the FSA MPD: "Dependent Care FSA: • The Dependent Care FSA is an option to pay for childcare or adult dependent care to allow a participant and their spouse (if married) to attend school full time, work, or to look for work. • The Dependent Care FSA covers expenses for a person being cared for as a dependent on their income tax return who is: – Younger than 13; or – Physically or mentally disabled individual aged 13 and above. Must be certified as disabled by a physician.	Recommended Action: Consider specifying in the FSA MPD that a DCFSA is an option for active employees covered under the PEBP CDHP, LD PPO, or EPO Plan.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	• Unauthorized institutions: correspondence classes and internet-based online learning programs		
Qualifying Individuals	A qualifying individual(s) is: • A qualifying child who has not attained age 13; or • A dependent of the taxpayer who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the taxpayer for more than one-half of the tax year; or • The spouse of the taxpayer, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of the tax year.	Per the FSA MPD: Day care expenses are limited to care for children under age 13 or a mentally/physically disabled dependent.	No action required.
Annual Contribution Limits	$7,500 a year for individuals or married couples filing jointly, or $3,750 for a married person filing separately.	DCFSA is limited to $7,500 for single taxpayers and $3,750 for married individuals filing separately.	No action required.
Use-or-Lose	Under the use or lose rule, costs payable under all three types of FSAs are required to be incurred during the plan year (except for grace period)	Per the FSA MPD: "If you have funds remaining in your DCFSA account at the end of the year, that amount will be forfeited by you as required by federal regulations."	No action required.
Grace Period (optional)	Allows costs to be incurred up to 2½ months after the end of the plan year.	Not applicable: There is no grace period.	No action required.
Run-Out Period (optional)	A predetermined amount of time (generally set by the employer) that allows reimbursement after the plan year ends. Most run-out	Per the FSA MPD:	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	periods are 90 days, starting the day after the plan year ends.	"All claims must be filed by October 31st following the end of the Plan Year."	
Qualifying Expenses	As set forth in the plan: • Payment for provision of services, which if paid for by the employee would be considered, employment-related expenses under I.R.C. § 21(b)(2). DCFSA-eligible expenses (i.e., expenses paid to enable the taxpayer to be gainfully employed) while the taxpayer is gainfully employed or is in active search for gainful employment. • Expenses paid for household services and services for the care of a qualifying individual with respect to the taxpayer, but only if the expenses are incurred to enable the taxpayer to be gainfully employed. • Expenses paid for household services performed in connection with the care of a qualifying individual. • Expenses paid for the performance in and around the taxpayer's home of ordinary and usual services necessary to the maintenance of a household • Expenses paid for services provided for the primary purpose of a qualifying individual's well-being and protection, including expenses for benefits which are incident	Per the FSA MPD, DCFSA qualifying expenses are: • 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.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	to and inseparably a part of the qualifying care services. • Expenses paid for services provided in dependent care centers that provide care for more than six individuals and are compensated in fees, payments, or grants for providing services for any of the individuals.		
Payments to Related Persons	No amount paid or incurred during the taxable year of an employee by an employer in providing dependent care assistance to such employee shall be excluded from income (a) if such amount was paid or incurred to an individual—(1) with respect to whom, for such taxable year, a deduction is allowable under section 151(c) (relating to personal exemptions for dependents) to such employee or the spouse of such employee, or (2) who is a child of such employee (within the meaning of section 152(f)(1)) under the age of 19 at the close of such taxable year.	The FSA MPD does not address payments to related persons.	Recommended Action: We suggest adding to the FSA MPD that: 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.
Substantiation Requirements	Receipts must include specific information to prove that the payment was for qualified expenses. Specifically, the receipt must note: • Recipient's Name: The name of the person who received the service • Provider's Name: The name, address, and taxpayer identification number of the	Per the FSA MPD: "The TPA will review claims and all supporting documentation. Claim reimbursements are typically issued within one business day of approval of the claim. The amount of the reimbursement will either be the full approved amount of the claim or the balance of the annual election, whichever is less.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	person performing the services are included on the return to which the exclusion relates, or if such person is a 501(3) € organization; the name and address of such person are included on the return to which the exclusion relates • Date of Service: The date when services were provided • Type of Service: A detailed description of the service provided • Cost: The amount paid for the service	Payment under the medical FSA is not limited to the amount in the account at the time of the claim, as monthly contributions will continue for the remainder of the Plan Year." "Participants must complete and submit a claim form along with copies of invoices or statements as verification of the qualifying expenses incurred. Invoices and/or statements must 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."	
DCFSA required notification	Employers must provide reasonable notification to employees of the availability of the program. Each employee must be furnished, on or before Jan. 31, a written statement showing the amounts paid or expenses incurred under the DCFSA during the previous calendar year. This requirement is usually met by reporting the amounts on the employee's Form W-2.	PEBP reported that PEBP's Benefits Administration System vendor, Telus Health, sends the necessary data for reporting on individual Form W-2s to the applicable participating agencies.	No action required.

Additional FSA rules

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Cannot transfer funds between the two accounts	Cannot transfer funds between the Health FSA and the DCFSA.	PEBP's funds cannot be transferred between the Health FSA and the DCFSA.	No action required.

Debit cards

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Card limit	The use of the card is limited to the maximum dollar amount of coverage available in the employee's health FSA or HRA.	PEBP's debit card is limited to the maximum dollar amount of coverage available in the employee's health FSA or HRA.	No action required.
Where can it be used for health expenses	The card can only be used at merchants and service providers that have merchant category codes related to health care, such as physicians, pharmacies, dentists, vision care offices, hospitals, and other medical care providers.	Per the FSA MPD: "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)."	No action required.
Substantiation rules	Flexible Spending Account (FSA) claims paid with a debit card must include the required substantiation, containing all of the information normally required for a claim submitted for reimbursement through means such as an online portal or mobile app. Expenses must be substantiated by an independent third party with the following information: • Name of the individual receiving the eligible service or purchasing the eligible item. • Date(s) the service was provided, or item was purchased (start and end dates if applicable). • Description of the service provided, or product purchased (e.g., prescription, copay, office visit, glasses, daycare).	Per the FSA MPD: Invoices and/or statements must 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 services was provided. We note that an earlier version of the FSA MPD had the following language, which is no longer in the current MPD: "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	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	• Name of the service provider or merchant where the item was purchased; and • Claim amount (dollar amount spent on the service or item). In addition, the health FSA sponsor may coordinate with an individual's insurance provider to use information provided in an explanation of benefits to substantiate a debit card charge without requiring more information.	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; all other purchased items must be paid for in a split tender transaction.)"	
Auto-substantiation	Exception for expenses from certain providers (e.g., pharmacies) that can be auto substantiated by the Merchant Category Code (MCC) of the provider's debit card machine and when the item or service is identified by an Inventory Information Approval System (IIAS). Automatic substantiation is allowed at merchants that have an IIAS in place to ensure that	Per the FSA MPD: "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)."	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
	cards are used only for eligible health-related expenses.		
Prohibition against self-substantiation	Section 105 and § 125 require the substantiation of all medical expenses as a precondition of payment or reimbursement. Self-substantiation or self-certification of an expense by an employee-participant does not constitute the required substantiation.	Per the FSA MPD: The Third-Party Administrator (TPA) will review claims and all supporting documentation. Per Section 125 MPD: "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."	No action required.
Use of Debit Card for DCFSA	An employer may use a payment card program to provide benefits under its DCFSA. However, dependent care expenses may not be reimbursed before the expenses are incurred. For this purpose, dependent care expenses are treated as having been incurred when the dependent care services are provided, not when the expenses are formally billed, charged for, or paid by the participant. Thus, if a dependent care provider requires payment before the dependent care services are provided, those expenses cannot be reimbursed at the time of payment, even through the use of a payment card program.	PEBP uses the debit card for DCFSA. Per the MPD: "Dependent care expenses are incurred on the day care is provided. Participants must receive the dependent care services before a claim can be filed."	No action required.

HSA/HDHP

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Only employees enrolled in a HDHP can enroll in the HSA	Section 223 requires that an employee must be enrolled in a High Deductible Health Plan (HDHP) to contribute to a Health Savings Account (HSA).	Per the CDHP MPD: "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."	No action required.
Annual Limits	HSA Contribution Limit: Plan / 2026 / 2027 Self-only / $4,400 / $4,500 Family / $8,750 / $9,000 HSA Catch-up Contributions: Plan / 2026 / 2027 Age 55+ / $1,000 / $1,000 HDHP Minimum Deductible: Plan / 2026 / 2027 Self-only / $1,700 / $1,750 Family / $3,400 / $3,500 HDHP Maximum Out-of-pocket Expense Limit (deductibles, copayments, and other amounts, but not premiums): Plan / 2026 / 2027 Self-only / $8,500 / $8,700 Family / $17,000 / $17,400	Per the MPD: 2026 HSA contribution: $4,400 / $8,750 HSA Catch Up Contribution: $1,000 HDHP Min. Ded. $1,700/$3,400 (ind./family) HDHP – OOP Max (in-network) $5,000/$10,000 (ind/family member/family)	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Funds can rollover indefinitely	HSAs have no use-or-lose provision. Any funds still in the plan at the end of the year can be rolled over indefinitely.	CDHP MPD: HSAs are employee-owned accounts, meaning the funds in the HSA remain with the employee and carry over from one year to the next.	No action required.
FSA carryover/grace period conflict	A participant who has FSA carryover amount who wants to switch to an HDHP with HSA for the next plan year is prohibited from contributing to the HSA for the entire plan year. Or if they have funds remaining in the health FSA and there is a grace period, contributions would be prohibited to an HSA during the grace period. Two ways to resolve the carryover issue are (1) to move the FSA funds to a limited purpose health FSA (dental and vision only) or (2) to allow the participant to decline the carryover and waive the funds prior to the end of the FSA plan year (it is not generally permissible to decline a grace period, however). Employers may allow participants to choose whether to convert a carryover amount to a limited purpose health FSA, but a health FSA having a grace period is generally not permitted to offer each participant that choice (but may impose a mandatory conversion for all participants).	Per the FSA MPD: "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."	No action required.

HRAs

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
Permitted Contributions	Employer contributions only	Per CCHP MPD: Active HRA: • 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. Per Medicare Exchange HRA MPD: • The HRA is funded solely by the Plan Administrator	No action required.
Integrated HRA	Must be integrated with employer group health plan that meets the ACA's market reform requirements. HRAs so integrated are deemed to comply with those requirements.	Per the Active Wrap Plan Doc: "Health Reimbursement Arrangement is intended to be integrated for purposes of ACA and related guidance."	No action required.
Retiree-Only HRA	Terminated/Retired employees only (limited to less than 2 active employees) Can reimburse their Medicare Part A, Part B and Part D premiums. Not subject to ACA market reforms but must satisfy: Reporting of minimum essential coverage (6055 reporting generally only for pre-Medicare retirees and dependents) and PCOR fee. For purposes of nondiscrimination testing, a key employee includes a retiree who was a key employee when he or she retired.	Per the Medicare HRA MPD: The HRA is provided to eligible retirees enrolled in a Medicare Plan through Via Benefits or who have Tricare for Life, and Medicare Parts A and B.	No action required.

Federal Law	Requirement Overview	Materials Reviewed & Findings	Action Items
COBRA	Eligibility	Integrated HRA: can elect COBRA for HRA only if COBRA is elected for group health plan. COBRA is offered for the HRA. If a participant elects COBRA coverage, the HRA account will remain in place until COBRA coverage is terminated.	No action required.
COBRA	Premium	At the beginning of each plan year, the employer should calculate a reasonable premium for the HRA, both for single and family coverage. The IRS has defined two methods for determining the COBRA premium: the actuarial method and the past-cost method. PEBP does not charge an additional COBRA premium.	No action required.
Coordination with Health FSA	While an employee can have both an HRA and an FSA at the same time, the same expense cannot be reimbursed from both accounts. The IRS states that special coordination rules should be implemented to determine whether the HRA or FSA should be used first. As a general rule, the HRA funds must be used first prior to the FSA. IRS Notice 2002-45.	Health Scope Benefits has confirmed that the participant signs an attestation including that the expenses are not eligible for reimbursement under any other health plan. The FSA and HRA SPDs state that if an employee has coverage under both the Health FSA and HRA, claims should be submitted to the health FSA first until that account is exhausted.	No action required.

Section 4. State Findings in Detail

State Law	Description	Findings	Action Items
Eligibility and Participation: Definition of Dependent, Participant and Domestic Partner NAC 287.035 NAC 287.311 NAC 287.312 NAC 287.313 NRS 689B.035	Definition of Dependent: • Dependents: Enrollment and disenrollment. • Dependents: Eligibility of child of participant, spouse, or domestic partner. • Responsibility for final determinations concerning eligibility. • Required provision in certain policies concerning termination of coverage on dependent child.	MPD defines dependent child, domestic partner, and outlines eligibility. MPD defines participant and eligibility. MPD provides for provisions concerning termination of coverage of dependent children.	No action required.
Eligibility and Participation: Definition of Full-Time Employment and Eligibility Waiting Periods NRS 287.045 NAC 287.150 NAC 287.313	• Persons eligible to participate in Program; receipt of notice of eligibility; automatic enrollment; limited affiliation period. • Full-time employment interpreted. • Responsibility for final determinations concerning eligibility.	MPD outlines eligibility, full-time employment.	No action required.
Eligibility and Participation: Retirees NAC 287.530 NAC 287.540 NRS 287.023 NRS 287.047	• Coverage of retired person, spouse, domestic partner or surviving dependent. • Coverage of participating employee of State who reenrolls upon retirement or total disability, coverage of nonparticipating employee of State. • Option of retired officer or employee or dependent to cancel or continue group	MPD outlines retiree eligibility and enrollment process.	No action required.

State Law	Description	Findings	Action Items
	insurance, plan of benefits, medical and hospital service or coverage under Public Employees' Benefits Program; notice of selection of option; payment of costs for coverage. • Retention by certain retired state officers and employees of membership in and dependents' coverage under Program.		
Eligibility and Participation: Seasonal Employees and Employees on a Biennial Plan NRS 287.0467	Retention by certain short-term state employees of membership in and dependents' coverage under Program.	PEBP states that the employers report employee eligibility.	No action required.
Eligibility and Participation: Individual as Both Employee and Dependent NAC 287.520	Coverage of person qualified as both employee and dependent; change of status from employee to dependent.	Per the MPD: • 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. • If a participating officer or employee changes his or her status to that of a dependent because he or she no longer qualifies as an employee, he or she must enroll as a dependent within 60 days after losing status as an employee to be eligible for coverage and insurance as a dependent. If a	No action required.

State Law	Description	Findings	Action Items
		participant complies with the requirements of this subsection, his or her coverage or insurance is not limited by any waiting period that would otherwise apply.	
Eligibility and Participation: Surviving Spouse/ Dependents NAC 287.530 NRS 287.0475 NRS 287.0477	• Coverage of retired person, spouse, domestic partner or surviving dependent. • Reinstatement of insurance by retired public officer or employee or surviving spouse. • Option of surviving spouse or child of police officer, firefighter or volunteer firefighter killed in line of duty to join or continue coverage under Public Employees' Benefits Program; notification; payment of costs for coverage; duration of eligibility.	MPD outlines surviving spouse/dependents eligibility and reinstatement of coverage. MPD highlights that 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.	No action required.
Eligibility and Participation: Coverage of Newly Born and Adopted Children NRS 689B.033	Certain policies covering family members required to include certain coverage for insured's newly born and adopted children and children placed with insured for adoption.	Per the MPD, 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) NRS 689B.033. If the newborn is covered under	No action required.

State Law	Description	Findings	Action Items
		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 CDHP, LD PPO, and EPO Plan Evidence of Coverage Certificate (as applicable). A newborn child who is adopted or placed for adoption may be covered the effective date of 1) adoption, or 2) placement for adoption, if the employee enrolls 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. 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.	
Eligibility and Participation: Orientation Program NAC 287.314 NAC 287.317	• Provision of information about Program to participants, representatives of participating public agencies and employees of Program. • Participating public agency to notify Program of appointment of persons eligible to participate in Program or of termination of appointment; enrollment.	PEBP provides enrollment materials; notices and MPDs to eligible participants; provides an internet website.	No action required.
Eligibility and Participation: Terminating Interlocal Contract and Withdrawing from Program NAC 287.320	Withdrawal from Program: Procedure; termination of coverage; limitation on reentry; eligibility of certain officers and	PEBP reports there have not been any interlocal contracts terminated or participated entities	No action required.

State Law	Description	Findings	Action Items
	employees after exclusion of group; liability of Program.	that have withdrawn from the program.	
Eligibility and Participation: Opt-out Plan Administration NAC 287.371 NAC 287.376	• Eligibility of officer or employee to join opt-out plan; ineligibility of officer or employee to continue participation in opt-out plan. • Participation in Program by certain persons eligible for coverage under or participating in opt-out plan prohibited; exceptions.	PEBP reports there are no opt-out plans maintained by local government agencies.	No action required.
Benefits Coverage NRS 287.0433 NRS 287.04062 NRS 287.0485	• Power to establish plan of life, accident or health insurance; reinsurance; power to use list of preferred prescription drugs developed by Department of Health and Human Services and obtain prescription drugs through certain purchasing agreements. • Program Fund defined. • No inherent right to certain benefits.	No exceptions noted. Per the MPDs no officer, employee, or retiree of the State has any inherent right to benefits provided under PEBP.	No action required.
Benefits Coverage: Reinstatement of Coverage by Retired Public Officer, Employee or Surviving Spouse NRS 287.0475	Reinstatement of insurance by retired public officer or employee or surviving spouse.	The Eligibility and Enrollment MPD states that “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.	No action required.

State Law	Description	Findings	Action Items
		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 who retired from a nonparticipating local governmental agency or the surviving spouse thereof, may reinstate insurance during the open enrollment period through the Medicare Exchange or under the Public Employees' Benefits Program if eligible, 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) was enrolled in the Program as a retiree on November 30, 2008; and (3) 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. All reinstatement applications are subject to the provisions of the Plan. 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	

State Law	Description	Findings	Action Items
		not later than 31 days before the commencement of the plan year.	
Benefits Coverage: Oral Chemotherapy Parity NRS 695G.167 NRS 287.04335	• Plan covering treatment of cancer through use of chemotherapy: Prohibited acts related to orally administered chemotherapy. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs indicate that the health plans cover orally administered chemotherapy with following cost sharing: LD: 80%/50% EPO: 80%. Not covered OON CDHP: 80% in network after deductible, or 50% out of network, or the Maximum Allowable Charge or 110% of the Medi Span AWP, after Plan Year Deductible has been met. PEBP confirmed the Plan does not require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. PEBP further confirmed that even though members are subject to their deductibles, the cost sharing is capped at $100 for LD PPO and EPO plans in accordance with NRS 695G.167.	No action required.
Benefits: Coverage: Services Provided Through Telehealth NRS 695G.162 NRS 287.04335	• Required provision concerning coverage for services provided through telehealth to same extent and in same amount as though provided in person or by other means; exception; prohibited acts. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	NRS 695G.162 requires plans to cover telehealth services to the same extent as though provided in person and by other means. The MPDs reflect that telemedicine is covered by Doctors on Demand, and alternatively, telemedicine is available from in-network providers is covered on the same basis as in-person services.	Recommended Action: PEBP should clarify in MPDs that audio-only (telephone) interactions involving counseling and treatment of mental health or substance use disorder conditions are covered under telemedicine services in compliance with NRS 695G.162(2)(b).

State Law	Description	Findings	Action Items
		The CDHP MPD reflects that telemedicine is covered at 80% in network after the deductible has been met but not covered out-of-network. The EPO and LD PPO MPDs state that failure to use in-network providers will result in a denial of benefits and higher cost. In addition, the MPDs indicate that telemedicine only involves audio-visual (video) communication technology and does not include communication through telephone, facsimile, or email.	
Benefits: Coverage: Continued Medical Treatment NRS 695G.164 NRS 287.04335	• Required provision in certain plans concerning coverage for continued medical treatment; exceptions; regulations. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs reflect continuation of coverage provisions.	No action required.
Benefits Coverage: Autism Spectrum Disorders NRS 695G.1645 NRS 287.04335	• Required provision in plan for group coverage concerning coverage for autism spectrum disorders for certain persons, prohibited acts. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs reflect autism coverage with the same copay, deductible, and coinsurance provisions as other medical services covered by the plan. MPDs state that autism treatment is covered until age 22.	Recommended Action: Consider removing the age limit to compliance with the most recent guidance for the federal mental health parity rules.
Benefits Coverage: Medically Necessary Emergency Services NRS 695G.170 NRS 287.04335	• Required provision concerning coverage for medically necessary emergency services at any hospital, prohibited acts. • Compliance with certain provisions required to provide	MPDs do not require precertification for medically necessary emergency services provided at any hospital.	No action required.

State Law	Description	Findings	Action Items
	health insurance through plan of self-insurance.		
Benefits Coverage: Submission to step therapy protocol NRS 695G.1702 NRS 287.04335	Plan covering prescription drugs: Submission to step therapy protocol for drug to treat psychiatric condition prohibited in certain circumstances.	MPDs provide that some classes of medications are excluded from step therapy including medications to treat mental health disorders, opioid disorders, substance abuse disorders, and certain types of cancer.	No action required.
Benefits Coverage: Biomarker testing NRS 695G.1703 NRS 287.04335	Required provision concerning coverage for biomarker testing for diagnosis, treatment, management and monitoring of cancer in certain circumstances; establishment of process to request exception or appeal denial of coverage; time for responding to request for prior authorization.	MPDs provide for biomarker testing and provide for 24-hour urgent prior authorization limit, and 72-hour prior authorization limit for other requests.	No action required.
Benefits Coverage: Hepatitis C and HIV NRS 695G.1705 NRS 287.04335	Required provision concerning coverage for drugs, laboratory testing and certain services related to human immunodeficiency virus and hepatitis C; reimbursement of certain providers of health care for certain services; prohibited acts.	NRS 695G.1705 requires coverage regarding the prevention, testing, and treatment for human immunodeficiency virus or hepatitis C. MPDs provide coverage for testing for HIV and hepatitis C and coverage for hepatitis C drugs, however, are silent on treatment for HIV, including coverage of medications.	Recommended Action: Consider clarifying language regarding coverage of drugs used for prevention and treatment of HIV in the MPDs, including all medications approved by the U.S. FDA.
Benefits Coverage: Sexually Transmitted Diseases NRS 695G.1707 NRS 287.04335	Required provision concerning coverage for testing, treatment and prevention of sexually transmitted diseases; required provision concerning coverage for condoms for certain insureds.	NRS 695G.1707 appears to mandate more extensive coverage than what is on the ACA preventive service requirements for sexually transmitted diseases. Additionally, the Statute mandates unrestricted coverage	Recommended Action: Consider clarifying language in the MPDs to include all coverage mandated by NRS 695G.1707 regardless of age. Refer to comments to clarify coverage of female condoms in coordination with federal preventive services rules.

State Law	Description	Findings	Action Items
		of condoms for insureds who are 13 years or older. MPD states the Plans provide for counseling for sexually transmitted diseases. Specifically: • The CDHP MAPD indicates coverage of Chlamydia and Gonorrhea screening in sexually active women under 24 and women aged 25 years and older at increased risk. • LD PPO indicates coverage of sexually transmitted diseases, including syphilis, screening in pregnant women and individuals aged 13 and above who are at increased risk. MPDs provide that condoms (male and female) are covered for individuals aged 13 and above.	
Benefits Coverage: BRCA gene NRS 695G.1712 NRS 287.04335	• Required provision concerning coverage for screening, genetic counseling and testing related to BRCA gene in certain circumstances.	MPDs provide coverage for: • Genetic Testing, including BRCA • Biomarker testing for the diagnosis, treatment, appropriate management, and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence. • BRCA risk assessment for women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations.	No action required.

State Law	Description	Findings	Action Items
Benefits Coverage: Prohibition on Pre-Existing Conditions; Health Status NRS 695G.155 NRS 287.04335	Managed care organization required to offer and issue plan regardless of health status of persons; prohibited acts; authority to include wellness program in plan that offers discounts based on health status under certain circumstances.	The MPDs, under Benefits Limitations and Exclusions, contain the following exclusion: Illegal Act Exclusion: Injuries sustained during the course/because of committing illegal acts is not covered.	Recommended Action: Consider adding in MPDs: Injuries or illnesses that are due to an underlying physical condition or medically diagnosed Mental or Nervous Disorder, or that occur during acts of domestic violence will not be excluded from coverage.
Benefits Coverage: Required Provision Concerning Coverage for Human Papillomavirus Vaccine NRS 695G.171 NRS 287.04335	• Required provision concerning coverage for certain tests and vaccines relating to human papillomavirus, prohibited acts. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide coverage for HPV testing and vaccine.	No action required.
Benefits Coverage: Treatment Received as Part of a Clinical Trial or Study NRS 695G.173 NRS 287.04335	• Required provision concerning coverage for certain treatment received as part of clinical trial or study for treatment of cancer or chronic fatigue syndrome; authority of managed care organization to require certain information; immunity from liability. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide coverage for Experimental and/or Investigational Services as provided under NRS 695G.173.	No action required.
Benefits Coverage: Required Provisions for Prescription Drugs Irregularly Dispensed for Synchronization of Chronic Medications NRS 695G.1665 NRS 287.04335	• Required provision in plan covering prescription drugs concerning coverage for prescription drugs irregularly dispensed for purpose of synchronization of chronic medications; prohibited acts; exception.	MPDs do not provide provision concerning coverage for prescription drugs irregularly dispensed for the synchronization of chronic medications.	Recommended Action: Consider adding language in the MPDs concerning coverage of irregularly dispensed prescription drugs for the synchronization of chronic medications in compliance with NRS 695G.1665.

State Law	Description	Findings	Action Items
	• Compliance with certain provisions required to provide health insurance through plan of self-insurance.		Additionally, unless it is stated otherwise in its network contract, PEBP should confirm that pharmacy dispensing fees are not prorated for handling synchronized partial refills.
Benefits Coverage: Required Provisions for Early Refills of Topical Ophthalmic Products NRS 695G.172 NRS 287.04335	• Plan covering prescription drugs: Denial of coverage prohibited for early refills of otherwise covered topical ophthalmic products. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs state: If participants are going to be away from their home for an extended period, either in the country or outside of the country, participants may obtain an additional fill (30- or 90-day supply) of the prescription drugs from their 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. However, the MPDs do not specifically refer to early refill of topical ophthalmic products.	Recommended Action: Consider specifically including the early refill of topical ophthalmic products in the MPDs per NRS 695G.172.
Benefits Coverage: Required Provisions for Coverage for Prostate Cancer Screening NRS 695G.177 NRS 287.04335	• Required provision in plans covering treatment of prostate cancer concerning coverage for prostate cancer screening; prohibited acts. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide this benefit if covered as a preventive care service.	No action required.
Benefits Coverage: Claims Involving Intoxication NRS 695G.405 NRS 287.04335	• Managed care organizations prohibited from denying coverage solely because applicant or insured was intoxicated or under the	MPDs provide that PEBP excludes a claim for injuries sustained during the course/because of committing illegal acts.	Recommended Action: PEBP should consider revising this exclusion to clarify compliance with NRS 695G.405

State Law	Description	Findings	Action Items
	influence of controlled substance, exceptions. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.		and federal HIPAA nondiscrimination rules.
Benefits Coverage: Sickle Cell Anemia Treatment NRS 695G.174 NRS 287.04335	• Required provision concerning coverage for management and treatment of sickle cell disease and its variants; plan covering prescription drugs required to provide coverage for medically necessary prescription drugs to treat sickle cell disease and its variants. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide coverage for sickle cell disease. MPDs provide for coverage for prescription drugs to treat sickle cell disease. Case management is available for individuals diagnosed with sickle cell or its variants consistent with NRS 695G.174.	No action required.
Benefits Coverage: Gestational Maternity Care NRS 695G.1716 NRS 287.04335	• Health care plan covering maternity care: Prohibited acts by managed care organization if insured is acting as gestational carrier; child deemed child of intended parent for purposes of plan. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Per the MPDs, maternity services include gestational carrier who is a primary member or the spouse/domestic partner of the primary member.	No action required.
Benefits Coverage: Electronic Health Information NRS 439.581 to NRS 439.597 NRS 287.04335	• Certification for health information exchange required; disciplinary action for failure to comply with law; administrative fine for operating without certification; regulations • Limitations on use, release or publication of certain information; penalty for	PEBP provided a copy of its PHI security procedures. Additionally, PEBP provided that PEBP staff, with exception of the Executive Officer and Quality Control (QC) staff, do not handle EHRs. PEBPs Executive Officer and QC staff have access to vendor portals such as UMR and ESI in	No action required.

State Law	Description	Findings	Action Items
	unauthorized access to electronic health records or health information exchange; establishment of complaint system. • Patient not required to participate in health information exchange; notification to patient of breach of confidentiality of electronic health records or health information exchange; patient access to electronic health records. • Electronic health records, electronic signatures and electronically transmitted or retrieved health information deemed to comply with certain writing and signature requirements; information maintained or transmitted in electronic health record or retrieved by a health information exchange deemed to comply with certain confidentiality requirements; exception. • Electronic transmission of health information: Exemption from state law concerning privacy or confidentiality of certain health information; ability of person to opt out of electronic disclosure of certain health information.	order to review claims for level 2 appeals. The claims data does not include diagnosis or medical notes; rather, it includes the providers' name, the billed amount, and the CPT code for the procedure. In addition, members may provide QC staff with copies of prior authorizations and appeal decision letter with health information as component of a compliant or an appeal. Lastly QC staff facilitate the External Review Process. As with complaints/appeals, QC staff may receive copies of prior authorizations, medical records, etc. as a component of an external review. Health records are sent and received securely between PEBP and their various vendors.	
Contract Provisions: Vision Care NRS 686A.135 NRS 287.04335	Vision care: Prohibited provisions in contract between insurer and provider; insurer required to provide list of reimbursement	This section sets out certain prohibited contract provisions between insurers and providers.	No action required.

State Law	Description	Findings	Action Items
	rates to provider before entering contract; insurer required to disclose in policy pecuniary interest in supplier or provider; prohibited advertisements by insurer related to coverage; provider required to disclose pecuniary interest in supplier; use of in-network source or supplier not prohibited.	PEBP should operate due diligence in ensuring its vendors comply with contract prohibitions mandated by NRS 686A.135.	
Contract Provisions: Medicare Supplemental Policies NRS 687B.352 NRS 287.04335	Open enrollment period for Medicare supplemental policies required; prohibited acts; notice; treatment of Medicare supplemental policies purchased during open enrollment period for purposes relating to payment of commissions.	PEBP does not offer Medicare supplemental coverage. This section is not applicable.	No action required.
Contract Provisions: Mental Health and Substance Abuse Payments NRS 687B.409 NRS 287.04335	Payments to out-of-network providers for treatment of mental health or alcohol or substance use disorder, assignment of benefits.	This section outlines certain mandates as to payments to out-of-network mental health and substance use providers. PEBP should continue its due diligence to ensure vendors are following NRS 687B.409 procedures for payments to out-of-network mental health and substance use disorder providers.	No action required.
Contract Provisions: Dental Care NRS 687B.723 NRS 287.04335	Claim for dental care: Health carrier or administrator of health benefit plan prohibited from denying claim for which prior authorization has been granted; exceptions.	PEBP has not encountered any concerns regarding denial of claims after prior authorization was granted.	No action required.
Claims: Dental Care NRS 687B.725 NRS 287.04335	Claim for dental care: Requirements and limitations related to recovery of overpayments.	No concerns noted. PEBP should continue its due diligence to ensure vendors are following overpayment	No action required.

State Law	Description	Findings	Action Items
		procedures mandated by NRS 687B.725.	
Benefits Coverage: Inherited Metabolic Disease NRS 695C.1723 NRS 287.04335	Required provision concerning coverage for treatment of certain inherited metabolic diseases.	MAPDs indicate that PEBP provides coverage for inherited metabolic diseases. Documentation to substantiate the presence of an inherited metabolic disease, including documentation that the product purchased is a special food product or enteral formula, may be required before the Plan will reimburse costs associated with special food products or enteral formulas. MPD states there is coverage for enteral formulas for treatment of inherited metabolic diseases, with a $2,500 annual limit.	No action required.
Benefits Coverage: Authorization of Recommended and Covered Services NRS 695G.150 NRS 287.04335	Authorization of recommended and covered health care services required.	Per the MPDs, "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 Plans appear to comply with NRS 695G.150's requirements.	No action required.
Benefits Coverage: Prescription Coverage during Emergency Declaration NRS 695G.1635 NRS 287.04335	Plan covering prescription drugs: Required actions by managed care organization related to acquisition of prescription drugs for certain insureds residing in area for which emergency or disaster has been declared.	CDHP and EPO MPDs state that PEBP allows for three (3) emergency refills per plan year, including in a declared disaster area.	Recommended Action: PEBP should consider explaining in the MPDs the procedure to obtain emergency prescription coverage during emergency or disaster declaration, and any

State Law	Description	Findings	Action Items
			geographic limitations to this benefit.
Benefits Coverage: Step Therapy Cancer Protocols NRS 695G.1675 NRS 287.04335	Plan covering prescription drug for treatment of cancer or cancer symptom that is part of step therapy protocol: Managed care organization required to allow insured or attending practitioner to apply for exemption from step therapy protocol in certain circumstances; procedure for applying for and granting exemption.	MPDs provide that some classes of medications are excluded from step therapy including medications to treat mental health disorders, opioid disorders, substance abuse disorders, and certain types of cancer. The MPDs do not provide for step therapy exemption procedures.	Recommended Action: PEBP should consider clarifying step therapy exemption procedures in the MPD consistent with NRS 695G.1675.
Benefits Coverage: Examination of pregnant person for certain diseases NRS 695G.1714 NRS 287.04335	Required provision concerning coverage for examination of person who is pregnant for certain diseases.	While the MPDs refer to coverage of testing for some sexually transmitted diseases, they do not specifically indicate whether testing for all diseases referenced in NRS 695G.1714 are covered as part of maternity coverage. • LD PPO MPD indicates coverage of sexually transmitted diseases, including syphilis, screening in pregnant women and individuals aged 13 and above who are at increased risk. • EPO MPD states testing for chlamydia, gonorrhea, diabetes/pre-diabetes, Hep B, Hep C, HIV, HPV, hypertension, TB, osteoporosis, depression, anxiety, drug and alcohol use, RH factor, syphilis, and other STDs as recommended for individuals and pregnant women. • CDHP MPD indicates coverage for chlamydia and gonorrhea	Recommended Action: The Plan should consider clarifying in the MPDs that it provides coverage for testing for diseases references in NRS 695G.1714 as part of maternity coverage, without any prior authorization requirements or age an age restriction.

State Law	Description	Findings	Action Items
		screening in sexually active women under 24 and women aged 25 years and older at increased risk, as preventive services under the ACA as well as screening for syphilis in pregnant women.	
Benefits Coverage: Contraception and related health services NRS 695G.1715 NRS 287.04335	Required provision concerning coverage for drug or device for contraception and related health services; prohibited acts; exceptions.	MPDs state that "the Plan adheres to NRS 695G.1715 regarding contraception and related health services." MPDs provide coverage for tubal ligations. MPDs additionally state that the Plan covers FDA approved contraceptive methods, including contraceptive injection or the insertion of a device at a hospital immediately after an insured gives birth, sterilization procedures, and patient education and counseling for women with reproductive capacity.	No action required.
Benefits Coverage: Drugs related to Substance and opioid use disorder NRS 695G.1719 NRS 287.04335	Required provision concerning coverage for certain drugs and services related to substance use disorder and opioid use disorder; reimbursement of pharmacists and pharmacies for certain services; prohibited acts.	MPDs state that the Plan covers medication for treatment of opioid and substance use disorders, however, they do not provide language for medication-assisted treatment and specify the medications required to be covered under NRS 695G.1719. Additionally, the MPDs do not provide language for benefits for safe withdrawal from substance use disorder, including lofexidine.	Recommended Action: PEBP should consider specifying in the MPDs that the Plan covers the specific medications and services related to substance use disorders and include language to support safe withdrawal from substance use disorder, including, without limitation, lofexidine. PEBP should clarify that the Plan does not subject these benefits to medical management techniques, other than step therapy.

State Law	Description	Findings	Action Items
Benefits Coverage: Gender Dysphoria NRS 695G.1718 NRS 695G.415 NRS 287.04335	• Required provision concerning coverage for medically necessary treatment of conditions relating to gender dysphoria and gender incongruence; restriction on refusal to cover certain treatments; authority of managed care organization to prescribe requirements for covering surgical treatments for minors; determination of medical necessity. • Managed care organizations prohibited from discriminating against person with respect to participation or coverage on basis of gender identity or expression.	MPDs state: "This Plan provides benefits to individuals seeking medically necessary services for the treatment of gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders." PEBP provides the coverage mandated by this statute.	No action required.
Benefits Coverage: Preventive and Wellness services, tests, and screenings NRS 695G.1717 NRS 287.04335	Required provision concerning coverage for certain services, screenings and tests relating to wellness, prohibited acts.	MPDs provide for the following coverage: • Breastfeeding support, supplies, and counseling • Screening for interpersonal and domestic violence • Counseling for sexually transmitted infections (STI), HIV counseling and testing • Screening for gestational diabetes • Prenatal care • Screening for depression, diabetes, including gestational diabetes, hypertension, various cancers • Routine gynecologic examination (one per Plan Year), including annual	No action required.

State Law	Description	Findings	Action Items
		cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination. • Evidence-based items or services that have an “A” or “B” Recommendation by the United States Preventive Services Task Force (USPSTF). • Immunizations recommended by the federal Advisory Committee on Immunization Practices (ACIP). • 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 • 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. • Smoking/tobacco cessation • Hormone replacement therapy	
Plan covering anatomical gifts, organ transplants or treatments or services related to organ transplants	Plan covering anatomical gifts, organ transplants or treatments or services related to organ transplants: Prohibited acts by	No issues noted.	No action required.

State Law	Description	Findings	Action Items
NRS 695G.176 NRS 287.04335	managed care organization if insured is person with disability.		
Benefits Coverage: Prescription Drug Coverage NRS 287.0433	Power to establish plan of life, accident or health insurance; reinsurance; power to use list of preferred prescription drugs developed by Department of Health and Human Services and obtain prescription drugs through certain purchasing agreements.	No issues noted.	No action required.
Funding Requirements: Payment of Premiums NAC 287.420 NRS 287.04385 NRS 287.044	• Payment of premiums or contributions by public employer; Due date; penalty. • Action by Program to recover delinquent payments, penalties or late fees, statute of limitations. • Payment of premiums or contributions to Program; coverage of dependents; allocation of money paid to Program; establishment of Active Employee Group Insurance Subsidy Account.	NAC 287.420 provides penalties to be assessed in the event of nonpayment of insurance premiums or contributions by the participating public agency. PEBP provided its procedures for billing and collection of payments of non-state entities. No concerns were noted in review of billing and collection procedures.	No action required.
Funding Requirements: Direct Payment of Premiums for Retirees, LOAs Without Pay and LOAs due to Work Injury NAC 287.430 NAC 287.440 NAC 287.450 NAC 287.460 NRS 287.046 NRS 287.0439 NRS 287.0445	• Direct payment of premiums or contributions: Date due; cancellation of coverage. • Payment of premiums or contributions by retired officers and employees. • Employees on leave without pay: Conditions for payment of premiums or contributions by participating public agency; continuation of or eligibility for coverage or insurance; coverage and insurance upon return to full-time employment.	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	No action required.

State Law	Description	Findings	Action Items
	• Officers and employees on leave because of injuries in course of employment: Payment of premiums or contributions; reports of change in status; coverage of dependents upon return to work. • Office of Finance to establish assessment to pay portion of premiums or contributions for participating retirees with state service; amounts assessed to be deposited in Retirees' Fund; adjustments to portion paid to Program by Retirees' Fund. • Participating public agency required to furnish certain notice and information to Board and make records available for inspection; reimbursement of Program for premiums or contributions if agency fails to notify Program of change in status of employee. • Payment of premiums or contributions for state officer or employee injured in course of employment while member of Program.	dependent of another PEBP covered participant. Employee and dependent health care coverage during the period of Workers' 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. Following the 9-month period during which the employee has been on Workers' 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.	
Funding Requirements: Procedures Regarding Handling Over/ Underpayments of Premiums NAC 287.470	• Overpayment or underpayment of premiums or contributions. • Powers and duties.	PEBP has confirmed it has over and underpayment procedures in place, including assessments of underpayment penalties. No concerns noted.	No action required.

State Law	Description	Findings	Action Items
Subrogation to Rights of Officer, Employee or Dependent NRS 287.0465	Board subrogated to rights of member; lien upon proceeds of recovery from person liable for illness or injury.	The Active Wrap Plan Document highlights the subrogation rights.	No action required. PEBP's legal counsel should review the subrogation rights.
Claims and Appeals Procedures NRS 287.608 NAC 287.610 NAC 287.620 NAC 287.660 NAC 287.670 NAC 287.680 NAC 287.690 NRS 287.695 NRS 287.04335	• Claims administrator or vendor required to be independent contractor • Period for submission. • Assumption regarding availability of benefits under Medicare; coordination under Medicare. • Notification of adverse determination; grounds for appeal. • Appeal of adverse determination: Requirements; duties of Appeals Manager. • Appeal of decision of Appeals Manager: Requirements; duties of Executive Officer or designee. • Request for external review. • Request for expedited review by Claims Administrator • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	The Active Wrap Plan Document and medical MPDs outline the claims and appeals procedures. The MPDs do not contain procedures for disability-related claims. PEBP reported that disability-related claims are administered according to the PEBP MPDs and Nevada state regulations.	Recommended Action: Consider stating in the MPDs that the claims and appeals procedures for post-service claims discussed in the MPDs also apply to disability-related claims. Identify any differences in the claims and appeals procedures for disability-related claims.
Claims and Appeals Procedures: Complaint System; Notice Requirements to Insured NAC 287.750 NRS 695G.200 NRS 695G.220 NRS 287.04335	• System for resolving complaints of insureds: Requirements for approval and annual report. • Establishment; approval; requirements; assistance for persons filing complaints; examination.	PEBP has confirmed they have a complaint resolution system for the Division of Insurance as noted in NAC 287.750.	No action required.

State Law	Description	Findings	Action Items
	• Annual report: managed care organization required to maintain records of and report complaints concerning something other than health care services. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.		
Claims and Appeals Procedures: Notice to Insured; Expedited Review Process NRS 695G.210 NRS 287.04335	• Review board; appeal; right to expedited review of complaint; notice to insured. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	In the MPDs, the 72-hour expedited review processing is noted under prescription drugs claims and appeals section, however, it is not discussed under general claims processing as required under NRS 695G.210(3).	Recommended Action: Consider clarifying, under the Claims Administration sections of the MPDs, how expedited reviews are processed.
Claims and Appeals Procedures: External Review Process NRS 695G.241 NRS 695G.300 NRS 695G.310 NRS 287.04335	• Circumstances under which adverse determination may be subject to external review, exceptions. • Submission of complaint of covered person to independent review organization. • Annual report; requirements. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs outline the external review process. PEBP stated that it has completed the 2024 and 2025 annual reports and will complete and submit the 2026 report as required under NRS 695G.310.	Recommended Action: See notes in the MPDs suggesting some language clarification.
PEBP Board Authority and Duties NRS 287.04062 NRS 287.043 NRS 287.0487 NRS 287.04335 NRS 287.0434	Program Fund defined. Powers and duties. • Participant in Program may seek assistance from Office for Consumer Health Assistance regarding coverage. • Compliance with certain provisions required to provide	No issues noted.	No action required.

State Law	Description	Findings	Action Items
	health insurance through plan of self-insurance. • Power to use assets, contract for services and charge and collect certain fees and payments.		
Taxable compensation reduction NRS 287.245	Employer may agree with employee to reduce taxable compensation; federal requirements prerequisite for operation of program; powers of Board of the Public Employees' Benefits Program.	No issues noted.	No action required.
Local governmental agency may contract with Public Employees' Benefits Program NRS 287.025	Local governmental agency may contract with Public Employees' Benefits Program or other local governmental agency or participate as member of nonprofit cooperative association or corporation for group insurance, related medical services or health-related information.	PEBP confirmed several agencies contract with PEBP.	No action required.

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