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AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: January 26, 2023

Item Number: VII

Title: Proposed Changes to the Master Plan Documents (MPDs)

SUMMARY

This report will go over the benefit changes to the Master Plan Documents (MPD) for plan year 2024 for the following MPDs:

- Enrollment & Eligibility Master Plan Document
- Flexible Spending Account Master Plan Document
- Medicare Health Reimbursement Arrangement Master Plan Document
- Section 125 Master Plan Document
- Consumer Driven Health Plan Master Plan Document
- Low Deductible Master Plan Document
- Exclusive Provider Organization Master Plan Document
- Dental and Life
- Active Health and Welfare Wrap
- Retiree Health and Welfare Wrap

To see every change please visit https://pebp.state.nv.us/meetings-events/board-meetings/ for digital, PDF copies of plan documents. This is due to file size.

BACKGROUND

NRS 287.0425(2)(b) requires PEBP to undergo a compliance review once every two years. Historically, the compliance reviews have focused broadly on the plan's legal compliance to federal and state statutes, but, to date, PEBP has never performed an in-depth clinical level review to ensure the program is not only in legal compliance but that the plan aligns with industry standards and antiquated policies are updated.

PEBP staff and its vendor partners, including clinicians and legal experts, spent several months combing through each Master Plan Document. The proposed changes stem from input received from the subject matter experts – some changes being simply housekeeping efforts, while others are regulatory and compliance matters. Additional edits will likely be necessary once testing relating to the Mental Health Parity and Addiction Equity Act is conducted later this year.

REPORT

"HOUSEKEEPING" CHANGES

There were several updates and changes implemented across all plan documents. These include the following list of changes:

- Formatting
- Plan year timeframe updated to 07/01/2023 through 06/30/2024,
- Participant Responsibilities and Plan commitments were removed due to concerns under HIPAA, MHPAEA, nondiscrimination, medical advice, etc.
- Removed references or directions to prior vendors such as The Standard for Basic Life Insurance.
- Participant Contact Guide updated for vendor information.
- Removing "Premier" from the Premier Exclusive Provider Organization Plan to keep in line with the Affordable Care Act glossary of terms.
- Updated references to Nevada Revised Statute or Nevada Administrative Code throughout documents:
    - Health benefits covered under NRS were cited in the MPD next to appropriate benefit language and hyperlinked to the legislative website.

PLAN CHANGES FOR THE CDHP, LD, AND EPO

Utilization Management

#	Change Type	Proposed Change	Justification
1	Added	Intraoperative neuromonitoring devices, Prophylactic surgery, Applied Behavioral Analysis, PET, SPECT, MRI, Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), Sickle Cell Disease	Added per UM request. This allows UM to evaluate whether the requested services are medically necessary and will reduce denied claims for items if they are not precertified. Sickle Cell added per NRS
2	Clarification	For prior authorizations, clarified that bariatric surgery should be performed at a Centers of Excellence	To comply with plan documents and steerage
3	Clarification	Orally administered chemotherapy is provided by Pharmacy Benefit Manager	Informative information for members. This is not managed or administered by the UM or Third-Party Administrator.
4	Removed	Vascular access devices for chemotherapy, Creation and revision for arteriovenous fistula, Sleep study, Monetary Threshold for injectables	UM recommendation because this is not commonly reviewed by UM
5	Clarification	Updated "Gender Related Services" to "Gender Dysphoria Related Services" Removed documentation requirements and reference to specific surgery types	Removed plan language that may present barriers to services or unintentional limitation to services.
6	Replacement	Changed "Mental health and substance abuse" to "Behavioral Health."	To keep in line with the MHPAEA

Medical Benefits

	Change Type	Proposed Change	Justification
7	Enhancement	Real Appeal	Board approved

8	Enhancement	HSA/HRA Contribution	Board approved
9	Enhancement	Out-of-Network air ambulance explanation and limitations to remove Maximum Allowable Charge	Required per No Surprises Act
10	Clarification	Deductible and/or Copays and Coinsurance	Information regarding member financial responsibility, such as, amounts exceeding the Plan's referenced-based pricing, and preauthorization penalties.
11	Clarification	In-Network and Out-of-Network	Expanded language to include in-network and out-of-network descriptions, and how to access and utilize provider network directories.
12	Clarification	Language to include references to Behavioral Health.	Changed the term "Mental Health and Substance Use" to the all-inclusive term "Behavioral Health"
13	Clarification	Bariatric/Weight Loss Surgeries clarified the clinical criteria for weight loss surgery is managed by UM.	Removed the clinical criteria to allow for future changes to the clinical requirements as administered by UM.
14	Clarification	Chemotherapy referring to prescription benefits for orally administered chemotherapy drugs	Added "oral chemotherapy" under Chemotherapy in the Prior Authorization requirements to advise members that oral chemotherapy is reviewed by the Pharmacy Benefit Manager.

15	Clarification	Autism Spectrum Disorders updated to cite/refer to NRS.	Removed Autism Spectrum Disorders language applicable to NRS 695G.1645 and replaced with reference to the NRS to allow and comply with future changes to the NRS.
16	Clarification	Clinical Trials updated to cite/refer to NRS.	Removed Clinical Trials language and replaced with NRS 695G.173 to allow and comply with future legislative changes.
17	Clarification	Updated provider information to include licensed providers acting within the scope of their license throughout the Plan Documents	Removes potential Provider discrimination under the Affordable Care Act.
18	Exclusion	Over-the-counter hearing aids	OTC hearings aids approved by the FDA October 17, 2022. OTC hearings aids are only approved for use in adults with mild to moderate hearing loss and are not appropriate for all levels of hearing loss. They do not include advanced hearing technology or in-person care by a hearing specialist and may be purchased without a prescription and an audiologist visit. In addition, the current Plans offer a hearing aid discount program through Amplifon. Staff recommends excluding OTC hearing aids.

19	Clarification	Enteral Formulas and Special Food Products updated to cite/refer to NRS.	Inserted NRS 689B.0353 and removed the existing language comply with future legislative changes.
20	Clarification	Bariatric/Weight Loss surgery benefits may be reduced if not preauthorized	Amended language related to bariatric surgery to clarify services may be reduced in lieu of denied without precertification.
21	Change	Added "Infertility" section to the "Family Planning, Fertility, Sexual Dysfunction, and Male Contraception" section	Combined the Infertility section with Family Planning, Fertility, Sexual Dysfunction and Male Contraception for relevancy.
22	Reduction	Removed Intrauterine Insemination (IUI) also known as artificial insemination.	IUI clinically leads to multiple births and many local OBGYN's perform IUI without having a member evaluated by a reproductive endocrinologist. There could be other underlying medical conditions that go unaddressed with this pathway. This is not typically covered by health plans due to its high risk and low success rate.
23	Reduction	Travel expenses reduced to exclude meals with cited references to IRS Regulation and Publications added.	Per IRS Publication 502 and IRS Section 213(d), meals are not a tax-exempt benefit.
24	Clarification	Inserted NAC 287.610 In the "How to file a Medical Claim" section which states all claims must be submitted within 12-months of date of service.	Citation of NAC 287.610 inserted as a reference to the claim filing provision.

25	Enhancement	Gender Dysphoria Related Services: All procedures, services, and supplies related to surgery and sex hormones associated with gender affirmation/confirmation should be reviewed by UM for medical necessity.	Removing the plan language and instead, allowing UM to apply industry standard requirements/guidelines allows for more flexibility.
26	Enhancement	Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions: Benefit enhanced from a limitation of 3 sessions per plan year to 12 sessions.	Per recommendation from USPSTF
27	Enhancement	Hospice Services: Additional time after six (6) months will require preauthorization	Opened hospice care to potentially exceed six (6) months, as this time frame is arbitrary and can become problematic.
28	Enhancement	Hospice Services: social worker updated to "Masters level clinician"	A masters level clinician encompasses social workers and allows for other health care provider services.
29	Enhancement	Abortion travel: Travel for a participant located in a State with restricted access to abortion to the nearest care center for abortion services covered under this Plan.	Board approved
30	Change	Changed "Emergency Services" to "No Surprises Act" including a description of emergency, post stabilization, non-emergency items or services from a non-PPO provider at a PPO facility, air ambulance services, the payment process for non-PPO providers and facilities,	Required per the No Surprises Act

		and the external review process for adverse benefit determinations.	
31	Clarification	For inpatient hospitalization: removed 24-hour requirement if the member is incapacitated	Restrictive language if the member is incapacitated to notify the UM company.
32	Clarification	Moved compliance with Women's Health and Cancer Rights Act of 1998 (WHCRA) from definitions to section for "Mastectomy and Reconstructive Surgery"	Moved for relevancy in applying benefits.
33	Reduction	Meal replacement therapy removed from the Obesity Care Management Program.	To comply with IRS Regulation 213(d) Qualified Medical Expenses and IRS Publication 502 Medical and Dental Expenses.
34	Clarification	Obesity Care Management is managed by the Third-Party Administrator and removed plan clinical criteria	The plan does not administer this program. Also removes plan-imposed barriers to care to follow TPA clinical criteria.
35	Clarification	Removed "overweight" from obesity care management program	Overweight is not applicable as the program references "obese or greater."
36	Clarification	Removed "sound and natural" related to "teeth"	Removed preexisting condition exclusion per ACA.
37	Clarification	Added verbiage for HPV testing and vaccination	Per NRS 695G.171
38	Clarification	Mammograms clarified the first mammogram of the Plan year are covered if preventative.	Follows USPSTF guidelines

39	Enhancement	Continued Coverage for pregnancy updated from 45 days to 90 days	Required per No Surprises Act
40	Clarification	Removed the FDA approved listing for female contraceptives and cited adherence to NRS 695G.1715	Cited NRS 695G.1715 to comply with future legislative changes for approved female contraceptives.
41	Clarification	Inserted language: Routine lab services from independent labs may not be paid as wellness unless the TPA system finds a corresponding wellness office visit within a reasonable number of days prior or after the date lab services obtained to validate wellness diagnosis.	Clarification language that routine/preventive lab services must be accompanied by a wellness office visit to be paid as preventive.

Prescription Drug Benefits

	Change Type	**Proposed Change**	**Justification**
42	Enhancement	Hinge Health	Board approved
43	Clarification	Changes "Express Advantage Network" (EAN) to "Preferred Retail Network"	Aligns with Pharmacy Benefit Manager
44	Clarification	<u>For the Obesity Care Management Program</u> <u>LD and EPO</u>: Eliminated the copay for Preferred/Formulary Generic prescriptions. Added Coverage for Preferred/Formulary Brand and Non-Preferred/Non-Formulary Brand prescriptions subject to copay. <u>CDHP</u>: Added coverage for preferred brand drugs. Coverage includes copays for the preferred brand.	Although this has been offered in practice for many years, this was never captured in Master Plan Documents when initially implemented.

		Non-Preferred Brand change from Not Covered to 100% Copay	Non preferred brands will still be filled at a pharmacy; however, there is no reduced cost for non-preferred brand drugs under the OCM.
45	Enhancement	Added "and insulin pump supplies."	Per Pharmacy Benefit Manager, increases access to care for insulin supplies and aligns with industry standard coverage.
46	Clarification	Consolidated the "Specialty Drug Program" with the "Prescription Retail Drugs" section	Duplicate wording between both subjects, so consolidated for clarity.
47	Clarification	Removed in-depth explanation on How to Price a Medication and replaced links to the PEBP website and Participant Contact Guide.	Unnecessary lengthy explanation of the Price a Medication tool.

Benefit Limitations and Exclusions

	Change Type	**Proposed Change**	**Justification**
48	Clarification	Removed phrasing under "Expenses That Do Not Accumulate Toward Your Out-of-Pocket Maximum"	Unnecessary wording
49	Clarification	Removed various NRS's cited in exclusions and added citations throughout the plan documents.	Exclusions is not a place for NRS citations.
50	Clarification	Items listed are definitions and moved to "Key Terms and Definitions	Exclusions is not a place for definitions.
51	Clarification	Cosmetic Surgery is covered if already noted as covered	Clarify that not all surgeries that may be viewed as "cosmetic" are excluded.
52	Clarification	Removed "Sound and Natural" as it related to Teeth exclusions.	ACA preexisting condition restrictions.
53	Clarification	Added ACA caveat to "Drugs, Medicines, Nutrition, or Devices"	To comply with the ACA.

54	Clarification	Directed "Expenses for Which a Third-Party Is Responsible" to Health and Welfare Wrap and cited NRS	Exclusions is not a place for definitions, and this is covered in depth in the Wrap documents.
55	Clarification	Definition for "Experimental and/or Investigational" is determined by plan administrator, UM company, or designee	This exclusion had unnecessary wording. UM clinical policy may have great update cadence than updating the MPD.
56	Reduction	For Fertility and Infertility Treatment: removed exception for IUI	To keep in line with the initial benefit reduction.
57	Removed	Government Provided Services is a definition	Moved to Key Terms and Definitions
58	Clarification	Over the Counter hearing aids are excluded from the Plan.	Consistency with plan benefits.
59	Clarification	Home Health Care exclusions update to remove provider restrictions	ACA provider non-discrimination
60	Removed	Intensive Outpatient Program is defined	Moved to Key Terms and Definitions
61	Removed	Medically Necessary Emergency Services	Not a definition. This is in the plan documents per NSA
62	Clarification	No Provider Recommendation or Order	ACA provider non-discrimination
63	Removed	Partial Hospitalization Service is defined	Moved to Key Terms and Definitions
64	Removed	Prospective Payment Systems is defined	Moved to Key Terms and Definitions
65	Clarification	Rehabilitation Therapy updated by removing reference to intellectual disability.	Per the MHPAEA
66	Removed	Under Other Benefit Exclusions references to eating disorder is removed	Per the MHPAEA

67	Removed	Expenses for which a third party is responsible: Removed language and replaced with references to the Health and Welfare Wrap Document and NAC 287.755.	Added language to view the Health and Welfare Wrap document.

Medical Claims Administration

	Change Type	Proposed Change	Justification
68	Removed	Reference to Held or Soft Denied claims	The ACA requires claims determinations within 30-days

Appeals

	Change Type	Proposed Change	Justification
69	Clarified	Added verbiage for notices of adverse benefit determinations and level 1 claim appeal adverse benefit determinations	Required per No Surprises Act

Coordination of Benefits

	Change Type	Proposed Change	Justification
70	Clarified	Updated Coordination of Benefits section in the plan documents to direct members to Health and Welfare Wrap Plan document.	This direction will allow for consistency between plans and will avoid any erroneous errors when updating plan documents.

Key Terms and Definitions

	Change Type	Proposed Change	Justification
71	Added	Definition for Air Ambulance	Per No Surprises Act

72	Updated	Definition for Ambulance	Per No Surprises Act, defined in Air Ambulance
73	Added	Definition for Ancillary Services	Per No Surprises Act
74	Updated	Definition for Autism Spectrum Disorders and Related terms	Cited NRS 695G.1645 and NRS 427A.875
75	Updated	Definition for Base Plan	Cited NRS 287.045
76	Updated	Definition for Business Day	Reference Nevada Holiday
77	Updated	Definition for Certified Surgical Assistant	Per ACA provider non-discrimination
78	Added	Definition for Clinical Trials	For consistency throughout the plan document and NRS. This directs people to the definition for Experimental and Investigational
79	Added	Definition for Continuing Care Patient	Per No Surprises Act
80	Removed	Definition for Coronavirus Aid, Relief, and Economic Security Act and Families First Coronavirus Response Act	This is already separately listed in plan benefits.
81	Added	Definition for Cost Sharing	Per No Surprises Act
82	Added	Definition for Cost Sharing Amount	Per No Surprises Act
83	Clarification	Definition for Dependent Children	Citation to NAC 287.312
84	Added	Definition for Emergency Medical Condition	Per No Surprises Act

85	Added	Definition for Emergency Services	Per No Surprises Act
86	Updated	Definition for Gender Dysphoria. Removed reference to Gender Identity Disorder, Transsexualism, Transgender, and Gender nonconforming	The definition provided is only for gender dysphoria as defined by the American Psychiatric Association.
87	Added	Definition for Government-Provided Services	From exclusions, above.
88	Added	Definition for Health Care Facility	Per No Surprises Act
89	Added	Definition for Independent Freestanding Emergency Department	Per No Surprises Act
90	Removed	Removed "Sound and Natural" as it related to Teeth exclusions.	ACA preexisting condition restrictions.
91	Clarification	Updated Maximum Amount; Maximum Allowable Charge to include consideration for Medical Allowable	Expands the administrator review to factor Medicare allowable per Board Approval in November 23, 2020 board meeting.
92	Removed	Definition for Medical Emergency	Updated to other definitions per No Surprises Act
93	Added	Definition for Morbid Obesity	Mentioned throughout the document; however, not previously defined
94	Added	Definition for No Surprises Act	Per No Surprises Act
95	Added	Definition for Non-PPO emergency facility	Per No Surprises Act
96	Added	Definition for Non-PPO Provider or Non-Participating Provider	Per No Surprises Act
97	Added	Definition for Obesity	Mentioned throughout the document; however, not previously defined

98	Added	Definition for Out-of-Network Rate	Per the No Surprises Act
99	Clarification	Definition for Qualified Medical Child Support Orders (QMCSO)	Allows for National Medical Support notices
100	Added	Definition for Qualifying Payment Amount	Per 29 CFR 716-6(c)
101	Clarification	Definition for Recission removed Fraud	Per Affordable Care Act, Recission due to Fraud is a retroactive cancellation
102	Added	Definition for Recognized Amount	Per the No Surprises Act
103	Clarification	Definition for Reference Based Pricing/Reference Price	Updated definition defines this is a methodology
104	Added	Definition for Serious and Complex Condition	Per the No Surprises Act
105	Clarification	Definition for Sickle Cell Disease	Cited NRS 439.4927
106	Removed	Definition for Sound and Natural Teeth	Per Affordable Care Act preexisting conditions limitation
107	Clarification	Definition for Speech Therapy	Updated due to plan documents citing applied behavioral analysis in Utilization Management
108	Clarification	Definition for Step Therapy	Citation to NRS 689B.0305 and NRS 695C.17333
109	Clarification	Definition for Telehealth	Citation to NRS 629.515
110	Clarification	Definition for Telemedicine	Removed examples to prevent interpretation conflicts
111	Added	Definition for Termination	Per the No Surprises Act

BENEFIT CHANGES SPECIFIC TO PLAN DOCUMENT

The following changes were made specific to the listed plans and are noted on the respective Master Plan Document, respectively.

Enrollment & Eligibility Master Plan Document

	Change Type	Proposed Change	Justification
112	Clarification and Updated	Recission of Coverage: Included verbiage for 30-day advanced notice. Removed prohibition to retroactive termination points ii and iii	To comply with PHSA Removed these points as they fall under misrepresentation that is already addressed
113	Clarification	For Initial Enrollment: Benefit eligibility is reported to PEBP by the employer. Initial enrollment is also called a "New Hire" event. If a member's initial enrollment occurs during Open Enrollment, the initial enrollment must be completed before Open Enrollment elections.	PEBP does not determine individual members benefit eligibility and cannot track hours necessary for eligibility. This is clarified for members. PEBP uses "initial enrollment" and "new hire" interchangeably. This is to make members, who are benefits eligible during Open Enrollment, aware they must complete their new hire event and the Open Enrollment event separately.
114	Clarification	Retiree Late Enrollment: included citation to NRS and rearranged how to reenroll as a late enrollee.	Cited NRS and separately out a paragraph regarding how to reenroll as a late enrollee to be easier to read.

115	Clarification	HIPAA Special Enrollment notice: Interpreted a completed request for enrollment.	To make members aware what is a complete enrollment which must be done before requested benefit changes can take effect.
116	Addition	Added Retroactive Premiums for catch-up of premiums	Educate members that benefit changes may take more than one pay cycle to process resulting in retroactive premiums.
117	Clarification	Eligibility for Dependent-Spouses updated to "lawful spouse."	This is to address other states who may have a definition of lawful spouse contrary to Nevada state law.
118	Clarification	Added information for termination of stepchildren	To inform members when stepchildren benefits end
119	Added	Dental Eligibility for when retirees can change their dental plan.	This adds clarifying language for Medicare retirees on PEBP dental that they can change elections during Open Enrollment.
120	Clarification	Consolidated paragraphs for "New Hire," "Reinstated," and "Rehired" Employees.	Information was redundant and consolidated to make easier to read.
121	Clarification	Throughout the Master Plan Document, listed dependent examples of Dependent Spouse, Dependent Domestic Partner, Dependent Child is consolidated to Dependent.	The definition for Dependent encapsulates the various types of dependents. Consolidating this verbiage avoids erroneously omitting a dependent.
122	Removal	When Coverage Ends: Removed "the last day of the month that precedes the effective date of the other employer's coverage…"	Removed because this is an IRS permitted mid-year change.
123	Clarification	Retiree coverage ends on the last day of the month preceding coverage through the Medicare Exchange	Addresses confusion for when members overage ends. This is

			concurrent with Enrollment & Eligibility practices.
124	Clarification	PEBP will estimate a retiree or spouses Medicare Part B benefit.	This is to add additional clarity to members who qualify for Medicare B but do not enroll. This is current plan practice.
125	Clarification	Restated 60-day timeframe for requirement to provide Medicare Part B card.	To bring verbiage in compliance with preceding plan language.
126	Clarification	Failure to pay PEBP Dental premiums will result in termination of PEBP Dental coverage	Coincides with recission of coverage and ACA
127	Clarification	Medicare coverage must be maintained for Part B premium subsidies.	Members are notified Medicare Part B is required for subsidies.
128	Clarification	Medicare coverage must be maintained for Part B premium HRA contribution.	Members are notified that once Medicare eligible, that maintaining coverage is required for HRA contribution.
129	Updated	Enrollment and Eligibility Quick Reference Table for children updated to include children of a domestic partnership.	Spells out clarification per ACA.
130	Updated	Qualifying Life Events are based on receipt of notice and not date of the event.	Prospective changes are required under IRS Section 125 for pre-tax deductions.
131	Clarification	When primary Participant Moves Outside of EPO or HMO coverage area: requesting proof of address change.	To substantiate mid-year Plan changes.
132	Clarification	Gain of other employe group coverage to allow plan changes based on spouse's initial enrollment with supporting documentation.	This is to clarify preceding plan language.

133	Clarification	For Leave Without Pay inserted exception for FMLA	Per FMLA, members on FMLA are subject to employee portion of premiums
134	Removal	Nonpayment of dental will not result in forfeit benefits.	Under the ACA, nonpayment of premiums will rescind benefits to last paid-through date.
135	Clarification	COBRA updated to "beneficiary"	Initial plan language only specified employee. COBRA may include dependents.
136	Addition	Full-Time employment means an employee who averages at least 130 hours per month over a 12-month period.	Align withIRS definition of "Identifying Full-Time Employees."
137	Key Terms and Definitions	Added definition for Mini-med or other limited benefit plan	This is part of the definition for significantly inferior coverage, however "mini-med or other limited benefit plan" was not previously defined.

Flexible Spending Account Master Plan Document

	Change Type	**Proposed Change**	**Justification**
138	Added	Added what program pays first for claims when members have 1) a Health FSA and HRA or 2) Limited-Purpose FSA and HSA	Recommendation from compliance review.
139	Added	Minimum plan election for FSAs of $100	Per IRS annual election requirements

Medicare Health Reimbursement Arrangement Master Plan Document

	Change Type	**Proposed Change**	**Justification**

140	Clarification	For retirees residing outside of the US.	Making the language easier to understand.

Section 125 Master Plan Document

	Change Type	Proposed Change	Justification
141	Addition	Additional Permitted Election Changes for Health Coverage under Section 125 Cafeteria Plans	Per IRS Notice 2022-41 an employee may change their tier from "family" or "employee + child" to "employee only" when a dependent enrolls in a Qualified Health Plan through the Health Insurance Exchange.

Consumer Driven Health Plan

	Change Type	Proposed Change	Justification
142	Clarification	Preventative drugs under the ACA are covered 100% and other preventative drugs are subject to coinsurance	Per ACA and IRS rules for high-deductible health plan with and Health Savings Account
143	Reduction	Updated Vision Screening Exam from $25 Copay; $95 maximum benefit to 80% after deductible.	Required change to comply with IRS rules for high-deductible health plans.
144	Changes	"Blood Transfusions" changed to "Blood Services for Surgery"	To align with the EPO and LD plan
145	Enhancements	Increased Acupuncture and Acupressure to 20 visits in a plan year	To align with the EPO
146	Clarification	For Transplant services: removed reference to benefit maximum	There is no benefit maximum when performed In-Network.

147	Reductions	Vision Screening Exam: removal of copays. This is subject to deductible and coinsurance	As determined through the compliance review, the vision benefit is not an excepted benefit, so this is subject to deductibles per IRS regulations for high-deductible health plans.
148	Clarification	Obesity Care Disease Management Program: Inserted "Benefits provided under the Obesity Care Disease Management Program are not subject to deductible if determined to be preventive under the ACA and IRS guidelines.	To comply with the ACA and IRS guidelines for HSA qualifying high deductible health plans.
149	Clarification	Diabetes Care Management Program: Inserted "Benefits provided under the Diabetes Care Management Program are not subject to deductible if determined to be preventive under the ACA and IRS guidelines.	To comply with the ACA and IRS guidelines for HSA qualifying high deductible health plans.
149	Clarification	Telemedicine may be available from in-network providers and is covered on the same basis as in-person services. It is your responsibility to ensure the providers you use are in-network providers. Failure to use in-network providers will result in a denial of benefits and higher cost to you	Per MHPAEA and to match wording in the LD and EPO plans.

Low Deductible Plan

	Change Type	**Proposed Change**	**Justification**
150	Consolidation	Combined table for Alcohol and Substance Abuse Treatment with Mental Health and renamed to "Mental/Behavioral Treatment."	To keep in line with the MHPAEA
151	Enhancement	Increased Acupuncture and Acupressure to 20 visits in a plan year	To align with EPO
152	Reduction	Out-of-Network Deductible $500 individual $1,000 Family	It is not industry standard to have $0 Out-of-Network deductibles and

			contradicts steerage to In-Network providers. This was not PEBP's intention and was likely an oversight when the LD plan was developed.
153	Clarification	Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year (limit not applied to therapy treating a behavioral health condition). There is no limit for Cardiac Rehabilitation services.	This is to keep on congruence with the CDHP and Utilization Management requirements.
154	Clarification	Moved definition of Chiropractic Services and Spinal manipulation to Key Terms and Definitions	Moved for consistency and clarity
155	Clarification	Chiropractic Care and Spinal Manipulation maintenance services are not a covered benefit	Parity with the CDHP
156	Clarification	Prescription Benefits: Removed example table for Generics preferred program	Clarity and to not misconstrue benefits.
157	Clarification	Removed pre-existing condition exclusion form orthopedic devices and prosthetic devices and prosthetic devices: Devices provided in connection to an illness or injury that occurred after your effective date of coverage.	Pre-existing condition exclusions do not apply.
158	Clarification	Expanded language for Radiation Therapy to include MRI, MRA, MRS, MRT, PET, SPEC, and CT scan.	To clarify benefits covered under Radiation Therapy and for consistency with CDHP.
159	Clarification	Removed language describing spinal manipulation and adjustment	Language is non-essential to the document.
160	Clarification	In-network telemedicine is covered and paid on the same basis as in-person visits.	Clarification of telemedicine benefit.

Exclusive Provider Organization Plan

	Change Type	Proposed Change	Justification
161	Clarification	Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year (limit not applied to therapy treating a behavioral health condition). There is no limit for Cardiac Rehabilitation services.	This is to keep on congruence with the CDHP and Utilization Management requirements.
162	Clarification	Moved definition of Chiropractic Services and Spinal manipulation to Key Terms and Definitions	Moved for consistency and clarity
163	Clarification	Chiropractic Care and Spinal Manipulation maintenance services are not a covered benefit	Parity with the CDHP
164	Clarification	Doctor on Demand is PEBPs contracted telehealth provider and is considered In-Network	Contracted provider.
165	Clarification	Prescription Benefits: Removed example table for Generics preferred program	Clarity and to not misconstrue benefits.
166	Clarification	Removed pre-existing condition exclusion from orthopedic devices and prosthetic devices: Devices provided in connection with an illness or injury that occurred before the effective date of coverage.	Removed pre-existing language as it does not apply.

Dental and Life Plan

	Change Type	Proposed Change	Justification
167	Clarification	Removal of wording indicating PEBP or its designee determines that the services are the most cost-effective ones that meet the acceptable stands of dental practice and would produce satisfactory results.	Changed to prevent benefits from being misconstrued.
168	Enhancement	Maximum Dental Benefits increased to $2,000	Board approved.

169	Enhancement	The plan does not include a plan year maximum for dependent children under age 19.	Board approved.
170	Clarification	Deleted repeated sentence from the previous paragraph.	Clarity.
171	Clarification	Repair or re-cementing of inlays, crowns, bridges, and dentures which are 5 years old or more and cannot be repaired.	Amended the year frequency to match dentures.
172	Clarification	Moved Government-Provided Services (Tricare/Champus, VA, etc. to the definitions section.	Moved from Benefit Limitations and Exclusions to Definitions.
173	Added	Exclusion of Treatment of Disturbances of the joint linking the jaw to the skull and the associated muscles	Exclusion added to coincide with TMJ exclusion and expanding the definition.
174	Clarification	Removed reference to Held or Soft Denied claims	Per the ACA.
175	Clarification	Added verbiage for notices of adverse benefit determinations and level 1 claim appeal adverse benefit determinations	Per the NSA.
176	Clarification	Coordination of Benefits updated to direct members to Health and Welfare Wrap document that addresses Coordination of Benefits.	For consistency between plan documents.
177	Clarification	Added “and Subrogation” to Third-Party Liability	For consistency between plan documents.
178	Clarification	Members must be enrolled under a PEBP plan.	Language updated from covered to enrolled for nuance clarity.
179	Updated	Definition for Base Plan	Cited NRS 287.045
180	Updated	Definition for Business Day	Reference Nevada Holiday
181	Added	Definition for Dependent Child(ren)	For consistency between plan documents and NAC 287.312.

182	Added	Definition for FAIR Health	This is mentioned in the plan document, but not defined.
183	Clarification	Expanded language for Radiation Therapy to include MRI, MRA, MRS, MRT, PET, SPEC, and CT scan.	To clarify benefits covered under Radiation Therapy and for consistency with CDHP.

RECOMMENDATION

Approve the proposed changes for the Master Plan Documents for Plan Year 2024:

- Enrollment & Eligibility Master Plan Document
- Flexible Spending Account Master Plan Document
- Medicare Health Reimbursement Arrangement Master Plan Document
- Section 125 Master Plan Document
- Consumer Driven Health Plan Master Plan Document
- Low Deductible Master Plan Document
- Exclusive Provider Organization Master Plan Document
- Dental and Life Master Plan Document
- Active Health and Welfare Wrap Document
- Retiree Health and Welfare Wrap Document