JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

JACK ROBB
Board Chair

January 26, 2023

NICK STOSIC
INTERIM INSURANCE COMMISSIONER
NEVADA DIVISION OF INSURANCE
1818 E. COLLEGE PARKWAY, SUITE 103
CARSON CITY, NV 89706

Re: Public Employees' Benefits Program (PEBP) Appeals and Complaints Summary Report for Calendar Year 2022.

Dear Interim Commissioner Stosic:

In accordance with NAC 287.750, PEBP presents to the Nevada Division of Insurance, under the Department of Business and Industry, its annual Appeals and Complaints Summary Report for Calendar Year 2022. As required by code, the name of the employee(s) responsible for appeals and descriptions of notification procedures and explanation of rights are listed below, followed by a narrative summary of the attached appeals and complaints log. A graph showing the number of appeals and complaints resolved in Calendar Years 2017 through 2022 has been included for historical comparison.

NAC 287.750(1)(a), "name and title of the employee responsible for the system for resolving complaints":

Tim Lindley, Quality Control Officer, PEBP
Gina Reynolds, Quality Control Analyst, PEBP
Allison Walker, Quality Control Analyst, PEBP

NAC 287.750(1)(b), a "description of the procedure used to notify an insured of the decision regarding his or her complaint":

For the first half of the calendar year through 06/30/2022, PEBP was contracted with HealthSCOPE Benefits (HSB) located in Little Rock, Arkansas. For the 07/01/2022 going forward, PEBP is contracted with UMR located in Salt Lake City, Utah. These contracted vendors provide third-party administration services for PEBP's self-funded plans: the Consumer Driven Health Plan (CDHP), Low Deductible PPO (LD), and the Exclusive Provider Organization (EPO). As PEBP's claims administrator, HSB and UMR receive claims from physicians, dentists, psychiatrists, laboratories, and other providers. HSB and UMR review the claims and processes them in accordance with provisions located in the applicable plan year

PEBP Master Plan Document. Included at the bottom of every explanation of benefits (EOB) notice sent by HSB and UMR to participants is a statement that reads:

HealthSCOPE Benefits

"If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on your ID card or send a written request to the following address:

HealthSCOPE Benefits
Attn: Claim Inquiry,
PO Box 2860
Little Rock, AR 72203.

You may also contact us to request free of charge a copy of any rules, guidelines, protocols, or the scientific or clinical basis used in making the decision on the processing of your claim.

If you are not satisfied with this decision, either you or your authorized representative can start the appeal process by sending a written request to:

My Health Plan
c/o HealthSCOPE Benefits, Inc.,
PO Box 2860
Little Rock, AR 72203

Or as otherwise set out in your benefit plan blook within 180 days of receipt of this explanation of benefits (unless a longer term is permitted by your plan). Please note that if you choose to designate an authorized representative, you must make this designation to us in writing.

Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g., benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your name, 2) Account number from the front of this form, 3) ID number from the front of this form, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records, and other information about your claim, free of charge. You have the right to billing and diagnosis codes as well.
- If your situation is urgent, you may request an expedited appeal which will generally be conducted within 72 hours. If you believe that your situation is

urgent, follow the instructions above for filing an internal appeal and call Customer Service to request a simultaneous external review if permitted by your plan.

- You will be notified of the decision in a timely manner, as described in your plan materials.

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party after exhausting the internal appeal process.

You may have a separate time limitation for legal action regarding the recovery of benefits under the plan . Refer to your plan documents for the time limitation.

UMR

"**What if I have questions about this claims decision?**
If you have any questions about this explanation of benefits, please call the toll-free number on your ID Card.

What if I don't agree with this claim decision?
If your claims has been denied in whole or in part, you may file an appeal by sending a written request and pertinent information (eg: office notes, lab results, operative notes/reports, and medical history) within 180 days from the date of this notice, or the period otherwise established by your plan. Be sure to also check your benefits booklet for information about claim determination and your plan's specific appeal process.

How do I file an appeal?
If you are not satisfied with this decision, either you or your authorized representative can start the appeal process by sending a written request to:

Claims Appeal Unit
P.O. Box 30546
Salt Lake City, UT 84130-0546

or as otherwise set out in your benefit plan book within 180 days of receipt of this explanation of benefits (unless a longer term is permitted by your plan). The request for the appeal should clearly indicate that the participant is appealing an adverse benefit determination.

Your rights and other resources
If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party after exhausting the internal appeal process. Contact us at the phone number on your ID card to find out how to start an

external review.

This is the first step available to every participant in the three-level claims appeal process afforded by the PEBP CDHP, LD, or EPO plan. Participants have the right to file a Level 1 Claim Appeal for adverse benefit determinations. The written request for appeal is mailed to the address listed on the EOB. The Third-Party Administrator's (HSB or UMR) decision on the Level 1 Claim Appeal is mailed to the PEBP participant in writing. If the TPA approves the appeal, they reprocess the related claim(s). If the TPA denies the Level 1 Claim Appeal, the denial letter to the participant includes instructions on how to proceed to a Level 2 Claim Appeal, if the participant deems necessary. Level 2 Claim Appeals are adjudicated by PEBP, and decisions on approval or denial are sent to participants in writing. If the Level 2 Claim Appeal is denied, the denial letter to the participant may include instructions on how to proceed to an External Review. External Reviews are managed by the Nevada Office of Consumer Health Assistance (OCHA).

The claim appeal process that PEBP describes in its Master Plan Document is in compliance with the requirements established by the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Nevada Insurance Statutes in NRS 695G. Forms for completing the various levels of review are available by logging in to the E-PEBP Portal at www.pebp.state.nv.us or by calling the PEBP office.

Summary Narrative

The PEBP Quality Control Appeals and Complaints Summary Report for calendar year 2022 lists 22 Level 2 Claim Appeals, 5 External Reviews, and 79 Complaints totaling 106 resolved. Complaints are categorized by vendor, plan type, and complaint type. This compares to 10 external reviews, 36 appeals and 63 complaints totaling 109 resolved in 2021.

When compared to 2021, the 2022 Appeals and Complaints have decreased overall. The number of external reviews and appeals decreased; however, there was an increase in complaints. The increase in complaints can be attributed to a series of vendor changes that occurred in 2022. Name, there was a Benefit Management System change to a new vendor in January 2022 which reverted to the historical vendor in April 2022. Additionally, starting in July 2022, there were new vendors implemented for our Third-Party Administrator, Medical/Behavioral Network, Case Management, Health Reimbursement Arrangement and Health Savings Account administrator, that resulted in a disruption due to new vendor processes.

Willis Towers Watson's VIA Benefits experienced a maintained 11 complaints from 2021 to 2022, with most complaints relating to customer service. Express Scripts (ESI) experienced a decreased in complaints with 11 in 2022 compared to 18 in 2021. The majority of ESI complaints centered on price of prescriptions. With a new network and Third-Party Administrator starting mid-year, UMR experienced 11 complaints with most centered to claims processing and network access to In-Network Providers.

The number of complaints for PEBP, Diversified Dental, Health Plan of Nevada, HSA Bank, and Standard Insurance experienced a significant drop in 2022, from 21 overall complaints in 2020

down to 18 for 2021. Most of these complaints (16) are to PEBP and tied to transitions between management systems and new vendors.

Sincerely,

Tim Lindley
Quality Control Officer
Public Employees' Benefits Program
775-684-7000
tlindley@peb.nv.gov

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LAURA RICH
Executive Officer

JACK ROBB
Board Chair

January 26, 2023

RICHARD WHITLEY, MS
DIRECTOR OF DHHS
OFFICE OF CONSUMER HEALTH ASSISTANCE
400 W KING ST STE 300
CARSON CITY NV 89703

Re: Public Employees' Benefits Program (PEBP) Appeals and Complaints Summary Report Calendar Year 2022

Dear Mr. Whitley:

In accordance with NRS 695G.310, PEBP presents to the Office of Consumer Health Assistance, under the Aging and Disability Services Division of the Department of Health & Human Services, its annual Appeals and Complaints Summary Report for Calendar Year 2022. As required by NRS, the name of the employee(s) responsible for appeals and descriptions of notification procedures and explanation of rights are listed below, followed by a narrative summary of the attached appeals and complaints log. A graph showing the number of appeals and complaints received in Calendar Years 2013 through 2022 has been included for historical comparison.

Per NRS 695G.200, the name and title of the employee authorized for resolving complaints:

Tim Lindley, Quality Control Officer, PEBP
Gina Reynolds, Quality Control Analyst, PEBP
Allison Walker, Quality Control Analyst, PEBP

NRS 695G.200, a description of the system for resolving appeals and to notify an insured of the decision regarding their appeal:

For the first half of the calendar year through 06/30/2022, PEBP was contracted with HealthSCOPE Benefits (HSB) located in Little Rock, Arkansas. For the 07/01/2022 going forward, PEBP is contracted with UMR located in Salt Lake City, Utah. These contracted vendors provide third-party administration services for PEBP's self-funded plans: the Consumer Driven Health Plan (CDHP), Low Deductible PPO (LD), and the Exclusive Provider Organization (EPO). As PEBP's claims administrator, HSB and UMR receive claims from physicians, dentists, psychiatrists, laboratories, and other providers. HSB and UMR review the claims and processes them in accordance with provisions located in the applicable plan year PEBP Master Plan Document. Included at the bottom of every explanation of benefits (EOB) notice sent by HSB and UMR to participants is a statement that reads:

HealthSCOPE Benefits

"If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on your ID card or send a written request to the following address:

HealthSCOPE Benefits
Attn: Claim Inquiry,
PO Box 2860
Little Rock, AR 72203.

You may also contact us to request free of charge a copy of any rules, guidelines, protocols, or the scientific or clinical basis used in making the decision on the processing of your claim.

If you are not satisfied with this decision, either you or your authorized representative can start the appeal process by sending a written request to:

My Health Plan
c/o HealthSCOPE Benefits, Inc.,
PO Box 2860
Little Rock, AR 72203

Or as otherwise set out in your benefit plan blook within 180 days of receipt of this explanation of benefits (unless a longer term is permitted by your plan). Please note that if you choose to designate an authorized representative, you must make this designation to us in writing.

Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g., benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your name, 2) Account number from the front of this form, 3) ID number from the front of this form, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records, and other information about your claim, free of charge. You have the right to billing and diagnosis codes as well.
- If your situation is urgent, you may request an expedited appeal which will generally be conducted within 72 hours. If you believe that your situation is urgent, follow the instructions above for filing an internal appeal and call Customer Service to request a simultaneous external review if permitted by your plan.

- You will be notified of the decision in a timely manner, as described in your plan materials.

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party after exhausting the internal appeal process.

You may have a separate time limitation for legal action regarding the recovery of benefits under the plan . Refer to your plan documents for the time limitation.

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Sincerely,

Tim Lindley

Quality Control Officer
Public Employees' Benefits Program
775-684-7000
tlindley@peb.nv.gov

Level 2 Claim Appeals														
Plan	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	**YTD Totals**	% of Total
CDHP-PPO														
Claim Denial		3	1	1	1	1	1	1				2	**11**	50%
Exclusive Provider (EPO)														
Claim Denial						2		2					**4**	18%
Low Deductible-PPO														
Claim Denial	1		1			1	1	1		1		1	**7**	32%
Total	**1**	**3**	**2**	**1**	**1**	**4**	**2**	**4**	**0**	**1**	**0**	**3**	**22**	

External Review Appeals														
Plan and Outcome	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	**YTD Totals**	% of Total
CDHP-PPO														
Overturned		1					1						**2**	40%
Upheld	1												**1**	20%
Low Deductible-PPO														
Overturned								1		1			**2**	40%
Total	**1**	**1**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**1**	**0**	**0**	**5**	

Complaints														
Vendor, Plan, and Complaint Type	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	**YTD Totals**	% of Total
AETNA														
CDHP-PPO														
Customer Service				1									**1**	1%
Other						1							**1**	1%
BenefitFocus (BenefitPlace)														
CDHP-PPO														
Administration	1					1							**2**	3%
Diversified Dental														
VIA Benefits														
Network Provider Access										1			**1**	1%
ExpressScripts														
CDHP-PPO														
Administration												1	**1**	1%
Carrier Issues									1				**1**	1%
Claim Price Payment Dispute								1					**1**	1%
Customer Service	1												**1**	1%
Prescription Pricing	1					1	1						**3**	4%
Exclusive Provider (EPO)														
Network Provider Access				1				1					**2**	3%
Low Deductible-PPO														
Administration										1			**1**	1%
Customer Service									1				**1**	1%
Network Provider Access												1	**1**	1%
Plan Design				1									**1**	1%
Health Plan of NV														
HMO														
Customer Service								1					**1**	1%
HealthCare BlueBook														
Low Deductible-PPO														
Customer Service								1					**1**	1%
HealthSCOPE Benefits														
CDHP-PPO														
Claim Price Payment Dispute			1										**1**	1%
Customer Service			1										**1**	1%
Exclusive Provider (EPO)														
Claim Price Payment Dispute								1					**1**	1%
Network Provider Access			1										**1**	1%
Low Deductible-PPO														
Carrier Issues					1								**1**	1%
Claim Denial					1	1							**2**	3%
Customer Service	1												**1**	1%
HSA/HRA/FSA								1					**1**	1%
HSA Bank														
CDHP-PPO														
Customer Service								1	1				**2**	3%
Other										2	1		**3**	4%
VIA Benefits														
HSA/HRA/FSA								1					**1**	1%
Public Employees' Benefits Program														
CDHP-PPO														
Administration			1										**1**	1%
Customer Service								1					**1**	1%
Enrollment & Eligibility		1											**1**	1%
Plan Design											1		**1**	1%
COBRA														
Administration										1			**1**	1%
Enrollment & Eligibility								1					**1**	1%
Portal Administration		1											**1**	1%
Exclusive Provider (EPO)														
Enrollment & Eligibility			1										**1**	1%
Other						1							**1**	1%
Plan Design												1	**1**	1%
HMO														
Customer Service	1												**1**	1%

Enrollment & Eligibility										1			**1**	1%
Other					1								**1**	1%
Low Deductible-PPO														
Enrollment & Eligibility									1				**1**	1%
VIA Benefits														
Customer Service					1								**1**	1%
Other										1			**1**	1%
The Standard														
Retired														
Customer Service								1					**1**	1%
UMCM-SHO														
Low Deductible-PPO														
Prior Authorization									1				**1**	1%
UMR														
CDHP-PPO														
Administration												1	**1**	1%
Carrier Issues									2	1			**3**	4%
Claim Price Payment Dispute									1				**1**	1%
Customer Service								1		1			**2**	3%
Prior Authorization								1					**1**	1%
Provider														
Carrier Issues										1			**1**	1%
Claim Denial										1			**1**	1%
Network Provider Access										1			**1**	1%
Other									1				**1**	1%
Low Deductible-PPO														
Claim Denial									1		1		**2**	3%
UnitedHealthcare/SierraHealth Options														
Exclusive Provider (EPO)														
Network Provider Access						1							**1**	1%
VIA Benefits (Willis Towers Watson, One Exchange, Extend Health)														
Retired														
Administration					1								**1**	1%
VIA Benefits														
Carrier Issues						1							**1**	1%
Customer Service				2	1								**3**	4%
Enrollment & Eligibility			2		1								**3**	4%
Other					1							1	**2**	3%
Portal Administration			1										**1**	1%
TOTAL	**5**	**2**	**8**	**5**	**8**	**7**	**1**	**13**	**10**	**12**	**3**	**5**	**79**	

PEBP Complaints and Appeals History Comparison
2017 - 2021