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AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 5, 2022

Item Number: VII

Title: Biennial Compliance Report

SUMMARY

NRS 287.0425 requires PEBP to conduct a biennial review of the program to determine whether the program complies with federal and state laws relating to taxes and employee benefits. The review must be conducted by an attorney who specializes in employee benefits. PEBP enlisted the consulting services of Segal and their legal counsel to perform a thorough review and assessment of the PEBP program.

REPORT

COMPLIANCE REPORT

See Attachment A

PEBP RESPONSE

FINDING	PEBP RESPONSE
Mental Health Parity and Addiction Equity Act – MHPAEA (refer to section 3)	PEBP accepts this finding and will take action to ensure MHPAEA compliance. PEBP understands that to accomplish this, the program has the following options: • Opt-out – this allows the program to continue offering equal treatment of mental health and substance abuse disorders while eliminating the administratively burdensome federal requirements.

	• Continue to Opt-in (default) – PEBP will have to complete the following on an annual basis: 1. Review current financial requirements and quantitative treatment limitations (QTLs) described in the plan document applicable to mental health and substance use disorder benefits as compared to medical/surgical benefits 2. Review nonquantitative treatment limitations (NQTLs) under the plan both as written as well as applied in operation 3. Have a documented comparative analysis regarding how any NQTLs that apply to mental health/substance use disorder are applied as compared to when applied to medical/surgical benefits. 4. Collect information from appropriate benefit administrators; medical, mental health, pharmacy, and utilization management
Excepted Benefits – Dental (refer to section 4)	PEBP accepts this finding and will take action to ensure compliance with the Affordable Care Act (ACA). PEBP understands that to accomplish this, the program has the following options: • Unbundle dental by allowing members to opt-out of dental coverage. This move will ensure it meets the requirements of an "excepted benefit". • Administratively unbundle dental by securing a separate TPA to process dental claims. This action will ensure it meets the requirements of an "excepted benefit". • Extend ACA required pediatric dental essential health benefit by eliminating the dental annual maximum for children under the age of 19. This action will not result in dental being considered an excepted benefit but will instead allow PEBP to be in compliance with the ACA.
Nondiscrimination Testing	PEBP accepts this finding and will take appropriate action to ensure this is completed.
Summary of Benefits and Coverage language	PEBP has incorporated suggested language.
Preventive Care	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.
Provider Nondiscrimination	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.

Notice of Right to Continue Care	PEBP accepts this finding and will work with the TPA and network to ensure compliance. A process is already in place today but does not meet the requirement because it relies on a request triggered by the member rather than a notification to the member. PEBP will need to determine how to proactively identify members that meet the criteria.
No Surprises Act – Emergency Services	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.
Group Health Plan Transparency Rule 1/1/23	PEBP will work with the TPA to ensure the self-service tools offered through the member portal meet the requirements.
Qualified Medical Child Support Order	PEBP has incorporated suggested language to corresponding MPD.
Dependent Care FSA	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.
Coordination with Health FSA	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.
Sickle Cell Anemia	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.

STAFF RECOMMENDATION:

1. **MPHPEA: Opt-out but continue providing parity for mental health and substance abuse disorders through plan benefit design decisions. This relieves the program of burdensome federal requirements and removes the risk of federal audits and potential program liability.**

2. **Excepted Benefit (dental): Eliminate the annual maximum for pediatric dental. At a relatively low cost projection of $40,000 year, this option is both the least disruptive and least costly for the program.**

Public Employees' Benefits Program

Biennial Compliance Review

November 28, 2022

Segal

Table of Contents

Section 1. Introduction

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.

Our compliance review is based on documents received, statutes, and regulations as existing and in effect for PEBP's July 1, 2022—June 30, 2023 plan year ("PY 2023"). 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, Section 4, and Appendices A and B for detailed information and recommended actions.

Federal Law

Nondiscrimination Testing

- The IRC (and the regulations) require that certain welfare benefits be provided on a nondiscriminatory basis and also provide tests to assure that plans do not discriminate.
- PEBP should consider nondiscrimination testing of the self-funded medical plan, cafeteria plan and dependent care flexible spending account plan as imposed by Internal Revenue Code Sections 105(h), 125(h) and 129, respectively.
- Based on testing results, plan design changes may be necessary.

Electronic Disclosure of Important Notices to Spouses, Other Beneficiaries, and Employees without Routine Computer Access at Work

- PEBP should continue to work toward a system change that will allow it to get written consent to receive electronic notices from retirees and others without work access, as well as keep multiple addresses on file (e.g., COBRA, where spouse has different address from employee) to send separate notices to them when needed.

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

- Segal is not aware of PEBP performing a quantitative treatment limitations (QTL) or nonquantitative treatment limitations (NQTL) analysis or filed for a federal opt-out. PEBP should determine if it will elect the federal opt and also determine a plan for performing QTL and NQTL analysis.
- Options:
  - PEBP can opt-out on a year to year basis prior to the beginning of each plan year. A detailed discussion of the opt-out process is included in Section 3. This includes:
    - Annual Federal filing
    - Annual participant notice
  - › Can opt-out and still maintain compliance with MHPAEA requirements
    - Can still perform QTL and NQTL analysis and maintain documentation to support compliance

        - Opt-out elections for self-funded non-Federal governmental plans are posted on the CMS website.
    - Current compliance needs as a non-opt-out plan
        - Review all current financial requirements and QTLs described in the plan document applicable to mental health and substance use disorder benefits as compared to medical/surgical benefits
        - Review NQTLs under the plan both as written as well as applied in operation
        - Have a documented comparative analysis regarding how any NQTLs that apply to mental health/substance use disorder are applied as compared to when applied to medical/surgical benefits.
        - Collect information from appropriate benefit administrators; medical, mental health, pharmacy and utilization management.
- Refer to Section 3 for detailed information.

Excepted Benefit – Dental Program

- Our understanding is that the self-funded PPO dental plan is integrated with the medical plan. Participants are not charged a separate contribution for the coverage, and participants cannot opt-out of this coverage after electing medical coverage. The medical and dental benefits are both administered by UMR. Thus, we believe the dental PPO benefit is not an excepted benefit.
- Options:
    - Provide participants the ability to opt-out of dental.
        - A separate employee contribution is not required, nor is it necessary to revise the employee contribution amount. The participant needs to have the opportunity to decline dental coverage.
    - Have a separate contract from the claims administration for any other benefits under the plan.
    - Remove dental benefit plan year maximum for individuals up to age 19.
        - Segal's actuarial team estimates this would increase dental costs by $40,000 annually
- Refer to Section 4 for detailed information.

State Law

- PEBP should review the benefit requirements as listed under NRS 287.04335 – (Compliance with certain provisions required to provide health insurance through plan of self-insurance) that pertain to PEBP and update the Master Plan Documents (MPDs) as necessary.
- PEBP should review the MPDs and confirm the appropriate state laws applicable to PEBP.

Section 3. Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

Summary

- MHPAEA generally requires parity between medical/surgical and mental health/substance use disorder benefits.
- Under MHPAEA plans are required to comply with parity with respect to both financial requirements and quantitative treatment limitations (QTLs) (such as copayments, coinsurance, day or visit limits) and nonquantitative treatment limitations (NQTLs). NQTLs refer to wide range of medical management techniques such as prior authorization, network admission standards, and fail first policies. MHPAEA also imposes disclosure requirements.
- Congress amended MHPAEA to impose clearer expectations around NQTL compliance. The Consolidated Appropriations Act, 2021 was signed into law on December 27, 2020. The *Strengthening Parity in Mental Health and Substance Use Disorder Benefits* provisions amend the MHPAEA, requiring group health plans to perform and document comparative analyses of the design and application of NQTLs.
- The Act requires group health plans to be prepared to make these comparative analyses available to the Federal Departments of Labor, Health and Human Services (HHS) and Treasury upon request beginning 45 days after the date of enactment (February 10, 2021).
- Additionally, self-funded non-federal governmental plans are permitted to elect an exemption (or opt-out) from certain provisions of federal law, including the parity provisions.
- Segal is not aware of PEBP performing a QTL or NQTL analysis or filed for a federal opt-out. PEBP should determine if it will elect the federal opt and also determine a plan for performing QTL and NQTL analysis.

Background on MHPAEA

Final regulations implementing the Mental Health Parity and Addiction Equity Act (MHPAEA)[1] were issued by the Departments of Health and Human Services, Labor and the Treasury (the Departments) on November 13, 2013. The final rule generally became applicable for plan years beginning on or after July 1, 2014. As a result of additional legislation, the opioid crisis, and Federal

[1] The final rule is available at http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf. The Departments also released a set of Answers to Frequently Asked Questions on the final rule, available at http://www.dol.gov/ebsa/faqs/faq-aca17.html.

regulatory initiatives, the Departments have worked since then to build a strong MHPAEA compliance assistance and enforcement program.

MHPAEA generally requires parity between medical/surgical (Med/Surg) and mental health/substance use disorder (MH/SUD) benefits. Under MHPAEA plans are required to comply with parity with respect to both financial requirements and quantitative treatment limitations (QTLs) (such as copayments, coinsurance, day or visit limits) and nonquantitative treatment limitations (NQTLs). NQTLs refer to wide range of medical management techniques such as prior authorization, network admission standards, and fail first policies. MHPAEA also imposes disclosure requirements.

The final rule requires plan sponsors to measure parity within six separate benefit classifications: 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs.

Congress amended MHPAEA to impose clearer expectations around NQTL compliance. The Consolidated Appropriations Act, 2021 was signed into law on December 27, 2020. The *Strengthening Parity in Mental Health and Substance Use Disorder Benefits* provisions amend the MHPAEA, requiring group health plans to perform and document comparative analyses of the design and application of NQTLs. The Act requires group health plans to be prepared to make these comparative analyses available to the Departments upon request beginning 45 days after the date of enactment (February 10, 2021). The law also calls on the Federal Departments of Labor, Health and Human Services (HHS) and Treasury to issue additional implementing guidance. The Departments released Answers to Frequently Asked Questions on April 2, 2021. On January 25, 2022, the Departments issued the 2022 MHPAEA Report to Congress: Realizing Parity, Reducing Stigma, and Raising Awareness, along with the FY 21 MHPAEA enforcement fact sheet. No further guidance has been issued as of the date of this report.

The Department of Health and Human Services actively enforces the MHPAEA requirements with respect to nonfederal governmental plans.

Opt-Out Option

Sponsors of self-funded non-federal governmental plans are able to opt out of the requirements of MHPAEA. Specifically, self-funded non-federal governmental plans are permitted to elect an exemption from certain provisions of federal law, including the parity provisions.[2] By opting out of MHPAEA, PEBP could still choose to cover mental health and/or substance use disorder benefits, and can seek to achieve parity. However, plans that opt out are not subject to Federal oversight of the MHPAEA provisions. Federal audits often raise complex inquiries related to parity compliance and can be a resource intensive process. Further, if PEBP's self-funded plan is found out of compliance with MHPAEA, PEBP would not be liable for any period during which the opt-out was elected.

[2] In addition to MHPAEA, such plans may also opt out of the following federal laws: the Newborns' and Mothers' Health Protection Act (addressing the length of hospital stays for childbirth), the Women's Health and Cancer Rights Act (addressing reconstructive surgery following mastectomies) and Michelle's Law (addressing extended coverage for students on a medically necessary leave of absence).

Opt-Out Requirements

Electronic Filing

Plans generally must file an election with the Centers for Medicare & Medicaid Services (CMS) before the first day of the plan year (however, there are some special timing rules for collectively bargained plans). The filing is submitted electronically through the Non-Federal Governmental Plans Module in the Health Insurance Oversight System (HIOS).[3] Registering with HIOS and submitting the opt-out election can be time consuming so plan sponsors should begin the process well in advance of the applicable plan year. New HIOS users will need to register in the Enterprise Identity Management system through CMS's Enterprise Portal, available at https://portal.cms.gov. More information about the HIOS system can be found in the User Manual, available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-NonFed-UserManual.pdf.

Notice

Plans must notify each affected enrollee in writing of the election and explain the consequences. HHS has provided model notice language.[4] The plan can provide the notice by prominently including it in the summary plan description or equivalent descriptive materials provided to enrollees at the time of enrollment and annually. Initial notices must be provided prior to the first day of that plan year, and renewal notices must be provided no later than the last day of each plan year. New opt-out submissions must provide a copy of the notice with the election document. Renewal opt-out submissions must certify that notice has been or will be sent.

Detailed Requirements

An opt-out election for the PEBP plan must meet the following requirements:

- Be made in an electronic format;
- Be made in conformance with all the PEBP's rules, including any public hearing requirements;
- Specify the beginning and end dates of the period to which the election is to apply. This period can be either a single specified plan year or the "term of the agreement" for collectively bargained plans;
- Specify the name of the plan and the name and address of the plan administrator, and include the name and telephone number of a person CMS may contact regarding the election;
- State that the plan does not include health insurance coverage, or identify which portion of the plan is not funded through health insurance coverage;
- Specify each requirement from which PEBP elects to exempt the plan;

[3] Additional information is available at https://www.cms.gov/CCIIO/Resources/Files/hipaa_exemption_election_instructions_04072011.html

[4] http://www.cms.gov/CCIIO/Resources/Files/Downloads/model_enrollee_notice_04072011.pdf

- Certify that the person signing the election document, including (if applicable) a third party plan administrator, is legally authorized to do so by PEBP;
- For initial elections, include as an attachment, a copy of the notice to plan enrollees; and
- For renewal elections, certify that the notice has been or will be provided to enrollees.[5]

[5] https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/hipaa-exemption-guidance-7212014.pdf

Section 4. Excepted Benefits – Dental

Summary

Excepted benefits are exempt from several 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.

For self-funded benefits, limited scope dental benefits qualify as excepted benefits if they are not an integral part of the group health plan. Benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan, a separate plan, or as the only plan offered to participants) if either:

(A) Participants may decline coverage. For example, a participant may decline coverage if the participant can opt out of the coverage upon request, whether or not there is a participant contribution required for the coverage.

(B) Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan. [Source: 45 CFR §146.145(b)(3)(ii))].

Our understanding is that the self-funded PPO dental plan is integrated with the medical plan. Participants are not charged a separate contribution for the coverage, and participants cannot opt-out of this coverage after electing medical coverage. The medical and dental benefits are both administered by UMR. Thus, we believe the dental PPO benefit is not an excepted benefit.

Considerations

Plan changes for the dental benefit to be an "excepted benefit"

1) Allow the dental opt-out. A separate employee contribution is not required, nor is it necessary to revise the employee contribution amount. The participant needs to have the opportunity to decline dental coverage.

2) Confirm the contractual arrangement with UMR.

Plan changes to the dental benefit because it is not an "excepted benefit"

1) Essential Health Benefits under ACA. Under the Affordable Care Act, plans cannot have annual or lifetime maximums on "Essential Health Benefits". One of the ten categories of Essential Health Benefits include pediatric dental services. To address this, a plan design change as highlighted below to the Dental PPO could include the following:

Plan Year Maximum Dental Benefits

The Plan Year maximum dental benefits payable for any individual covered under this Plan *age 19 years and over* is $1,500. The Plan Year maximum dental benefit is combined to include both in-network and out-of-network services. Under no circumstances will the combination of in-network and out-of-network benefit payments exceed the $1,500 Plan Year maximum benefit. This maximum does not include your Deductible or any amounts over Usual and Customary. Benefits paid for eligible preventive dental services do not apply to the annual maximum dental benefit. *There is no Plan Year Maximum on dental benefits for individuals up to age 19.* Segal's actuarial team estimates removing the Plan Year Maximum for individuals up to age 19 would increase dental costs by $40,000 annually.

Appendix A. Summary of Findings - Federal

Description		Findings	Action Required
I. IRS Requirements			
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 Lifeworks sends the necessary data for reporting on individual employee W-2s to the applicable state employers.	Complete.
Nondiscrimination Testing	The IRC (and the regulations) require that certain welfare benefits be provided on a nondiscriminatory basis and also provide tests to assure that plans do not discriminate. Certain exceptions apply, particularly for collectively bargained plans: • Section 79- Group term life • Section 105(h)- Self-insured health plans • Section 125- Cafeteria plan, including employer and employee HSA contributions • Section 127- Educational assistance (PEBP does not have) • Section 129- Dependent care FSA • Section 137- Adoption assistance (PEBP does not have)	PEBP has not recently performed nondiscrimination testing.	To be in compliance, PEBP should perform ND testing of its plans.

Description		Findings	Action Required
II. ACA (Patient Protection and Affordable Care Act) Requirements			
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.	PY2023 SBCs provided: • PY2023 CDHP SBC Family • PY2023 CDHP SBC Individual • PY2023 EPO SBC Individual Family • PY2023 HPN HMO SBC • PY2023 LD PPO SBC Family • PY2023 LD PPO SBC Individual 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."	Segal has provided comments for PEBP review and incorporation as necessary.
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 the PCORI fee for all medical plans except the HMO. PEBP states that Health Plan of Nevada pays the PCORI fee for the HMO plan.	Complete.

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 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).	Per the 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 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.	Complete.
90-Day Waiting Period Rule	Plans must cover employees within 90 days of the date on which an employee is otherwise eligible.	MPD states new hire employees are eligible for coverage on the first day of the month concurrent with or following the date of hire.	Complete.
No Rescission	Plans may not rescind coverage retroactively (with limited exceptions).	MPD discusses no retroactive rescission with limited exceptions.	Complete.
Preexisting Condition Exclusions	Plans may not have preexisting condition exclusions or limitations. Hidden preexisting conditions are also prohibited.	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.	Complete.

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.	It does not appear that the PEBP plan imposes annual or lifetime dollar limitations on EHBs in the medical plan. However, the dental program appears to be bundled with the medical and contains an annual maximum benefit for children up to age 19. Pediatric dental is an EHB under the ACA. PEBP should adopt a benchmark plan. This includes selecting one of the 51 EHB base-benchmark plans from 2022 applicable in a State or DC, or to one of the 3 FEHBP EHB-base benchmark plans for purposes of justifying any lifetime or annual dollar limits being imposed by the plan.	See Section 4 for discussion regarding dental program status. PEBP should select benchmark plan if annual or lifetime dollar limits will be implemented.

Preventive Care	Non-grandfathered group health plans must provide certain specified preventive health services without cost sharing. Contraceptive care is provided in accordance with recent guidance and that an exceptions process is available for medical necessity exceptions (FAQ 54).	Per the MPD: Preventive Care/Wellness Benefits are covered 100% in-network not subject to the deductible. The CDHP plan covers mammograms – "the first 2-D or 3-D mammogram of the Plan Year is covered at 100% for women aged 40 years and older, regardless of diagnosis, or beginning at age 35 for members with a high-risk of breast cancer. UMR has confirmed the plan "covering the first mammogram of year as routine regardless of diagnosis." If the specific mammogram service is considered preventive it should be covered at 100% and not subject to the deductible. However, if the specific mammogram service is not considered preventive, then the service is subject to the deductible. To have a CDHP that is an IRS qualified High Deductible Health Plan, and to be eligible for an HSA, an individual can have no other coverage (other than preventive care) before the CDHP deductible is satisfied. UMR and ESI confirmed that contraceptive care is provided in accordance with recent guidance (FAQ 54) and that an exceptions process is available for medical necessity exceptions.	The CDHP MPD and administration should clarify when the mammogram service is considered preventive versus not preventive. If the mammogram is preventive it is not subject to the deductible. If the mammogram is not preventive it is subject to the deductible.
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). 2023 limits:$9,100 for an individual plan and $18,200 for a family plan before marketplace subsidies; maximum deductible is the same as the out-of-pocket maximum.	Per the MPD: OOP maximums: HDHP - $4,000/$8,000 (in-network) Low PPO - $4,000/$8,000 (in-network) EPO - $5,000/$10,000 (in-network)	Complete.

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.	Per the MPD – "The routine medical treatment costs, including all items and services that are otherwise generally available to Plan participants, received as part of a clinical trial or study, may be covered."	Complete.
Provider Nondiscrimination	Plans cannot discriminate against a health care provider acting within the scope of his or her license.	The MPD has reference to provider non-discrimination under PHSA 2706 in the Compliance with Federal Group Health Plan Benefits and Coverage Mandates section. Additionally, the definition of Health Care Practitioner includes a **"**physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice."	PEBP to review physician references in MPD and revise to Health Care Practitioner if appropriate.

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. Limited-scope dental benefits on a self-funded basis qualify as excepted benefits if they are not an integral part of a group health plan. This is met if one of the following conditions is satisfied: • Participants may decline coverage (for example, participants may opt out of the coverage upon request); or • Claims for benefits are administered under a contract separate from claims administration for any other benefits under the plan.	Per the Aon compliance report of 2020: "Based on documentation reviewed, self-insured dental coverage does not appear to be an excepted benefit as it is: (1) bundled with medical coverage for active employees; and (2) the claims administrator for both dental and medical coverage is HealthSCOPE. PEBP discussed with legal counsel and determined that the dental plan is an excepted benefit." For PY 2023 - Active employees cannot independently elect dental coverage without also enrolling in medical coverage. Dental claims are not administered under a separate contract from medical claims. UMR is the TPA for both the medical and dental plans.	The dental benefits do not appear to qualify as limited scope excepted benefits. This has been confirmed with PEBP's legal counsel. See Section 4 for further discussion on the dental benefits.
Employer Shared Responsibility Penalty **I.R.C. Sections 4980H(a) and 4980H(b).**	Employer responsible for counting hours and determining who is a full-time employee eligible for coverage. Medical coverage offered must meet 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 are defined as full-time. The employers may have received the Employer Shared Responsibility Payment notice from the IRS. No concerns reported.	Complete.
Minimum Value	Coverage must meet minimum value standard (60 percent)	SBCs state the plans meet minimum value.	Complete.

Affordability	Employer-offered coverage is considered affordable for an employee if the employee's required premium contribution (if any) is no more than 9.5% of that employee's household income (indexed annually) (9.83% for 2021, 9.61% for 2022, and 9.12% for 2023). 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.	PEBP uses the state of Nevada minimum wage for affordability. (Rate of Pay). Nevada minimum wage: $9.50 for employers offering qualifying health coverage. ($9.50 x 130 hours) = $1,235. $1,235 x 9.61% = $118.68 The lowest cost employee only contributions per month is $46.96 for the CDHP PPO plan.	Complete.
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 1/31 (extended to 3/2/22 for 2021 reporting) 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 central payroll and specific 1095 software. PEBP sends out the 1095-B and 1094-B forms when necessary, and files with the IRS. This is administered in house using 1099 Pro. No concerns reported.	Complete.

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 1/31 (extended to 3/2/22 for 2021 reporting) 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 central payroll and specific 1095 software. PEBP sends out the 1095-C and 1094-C forms, and files with the IRS. This is administered in house using 1099 Pro. No concerns reported.	Complete.
Notice of Choice of Providers (Patient Protection)	Group health plans that require a designation of a primary care provider (PCP) must provide the 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.	The Plan does not require a designation of a primary care physician.	Complete.
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.	Included within the link here: Mandatory Notices (state.nv.us)	Complete. This is an employer requirement. PEBP does not distribute this notice on behalf of the employers, but includes this in its Mandatory Notices on its website.
Notice of Grandfathered Status	A grandfathered plan must include a statement to that effect in any and all materials describing benefits under the plan.	N/A. The plan is not grandfathered.	N/A.
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.	Complete.

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 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. HHS' 2020 Rule repealed the requirement that covered entities provide taglines (short statements advising language services are available in the state's top 15 languages) in all significant communications. However, covered entities must continue to provide taglines whenever such taglines are necessary to ensure meaningful access by Limited-English Proficient (LEP) individuals to a covered program or activity. New proposed regulations may modify this if finalized.	MPD includes Section 1557 Notice. While not currently required, it is expected that the Section 1557 notice may be reinstated within 2023.	Complete. PEBP may want to keep the notice within the MPD while awaiting future guidance.

Description		Findings	Action Required
III. COBRA			
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.	Complete.
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.	Complete.
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.	Complete.
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.	Complete.
Notice of Insufficient Payment of COBRA Premium	Qualified beneficiaries must be notified that a COBRA payment was less than the correct amount 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.	Notice of Late payment provided. 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.	If needed, provide a notice of insufficient payment.

Description		Findings	Action Required
IV. Health Insurance Portability and Accountability Act (HIPAA)			
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 October 27, 2022.	Complete.
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.	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.	Complete.
Wellness Incentives	Plans that provide wellness incentives must meet 5-factor test, including 30 percent test and reasonable accommodations standards.	N/A. PEBP does not have a wellness program.	N/A.
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 7.2 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)"	Complete.

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 Privacy Notice – Disclosure and Access to Medical Information is located on the PEBP website (Mandatory Notices (state.nv.us)	Complete.
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 were emailed to all Active and Retired PEBP members October 27, 2022.	Complete.
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.	Privacy and Security of Protected Health Information (PHI) policy – updated 08.10.2021	Complete.
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	Complete.
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. We recommend supplementing this assessment with an additional review addressing issues such as how information is identified as PHI, when is PHI 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.	Complete. .
HIPAA Training	A covered entity must train all workforce members on its privacy and security policies and procedures.	HIPAA Privacy and Data Security Training – conducted August 2021. PEBP keeps training attestations.	Complete.

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 08.10.2021	Follow breach notification procedures if a breach occurs.
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 provides a service to, the plan that involves access to Protected Health Information (PHI) under the plan.		PEBP should continue to inventory current BAAs.

Description		Findings	Action Required
V. Medicare			
Medicare Part D Notices	Participants and beneficiaries eligible for Part D must be notified in writing, before October 15 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 2022.	Complete
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.	Complete.
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.	PEBP requests info from ESI and Health Plan NV and report and reconcile this information.	Complete.

Medicare Secondary Payer (MSP) Data Reporting	Plans (including HRAs with annual benefit levels of $5,000 or more as of the beginning of the 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.	UMR has stated that they "submits the quarterly Mandatory Insurer Reporting for Group Health Plans (also known as CMS Section 111 or MSP) files for our customers with medical administration. The regulations do require pharmacy benefit information to be reported on a quarterly basis. For groups that are UMR/OptumRx integrated customers we include the pharmacy benefit information in our MSP files that are submitted on a quarterly basis. For groups that are direct contracts with OptumRx, OptumRx files with CMS. For groups that direct contract with other PBMs, the PBM would be responsible for reporting." PEBP confirmed the ESI contract was amended to reflect this requirement is met.	Complete.

Description		Findings	Action Required
VI. Transparency – No Surprises Act			
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.	Complete.
Notice of Right to Continue Care	Under the No Surprises Act, beginning January 1, 2022, 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 has confirmed that under the NSA the plan must permit the Continuing Care Patient to elect to continue to have benefits provided under the plan/coverage under the same terms and conditions as they would have been covered had no change occurred beginning on the date the notice was provided and ending either 90 days later or the date on which the patient is no longer undergoing continuing care by that provider/facility, whichever is earlier. Patient must meet the definition of continuing care patient based on specific conditions to continue care.	PEBP should confirm with UMR how this process will work for a Continuing Care Patient and confirm how the participant will be notified about qualifying as a Continuing Care Patient..
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 2. Out-of-network allowed amounts and 3. Prescription drug negotiated rates Enforcement delayed until future rulemaking for prescription drug negotiated rate file.	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/	Complete.
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	PEBP has confirmed that UMR has updated the identification cards.	Complete.

	website) in clear writing on any physical or electronic plan or insurance identification card.		
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 should continue to coordinate with its medical and PBM vendors to confirm filing status due 12.27.2022 and ongoing.
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 new 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 could consider language enhancements in MPD to highlight when balance billing is not permitted.
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 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.		PEBP should determine how its service providers will meet this requirement.

Description		Findings	Action Required
VII. Families First Coronavirus Response Act ("FFCRA"), as amended by the Coronavirus Aid, Relief, and Economic Security Act ("CARES ACT") and IRS Notices 2020-29, 2020-33, 2021-15			
COVID-19 related testing and related services	Effective March 18, all group health plans — whether self-insured, fully insured, grandfathered or non-grandfathered — must cover COVID-19 testing and related services without cost sharing. This coverage mandate applies for the duration of the public health emergency,	Per the MPD, the "Plan shall comply with the CARES Act to the extent it applies. The Plan shall cover COVID-19 diagnostic testing and certain COVID-19 testing related items and services without cost sharing (deductibles, coinsurance, copayments), prior authorization, or other medical management requirements. This coverage includes the COVID-19 diagnostic test and COVID-19 diagnostic testing-related visit to order or administer the test. A testing related visit may occur in a physician's office, via telehealth, in an urgent care center or emergency room. In-network and Out-of-Network costing sharing will not apply. To the extent it applies, this Plan will cover qualifying items, services, or immunizations intended to prevent or mitigate COVID-19 (qualifying coronavirus preventive services) without imposing cost sharing."	Complete.
OTC Medical Product reimbursable.	OTC Medications and Menstrual Care Products qualifying medical expenses after 12/31/2019. No amendment needed if plan simply refers to expenses allowed under Code Section (Section 213(d)).	Per the MPD, effective January 1, 2020, "individuals may use HSAs, FSAs, and HRAs to purchase over-the-counter medicines without a prescription, and to purchase menstrual care products."	Complete.
Diagnostic testing with no cost-sharing /payment of testing to provider required.	CARES Act provides that health plans must cover an in vitro diagnostic test and the administration of such a test, for the detection of COVID-19, without any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, where (a) the test is approved, cleared or authorized by the FDA; (b) the test developer has requested emergency use authorization or fails to do so within a reasonable time; or (c) the test is developed in and authorized by a State that has notified the Department of HHS of its intention to review tests intended to diagnose COVID-19.	Per the MPD, the Plan shall cover COVID-19 diagnostic testing and certain COVID-19 testing related items and services without cost sharing (deductibles, coinsurance, copayments), prior authorization, or other medical management requirements.	Complete.

COVID-19 vaccine covered with no cost-sharing	CARES Act requires non-grandfathered group health plans and issuers to cover a COVID-19 vaccine or other preventive service — once available — without cost sharing upon the recommendation from the United States Preventive Services Task Force (USPSTF) or the Centers for Disease Control and Prevention (CDC).	Per the MPD, the "Plan will cover qualifying items, services, or immunizations intended to prevent or mitigate COVID-19 (qualifying coronavirus preventive services) without imposing cost sharing. To be covered, the services must be either (i) an evidenced-based item or service that has a "A" or "B" rating in the current recommendations from the United States Preventive Services Task Force, or (ii) an immunization with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	Complete.
Telehealth and Health Savings Accounts (HSAs)	CARES Act provides a temporary safe harbor allowing high-deductible health plans (HDHPs) to cover telehealth and other remote care services before participants have met their deductibles. The act also provides that having telehealth coverage outside of an HDHP will not make an individual ineligible for HSA contributions. This expansion of permissible telehealth for individuals with HDHPs and HSAs applies to all types of care, not just COVID-19 care. These changes took effect March 27, 2020, but only apply for plan years beginning on or before December 31, 2021. For calendar-year plans the temporary changes expire December. 31, 2021, but are renewed for the period April 1, 2022 – December 31, 2022.	The CDHP MPD highlights the plan will pay for telehealth services after the deductible is met.	Complete.
COVID-19 relief for HDHPs	CARES Act provides that a plan shall not fail to be treated as a high deductible health plan (HDHP) by reason of failing to have a deductible for telehealth and other remote care services IRS Notice 2020-15 allows HDHPs to cover COVID-19 testing and treatment before individuals have met their deductibles, without affecting eligibility for HSA contributions.	The CDHP MPD states that COVID-19 testing, COVID-19 testing related visits, COVID-19 Preventive Health Services, Laboratory Services related to COVID-19 will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network during the national public health emergency period.	Complete.

Description		Findings	Action Required
VIII. Other Laws Affecting Group Health Plans			
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.	Complete.
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 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 (nv.gov) Accessibility Information (nv.gov)	Complete.
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	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	Complete.

	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).	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."	
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 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.	Per the Active Wrap plan document: "**Genetic Information Non-discrimination Act of 2008 (GINA).** The Plan shall comply with the Genetic Information Non-discrimination Act of 2008 (GINA) to the extent applicable including: Title I (regarding genetic nondiscrimination in group health plans) and Title II (regarding genetic nondiscrimination in employment). Under GINA, the Plan shall not base enrollment decisions, premium costs, or Participant contributions on genetic information. The Plan shall not require that individuals undergo genetic testing. PEBP is prevented from conditioning hiring or firing decisions based on genetic information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information regarding either employment or the determination of benefits."	Complete.
Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART Act")	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 or a portion of any unused money (notwithstanding the normal "use it or lose it" 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.	Per the FSA MPD: "Under the Heroes Earnings Assistance & Relief Tax Act of 2008, employees called to active military duty for a period of at least six months can receive a taxable distribution of the HCFSA funds to avoid forfeiture."	Complete.
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 MPD: "Hospital length of stay for childbirth: This Plan complies with federal law that prohibits restricting benefits for any	Complete.

		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)."	
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 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.	Per the MPD: "Prenatal and delivery is covered for a female employee or spouse only. For covered dependent children, only prenatal coverage is provided for maternity, except for complications of pregnancy for the dependent child." "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."	Complete.
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).	PEBP revised the Plan Year 2023 MPD to reflect enhancements in plan design for gender dysphoria treatment.	PEBP will continue to monitor ongoing developments from the EEOC, and continue to review and revise plan documentation accordingly.
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 seniority that they would have attained with reasonable certainty had they remained continuously employed.	Per the MPD: "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	Complete.

	• 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.	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 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	Complete.

		• 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."	

Description		Findings	Action Required
IX. Certain Required Notices			
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 October 27, 2022.	Complete.
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 enrolment materials. Model notice updated 7/31/2022. 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 October 27, 2022.	Complete.
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.	Complete.
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 includes a section of the mid-year change events and is accessible on the PEBP website.	Complete.
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.	PEBP does not have a wellness program.	N/A.

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 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.	PEBP does not have a wellness program.	N/A.
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 October 27, 2022.	Complete.

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 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." PEBP has confirmed that coverage has been extended for students on a medical leave of absence	Complete. .

Qualified Medical Child Support Notice	Plans must acknowledge receipt of medical child support order and notify participants that its 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.	The Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as set forth in the MPD for the PEBP Enrollment and Eligibility. Qualified Medical Child Support Orders (QMCSO): QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce. A QMCSO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which: o Specifies your last known name and address and the child's last known name and address. o Describes the type of coverage to be provided, or how the type of coverage will be determined. o States the period to which it applies; and o Specifies each plan to which it applies. The QMCSO cannot require the Plan to cover any type or form of benefit that they do not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions. You and the affected child will be notified if an order is received.	Recommend adding 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*.

Description		Findings	Action Required
X. Cafeteria Plan, FSAs, HSA/HDHPs, HRAs			
CAFETERIA PLAN			
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.	Complete.
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.	Complete.
Salary reduction agreement	Required for participant to pay for benefits on a pre-tax basis	Defined and referenced throughout Section 125 plan document.	Complete.
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 • 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 mistake" 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.	Permitted mid-year events referenced in Status Change Elections; Special Enrollment; Other Election Changes section of the Section 125 plan document.	Complete.

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.	Complete.
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.	N/A. The cafeteria plan does not offer PTO that can be purchased or sold.	N/A.
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.	No flex credits.	N/A.
Nondiscrimination testing	Cafeteria plans are subject to the following nondiscrimination tests: (i) Eligibility Test: plan must benefit employees who qualify under an eligibility classification that does not discriminate in favor of highly compensated individuals (HCIs).(ii) Benefits and Contributions Test: contributions or benefits may not discriminate in favor of highly compensated participants; (iii) Key Employee Concentration Test: no more than 25% of the aggregate statutory non-taxable benefits provided to all employees through the cafeteria plan can be provided to key employees.	PEBP has not recently performed nondiscrimination testing.	To be in compliance, PEBP should perform ND testing.

HEALTH FSA				
Maximum annual employee contribution election		For 2022: $2,850	The limit for calendar year 2021 is $2,850 for the medical FSA or the Limited Purpose FSA.	Complete.
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.	N/A	N/A.
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: "You may be paid the full amount of your claim or the balance of your annual election, whichever is less, whenever you file a qualifying claim. Payment under the medical FSA is not limited to the amount in your account at the time of your claim. Your monthly contributions will continue for the remainder of the Plan Year."	Complete.
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.	N/A	N/A
Carryover (optional)		Maximum carryover amount indexed to 20 percent of the annual maximum election. For 2021 ($550); For 2022 & 2023 ($570). Not applicable to DCFSA.	The $2,850 limit does not include the potential carryover of up to $550 remaining in your HCFSA or Limited Purpose FSA from one Plan Year to another.	Complete.
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 MPD - Claims for expenses incurred during the Plan Year must be submitted to UMR by October 31st following the end of the Plan Year.	Complete.
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).	MPD confirms this does not apply to the health FSA or limited purposes states the change applies when the cost charged to employee for a benefits package option significantly increases or decreases.	Complete.
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 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.	Complete.

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.	Section in MPD "When Do I Have to Turn in Paperwork" discusses substantiation.	Complete.
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.	Complete.
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.	No employer contributions to health FSA.	N/A.
Integration with HSA		Employees with an HSA can only have a Limited Purpose FSA.	Per MPD - IRS provisions do permit enrollment in both an HSA and a LPFSA as LPFSA reimbursement is restricted to only vision and dental expenses.	Complete.
Nondiscrimination testing		Health Care FSA must pass the Eligibility Test and the Benefits Test, as required by Code § 105(h). A highly compensated individual is (a) one of the five highest-paid offers; (b) a more than 10% shareholder of the company; or (c) among the highest paid 25% of all employees (other than excludable employees). Eligibility Test (plan must benefit: (i) 70% or more of all nonexcludable employees; (ii) 80% or more of all employees who are eligible to benefit if 70% or more of all nonexcludable employees are eligible to participate in the plan; or (ii) the nondiscriminatory classification test (classification does not discriminate in favor of HCIs). Benefits Test: test consists of two requirements (i) benefits must be nondiscriminatory on the face of the plan and in operation (benefits provided to HCIs must be provided NHCIs) and (ii) required contributions must be the same for all benefit levels, and the maximum benefit cannot be based on percentage of compensation, age or years of service.	PEBP has not recently performed nondiscrimination testing.	To be in compliance, PEBP should perform ND testing.
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: • You cease paying the monthly administration fee; • Your remaining FSA balance is depleted; or, • At the end of the applicable Plan Year."	Complete.

			"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."	
	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.	Complete.
DEPENDENT CARE FSA				
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) fulltime student: 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 intuitions: high schools, colleges, universities, plus technical, trades, and mechanical schools Unauthorized institutions: correspondence classes and internet-based online learning programs	A DCFSA is an option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP), HMO or Premier EPO Plan.	PEBP should consider independent eligibility for the DCFSA from the medical plans. PEBP should also conduct ND testing.
Qualifying Individuals		A qualifying individual(s) who is: o A qualifying child who has not attained age 13; or o 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 ½ of the tax year; or o 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, for whom you have more than 50% custody, or for a spouse or dependent who is physically or mentally incapable of caring for himself or herself and who lives in your home at least 8 hours each day. The expenses may not be paid to a child of yours who is under the age of 19 at the end of the year in which the expenses are	Complete.

		incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent."	
Annual Contribution Limits	$5,000 a year for individuals or married couples filing jointly, or $2,500 for a married person filing separately.	DCFSA is limited to $5,000 for single taxpayers and $2,500 for married individuals filing separately.	Complete.
Use-it-or-lose-it	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."	Complete.
Grace Period (optional)	Allows costs to be incurred up to 2½ months after the end of the plan year.	There is no grace period.	N/A.
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, all claims must be filed by October 31st following the end of the Plan Year.	Complete.
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). DCAP-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 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.	Per the FSA MPD: "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."	Complete.

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.	Per the FSA MPD: "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."	Complete.
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 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	Per the FSA MPD "UMR will review your claim, and if approved will reimburse you. Claim reimbursements are issued within one business day of the receipt of your claim up to the amount that you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from your payroll contributions. You must submit a completed claim form along with copies of invoices or statements to serve as proof that you have incurred a qualified expense to receive payment. Statements are required to be from the provider/store stating the date of service/purchase, a description of services/products, the expense amount, the name of the service provider/store and the person for whom the service was provided."	Complete.
Nondiscrimination testing	DCFSA must pass four nondiscrimination tests per Code § 129: Eligibility Test (reasonable classification test); Contributions and Benefits Test; More Than 5% Owner Concentration Test; 55% Average Benefits Test. The average DCFSA benefits provided to non-highly compensated employees must be at least 55% of the average benefits provided to highly compensated employees. An HCE is a more than 5% owner during the current or preceding year, or an individual with compensation during the preceding year over the IRS dollar limit ($130,000 for 2021; $135,000 for 2022).	PEBP has not recently performed discrimination testing on the DCFSA plan.	To be in compliance, PEBP should perform ND testing.

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's Eligibility and Enrollment vendor Lifeworks sends the necessary data for reporting on individual employee W-2s to the applicable state employers.	Complete.
ADDITIONAL FSA RULES			
Cannot transfer funds between the two accounts	Cannot transfer funds between the Health FSA and the DCFSA.	PEBP has confirmed that funds cannot be transferred between the Health FSA and the DCFSA.	Complete.
DEBIT CARDS			
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 has confirmed that the card is limited to the maximum dollar amount of coverage available in the employee's health FSA or HRA.	Complete. .
Where can 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)."	Complete.
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); name of the service provider or merchant where the item was purchased; and claim amount (dollar amount spent for the service or item).	Per the FSA 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 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	Complete.

	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.	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 cards are used only for eligible health-related expenses.	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)."	Complete.
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: "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."	Complete.
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 when the day care is provided. You must receive the dependent care services before you file a claim for those services."	Complete.
HSA/HDHP			
Only employees enrolled in a HDHP can enroll in the HSA		Per the 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	Complete.

		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."	
Annual limits	HSA Contribution Limit: 2022 2023 Self-only $3,650 $3,850 Family $7,300 $7,750 HSA Catch-up Contributions: Age 55 + $1,000 $1,000 HDHP Minimum Deductible: Self-only $1,400 $1,500 Family $2,800 $3,000 HDHP Maximum Out-of-pocket Expense Limit (deductibles, copayments and other amounts, but not premiums) Self-only $7,050 $7,500 Family $14,100 $15,000	Per the MPD: 2022 HSA contribution: $3,650/$7,300 2023 HSA contribution: $3,850/$7,750 HSA Catch Up Contribution: $1,000 HDHP Min. Ded. $1,500/$3,000 (ind./family) HDHP – OOP Max - $4,000/$8,000 (in-network) (ind/family)	Complete.
Funds can rollover indefinitely	HSAs have no use-it-or-lose-it provision. Any funds still in the plan at the end of the year can be rolled over indefinitely.	HSAs are employee-owned accounts, meaning the funds in the HSA remain with the employee and carry over from one year to the next.	Complete.
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	Per the FSA MPD: "The $550 HCFSA 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."	Complete.

		permitted to offer each participant that choice (but may impose a mandatory conversion for all participants).		
HRAs				
Permitted Contributions		Employer contributions only	Per FSA 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: This is a Medicare Exchange HRA, Also referred to as a "benefit credit" is the amount of money determined by your years of service and retirement date that is deposited to your HRA account on a schedule determined by the Plan Administrator. Retired public employees enrolled in a medical plan through the Via Benefits may qualify for an HRA contribution based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employer	Complete.
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 PPACA and related guidance."	Complete.
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 Medicare Exchange HRA Plan is considered a retiree only arrangement and is not subject to PPACA group market reforms.	Complete.
COBRA	**Eligibility**	Integrated HRA:can elect COBRA for HRA only if COBRA is elected for group health plan.	COBRA is offered for the HRA.	Complete. .
	Premium	At the beginning of each plan year, the employer should calculate a reasonable premium for the HRA, both for single	PEBP does not charge an additional COBRA premium.	Complete.

		and family coverage. The IRS has defined two methods for determining the COBRA premium: the actuarial method and the past-cost method.		
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. While the general purpose FSA is permitted with the HRA, the FSA SPD does not discuss whether the HRA or FSA should pay first.	The FSA SPD should add language to discuss the order of payment for the HRA and FSA.

Appendix B. Summary of Findings - State

Description		Findings	Action Required
Eligibility and Participation: Definition of "Dependent" NAC 287.035 NAC 287.311 NAC 287.312 NAC 287.3125 NAC 287.313 NRS 689B.035	• Dependent: defined. • Dependents: Enrollment and disenrollment. • Dependents: Eligibility of child of participant, spouse or domestic partner. • Dependents: Terms and conditions of certain changes. • Responsibility for final determinations concerning eligibility. • Required provision in certain policies concerning termination of coverage on dependent child.	MPD defines dependent child and outlines eligibility.	Complete.
Eligibility and Participation: Definition of "Domestic Partner" NAC 287.035	• Dependent: defined.	MPD defines domestic partner and outlines eligibility.	Complete.
Eligibility and Participation: Definition of "Participant" NAC 287.095 NAC 287.135 NAC 287.150 NAC 287.313	• Participant: defined. • "Retired officer or employee" defined. • "Full-time employment" interpreted. • Responsibility for final determinations concerning eligibility.	MPD defines participant and eligibility.	Complete.
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.	Complete.

Description		Findings	Action Required
Eligibility and Participation: Retirees NAC 287.135 NAC 287.440 NAC 287.530 NAC 287.540 NAC 287.542 NAC 287.544 NAC 287.546 NAC 287.548 NRS 287.023 NRS 287.047	• "Retired officer or employee" defined. • Payment of premiums or contributions by retired officers & employees. • 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. • Coverage of participating employee of local governmental agency who retires on or before September 1, 2008 and reenrolls upon retirement or total disability. • Coverage of nonparticipating employee of local governmental agency who retires on or before September 1, 2008 and enrolls upon retirement or total disability. • Coverage of participating employee of local governmental agency who retires after September 1, 2008 and reenrolls upon retirement or total disability. • Coverage of nonparticipating employee of local governmental agency who retires after September 1, 2008. • Option of retired officer or employee or dependent to cancel or continue group 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.	MPD outlines retiree eligibility and enrollment process.	Complete.
Eligibility and Participation: Seasonal Employees and Employees on a Biennial Plan NAC 287.095 NAC 287.150 NRS 287.0467	• "Participant" defined. • "Full-time employment" interpreted. • Retention by certain short-term state employees of membership in and dependents' coverage under Program.	PEBP states that the employers report employee eligibility.	Complete.
Eligibility and Participation: Rehired Employees NAC 287.510 NAC 287.515	• Coverage of persons returning to work with previous employer within 1 year after leaving employment. • Coverage of retired participants upon reemployment with participating public agency	No exceptions noted.	Complete.
Eligibility and Participation: Individual as Both Employee and	• 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	Complete.

Description		Findings	Action Required
Dependent NAC 287.520		participant and a dependent shall be enrolled as a primary participant. • A child that is eligible as both a primary participant and a dependent may enroll as a primary participant or continue coverage as a dependent of a PEBP participant until age 26 years.	
Eligibility and Participation: Surviving Spouse/ Dependents NAC 287.530 NRS 287.021 NRS 287.0475 NRS 287.0477	• Coverage of retired person, spouse, domestic partner or surviving dependent. • Option of surviving spouse or child of police officer or firefighter killed in line of duty to accept or continue coverage for group insurance, plan of benefits or medical and hospital service; notification; payment of costs for coverage; duration of eligibility. • 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.	Complete.
Eligibility and Participation: Surviving Spouse/Child of a Police Officer, Firemen or Volunteer Firemen Killed in the Line of Duty NRS 287.0477 NRS 287.021	• 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. • Option of surviving spouse or child of police officer or firefighter killed in line of duty to accept or continue coverage for group insurance, plan of benefits or medical and hospital service; notification; payment of costs for coverage; duration of eligibility.	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.	Complete.
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 more than one	Complete.

Description		Findings	Action Required
		health insurance plan, the PEBP Plan reserves the right to coordinate benefits as stated in the Coordination of Benefits section of the PEBP Consumer Driven Health Plan, Low Deductible PPO Plan, and Premier Plan Master Plan Documents or HMO Evidence of Coverage Certificate (as applicable).	
Eligibility and Participation: Applications for Participation in PEBP by Local Government Agencies NAC 287.310 NRS 287.010 NRS 287.017 NRS 287.040	• Prerequisites to participation; fees; establishment of rates; provision to agency of report on history of claims. • Local governmental agency may adopt system of group insurance; payment of costs of premiums or contributions; provision of group insurance to members of board of trustees of school district and to officers and employees of legal services organization. • Trust fund for future retirement benefits of local governmental employees and their spouses and dependents. • Payments for group insurance, plan of benefits, medical and hospital services, coverage under Public Employees' Benefits Program or contributions to certain trust funds not compulsory for local governmental agency; assignment of wages or salary for such coverage not compulsory.	PEBP reports no applications for participation in PEBP by local government agencies have been made.	None.
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.	None.
Eligibility and Participation: Terminating Interlocal Contract and Withdrawing from Program NAC 287.320 NAC 287.355 NAC 287.357 NAC 287.359 NAC 287.361 NAC 287.363 NAC 287.367 NAC 287.369 NRS 287.0479	• Withdrawal from Program: Procedure; termination of coverage; limitation on reentry; eligibility of certain officers and employees after exclusion of group; liability of Program. • Procedure for applying to leave Program. • Application to leave Program: Contents. • Application to leave Program: Contents. • Application to leave Program: Considerations for approval or denial; basis for findings by Board. • Approval of application by Board: Format and contents of decision; responsibilities of and noncompliance by group. • Denial of application by Board: Procedure for reconsideration. • Effective date of departure from Program; coverage by Program until departure. • Option of large group of state officers and employees to leave Program and obtain group insurance from insurer or employee benefit plan; approval of proposed contracts by Board; disbursement of premiums and contributions; regulations.	PEBP reports there are no opt-out plans maintained by local government agencies.	None.

Description		Findings	Action Required
Eligibility and Participation: Opt-out Plan Administration NAC 287.371 NAC 287.373 NAC 287.375 NAC 287.379 NAC 287.381 NAC 287.383 NAC 287.385 NAC 287.387 NAC 287.389 NRS 287.010	• Eligibility of officer or employee to join opt-out plan; ineligibility of officer or employee to continue participation in opt-out plan. • Notification of Program regarding certain changes in status and court orders. • Eligibility for coverage under opt-out plan: Administration of requirements by Program; compliance with determinations of Program. • Options for coverage under opt-out plan: Annual notification of Program; effective period. • Premiums or contributions for participants in opt-out plans: General administrative duties of Program. • Premiums or contributions for participants in opt-out plans: Requirements for billing. • Premiums or contributions for participants in opt-out plans: Remittance or transfer of payments; nonpayment by participant. • Administrative fee: Establishment by Program; calculation; notice. • Duties of Program: Accounting for and remittance of payments; monthly reports. • Local governmental agency may adopt system of group insurance; payment of costs of premiums or contributions; provision of group insurance to members of board of trustees of school district and to officers and employees of legal services organization.	PEBP reports there are no opt-out plans maintained by local government agencies.	Complete.
Eligibility and Participation Definition of "Open Enrollment" NAC 287.085	• "Open enrollment" defined.	Per the MPD, open enrollment is typically held May 1 - May 31 and any changes made during open enrollment become effective on July 1st, immediately following the open enrollment period.	Complete.
Benefits Coverage: Definition of "Plan Year" NAC 287.100	• "Plan year" defined.	Per the MPD, the Plan Year typically is the 12-month period from July 1 through June 30.	Complete.
Benefits Coverage NRS 287.0433 NRS 287.04062 NRS 695G.160 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. • Written criteria concerning coverage of health care services and standards for quality of health care services. • No inherent right to certain benefits.	No exceptions noted. Per the MPD no officer, employee, or retiree of the State has any inherent right to benefits provided under PEBP.	Complete.

Description		Findings	Action Required
Benefits Coverage: Reinstatement of Coverage by Retired Public Officer, Employee or Surviving Spouse NRS 287.0205 NRS 287.0475	• Reinstatement of insurance by retired public officer or employee or surviving spouse.	Per the MPD, a retired public officer or employee or the surviving spouse thereof, may reinstate insurance, except life insurance, under the Public Employees' Benefits Program, if the retired public officer or employee (1) did not have more than one period during which he or she was not covered by insurance under the Program on or after October 1, 2011; (2) retired from a nonparticipating local governmental agency; (3) was enrolled in the Program as a retiree on November 30, 2008; and (4) is enrolled in Medicare Parts A and B at the time of the request for reinstatement. For Plan Year 2022 and this section only, retirees or the surviving spouse thereof, may apply for reinstatement by submitting the required reinstatement enrollment form(s) between July 1, 2021 – May 31, 2022. For Plan Years 2023 and beyond, requests for reinstatement must be completed through the submission of the required forms to the PEBP office between May 1st and May 31st.	Complete.
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.	Under NRS 287.04335, NRS 695G.167 is made applicable to self-insured health plans. MPDs indicate that the health plans cover orally administered chemotherapy.	Complete.
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. [Effective through 1 year after the date on which the Governor terminates the emergency described in the Declaration of Emergency for COVID-19 issued on March 12, 2020, if the Governor terminates that emergency before July 1, 2022, or June 29, 2023, if the Governor terminates that emergency on or after July 1, 2022.] • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	The NRS generally requires insurance to cover telehealth services to the same extent as services provided in-person or by other means. MPDs reflect COVID-19 related telemedicine provisions.	Complete. Note potential changes to reflect the termination of the Declaration of Emergency.

Description		Findings	Action Required
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.	Under NRS 287.04335, NRS 695G.164 is made applicable to self-insured health plans. MPDs reflect continuation of coverage provisions.	Complete.
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.	Under NRS 287.04335, NRS 695G.1645 is made applicable to self-insured health plans. MPDs reflect autism coverage.	Complete.
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 health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.170 is made applicable to self-insured health plans. MPDs do not require precertification for medically necessary emergency services provided at any hospital.	Complete.
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.	Under NRS 287.04335, NRS 695G.171 is made applicable to self-insured health plans. MPDs provide coverage for HPV testing and vaccine.	Complete.
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.	Under NRS 287.04335, NRS 695G.173 is made applicable to self-insured health plans. MPDs provide coverage for Experimental and/or Investigational Services as provided under NRS 695G.173.	Complete.
Benefits Coverage: Required Provisions for Prescription Drugs Irregularly Dispensed for	• Required provision in plan covering prescription drugs concerning coverage for prescription drugs irregularly dispensed for purpose of synchronization of chronic medications; prohibited acts; exception. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.1665 is made applicable to self-insured health plans.	Complete.

Description		Findings	Action Required
Synchronization of Chronic Medications NRS 695G.1665 NRS 287.04335		MPDs provide provision concerning coverage for prescription drugs irregularly dispensed for the synchronization.	
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.	Under NRS 287.04335, NRS 695G.172 is made applicable to self-insured health plans. MPDs provide required provision concerning coverage for early refills of topical ophthalmic products.	Complete.
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.	Under NRS 287.04335, NRS 695G.177 is made applicable to self-insured health plans. MPDs provide this benefit is covered as preventive care service.	Complete.
Benefits Coverage: Claims Involving Intoxication NRS 695G.405 NRS 287.04335	• Managed care organization prohibited from denying coverage solely because applicant or insured was intoxicated or under the influence of controlled substance; exceptions. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.405 is made applicable to self-insured health plans. MPDs provide this benefit is covered as preventive care service.	Complete.
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.	Under NRS 287.04335, NRS 695G.174 is made applicable to self-insured health plans.	PEBP to confirm coverage and administration with UMR of sickle cell anemia, and include in the MPD.
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.	Under NRS 287.04335, NRS 695G.1716 is made applicable to self-insured health plans. Per the MPD -	Complete.

Description		Findings	Action Required
		Medically necessary maternity services for pregnant participants are covered. No exclusions for gestational carriers noted.	.
Benefits Coverage: Claims NRS 689B.255 NRS 287.04335	• Claims relating to health insurance coverage: Approval or denial; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements; imposition of administrative fine or suspension or revocation of certificate of registration for failure to comply. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 689B.255 is made applicable to self-insured health plans. No exceptions noted.	Complete.
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 exceptions noted.	None.
Funding Requirements: Non-retiree plans NRS 287.0435 NRS 287.0434	• Creation; investment; disbursements; administration by State Treasurer; checking account for payment of claims. • Power to use assets, contract for services and charge and collect certain fees and payments. [Effective through December 31, 2025.]	No exceptions noted.	None.
Funding Requirements: Retiree Plans NRS 287.0434 NRS 287.0436 NRS 287.04362 NRS 287.04364 NRS 287.046	• Power to use assets, contract for services and charge and collect certain fees and payments. [Effective through December 31, 2025.] • Creation; purpose. • Limitation on use; investment and administration; sources; interest and income; no reversion of balance to State General Fund. • Uses; fiduciary duty of Board. • 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.	No exceptions noted.	None.
Funding Requirements: Payment of Premiums NAC 287.420	• Employer may agree with employee to defer compensation; investment of withheld money. • Action by Program to recover delinquent payments, penalties or late fees; statute of limitations.	Per the Aon report from 2020" "NAC 287.420 provides penalties to be assessed in the event of nonpayment by the participating public agency.	Confirmed.

Description		Findings	Action Required
NRS 287.04385 NRS 287.044	• Payment of premiums or contributions to Program; coverage of dependents; allocation of money paid to Program; establishment of Active Employee Group Insurance Subsidy Account.	In previous reviews, Aon was told that specific procedures exist regarding the billing and payment of premiums by participating employers to the PEBP. Accounting Unit Policies and Procedures, Collections and Bad Debt Write-Off, provides a process overview and procedures for collection of past due group accounts. Per conference call with PEBP on December 20, 2016, and again in conference call on 8/3/2018, PEBP provided that procedures: (1) exist for billing/monitoring invoicing of local government entities; and (2) identify who is responsible for payment of invoices. PEBP provided that they would send procedures to Aon, and PEBP provided local government agency application instructions. These instructions did not address the above-referenced procedures. Aon requested copy of procedures on January 13, 2017. Per conference call with PEBP on January 20, 2017, PEBP: (1) confirmed that the same procedures apply to local government entities; and (2) provided that they identify by role (other than by name) who is responsible for payment of invoices. Per conference call on September 15, 2020, PEBP confirmed no changes." PEBP has again confirmed no changes for 2022.	
Funding Requirements: Direct Payment of Premiums for Retirees, LOAs Without Pay and LOAs due to Work Injury NAC 287.430	• 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.	MPD states that a State agency that employs an individual who is on Leave without pay 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 for work actually performed, accrued annual leave or sick leave, or any combination thereof.	None.

Description		Findings	Action Required
NAC 287.440 NAC 287.450 NAC 287.460 NRS 287.046 NRS 287.0439 NRS 287.0445	• 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.		
Funding Requirements: Procedures Regarding Handling Over/ Underpayments of Premiums NAC 287.470	• Overpayment or underpayment of premiums or contributions. • Powers and duties.	Per the Aon 2020 report: Not clear from MPDs whether in the event of an underpayment of premiums, PEBP notifies the applicable entity. Per conference call with PEBP on December 20, 2016, PEBP described their collections process. In the event of an underpayment of premiums, PEBP notifies the applicable entity. In the event of an overpayment of premiums, it is a net-pay situation; the next month's premium is reduced by a certain amount. Confirmed again with PEBP in conference call of 8/3/2018. ▪ Confirmed again on conference call of September 15, 2020. ▪ PEBP has confirmed that billing reflects under and over payment situations..	Complete.
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.	Complete.
Claims and Appeals Procedures NAC 287.610 NAC 287.620	• 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.	The Active Wrap Plan Document and medical MPDs outline the claims and appeals procedures.	Complete.

Description		Findings	Action Required
NAC 287.660 NAC 287.670 NAC 287.680 NAC 287.690 NRS 287.043 NRS 287.04335 NRS 689B.255	• Appeal of decision of Appeals Manager: Requirements; duties of Executive Officer or designee. • Request for external review. • Powers and duties. • Compliance with certain provisions required to provide health insurance through plan of self-insurance. • Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements; imposition of administrative fine or suspension or revocation of certificate of authority for failure to comply.		
Claims and Appeals Procedures: Complaint System; Notice Requirements to Insured NAC 287.750 NRS 695G.200 NRS 695G.220 NRS 695G.230 NRS 287.04335	• System for resolving complaints of insureds: Requirements for approval and annual report. • Establishment; approval; requirements; assistance for persons filing complaints; examination. • Annual report; managed care organization required to maintain records of and report complaints concerning something other than health care services. • Written notice required by carrier to insured explaining rights of insureds regarding decision to deny coverage; written notice to insured when health carrier denies coverage of health care service. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	PEBP has confirmed they have a complaint resolution system to the Division of Insurance as noted in NAC 287.750.	Complete.
Claims and Appeals Procedures: Notice to Insured; Expedited Review Process NRS 695G.210 NRS 695G.230 NRS 287.04335	• Review board; appeal; right to expedited review of complaint; notice to insured. • Written notice required by carrier to insured explaining rights of insureds regarding decision to deny coverage; written notice to insured when health carrier denies coverage of health care service. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	No exceptions noted.	None.
Claims and Appeals Procedures: External Review Process NRS 695G.241 NRS 695G.300 NRS 695G.310	• 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.	No exceptions noted.	None.

Description		Findings	Action Required
NRS 287.04335			
Family Medical Leave Provisions NAC 284.52345 NAC 284.581 NAC 284.5811 NAC 284.5813 NAC 284.52315 NAC 284.5237	• "Family and Medical Leave Act" defined. • Adoption by reference of federal law and regulations. • Family and medical leave: Maximum amount in 12-month period; eligibility; use. • Family and medical leave: Records. • "Child" defined. • "Parent" defined.	No exceptions noted.	None.
Leave of Absence for Military Duty NAC 284.5875	• Military leave with pay: Annual period of eligibility.	No exceptions noted.	None.
PEBP Board Authority and Duties NRS 287.04062 NRS 287.0415 NRS 287.0424 NRS 287.0426 NRS 287.043 NRS 287.0487 NRS 287.04335 NRS 287.0402 NRS 287.041 NRS 287.0434	• "Program Fund" defined. • Quorum; Chair; meetings; closed sessions; posting of transcripts of meetings and closed sessions on website; advisory committees. • Executive Officer: Employment; unclassified service; delegation by Board of powers, duties and functions; qualifications; restrictions on other employment and participation in business enterprises and investments; salary. • Staff. • Powers and duties. • Participant in Program may seek assistance from Office for Consumer Health Assistance regarding coverage. • Compliance with certain provisions required to provide health insurance through plan of self-insurance. • Definitions. • Creation; composition; qualifications; terms; vacancies; removal. • Power to use assets, contract for services and charge and collect certain fees and payments. [Effective through December 31, 2025.]	No exceptions noted.	None.

Description		Findings	Action Required
Miscellaneous NAC 287.005 NAC 287.145	• Definitions. • "Vendor" defined.	No exceptions noted.	None.