Public Employees' Benefits Program

Biennial Compliance Review

Executive Summary

November 2024

Segal

Section 1. Introduction

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

Our compliance review is based on documents received, statutes, and regulations as existing and in effect for PEBP's July 1, 2024—June 30, 2025 plan year ("PY 2025"). 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 summary highlights key findings from the biennial review. As Federal and State benefits laws are continually changing, the review noted some areas which PEBP should update to enhance its compliance with Federal and State requirements. Below are some areas identified for PEBP's consideration.

Federal Findings

Notices

Segal reviewed PEBP's compliance with Federal notices required by the ACA, COBRA, HIPAA, No Surprises Act, and other Federal regulations. Based on the review of plan documents and responses, Segal recommends updating the ACA Marketplace Notice, the Surprise Billing Notice, and the Qualified Child Support Medical Order Notice. PEBP should also consider adopting the practice of distributing a new hire packet with mandatory notices in addition to annual distribution of notices, or update its new member letter to more clearly identify the availability and location of these notices.

Benefit Consistencies

During review, certain inconsistencies between plan documents were identified. PEBP should review its pediatric vision benefit schedule of benefits, physician references throughout the document, and DCFSA eligibility definition and clarify and/or update these sections as necessary.

HIPAA Privacy Protections

The Department of Health and Human Services (HHS) recently issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes. PEBP should review the new regulations and make updates to its policies, procedures, and Notice of Privacy Practices. PEBP should also ensure the HIPAA Privacy Notice is provided upon enrollment in the plan. The effective date is June 25, 2024, with a general compliance deadline of December 23, 2024. Privacy notices must be updated by February 16, 2026.

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

In 2023, PEBP implemented plan changes to comply with the proposed MHPAEA rules published on August 3, 2023. On September 23, 2024, the final rules for MHPAEA were published. The rules contain additional definitions, call for coverage of core treatments for covered mental health and substance use conditions, and require collection and review of data outcomes. Additional guidance is forthcoming, related to outcomes data collection and evaluation, as well as an updated self-compliance tool. PEBP should continue to evaluate the final rules and determine the impact on future MHPAEA compliance efforts.

Section 2. Summary of Findings (Continued)

State Findings

NRS 287.04335 directs that compliance with certain provisions in NRS and NAC is required to provide health insurance through a plan of self-insurance. Segal worked with PEBP to confirm the scope of review, and identify the applicable State statutes subject to review. NRS 287.04335 was amended in the 2023 Nevada Legislature, and made several changes applicable to PEBP.

PEBP should review the benefit requirements and new updates, and make updates to the Master Plan Documents (MPDs) as necessary. PEBP should also confirm with UMR that it is administering the benefits according to the amendments made to NRS 287.04335.

The following statutes were identified as areas PEBP should clarify:

- **Telehealth -** PEBP should clarify how out-of-network coverage is paid on the Low Deductible plan and whether this complies with the State mandate for telehealth coverage to mirror in person coverage.
- **Human immunodeficiency virus and hepatitis C -** PEBP should clarify the Plan provides for testing and other services for hepatitis C and HIV. PEBP should also clarify coverage for drugs used for prevention of HIV.
- **Coverage for testing, treatment and prevention of sexually transmitted diseases -** PEBP should update the MPDs to clarify all coverage mandated for testing, treatment, and prevention of sexually transmitted diseases is included. PEBP should also remove the exclusion for condoms. PEBP should confirm with UMR that coverage is provided according to State law.
- **Substance Use and Opioid Disorder Drugs -** PEBP should amend the MPDs to clarify the Plan provides benefits for substance use disorder for all drugs approved by FDA to support safe withdrawal from substance use disorder, including, without limitation lofexidine. PEBP should clarify that the Plan does not subject these benefits to medical management techniques, other than step therapy.
- **Mandates for certain wellness benefits -** PEBP should clarify that it covers hormone replacement therapy.
- **Emergency Prescription coverage during emergency or disaster declaration -** PEBP should consider adding language explaining procedure to obtain emergency prescription coverage during emergency or disaster declaration, and the geographic limitations as applicable.

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Table of Content

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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, Section 5 and Appendices A and B for detailed information and recommended actions.

Federal Findings

Notices

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

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During review, certain inconsistencies between plan documents were identified. PEBP should review its pediatric vision benefit schedule of benefits, physician references throughout the document, and DCFSA eligibility definition and clarify and/or update these sections as necessary.

HIPAA Privacy Protections

The Department of Health and Human Services (HHS) recently issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes. PEBP should ensure the HIPAA Privacy Notice is provided upon enrollment in the plan.

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

In 2023, PEBP implemented plan changes to comply with the proposed MHPAEA rules published on August 3, 2023. On September 23, 2024, the final rules for MHPAEA were published. The rules contain additional definitions, call for coverage of core treatments for covered mental health and substance use conditions, and require collection and review of data outcomes. Additional guidance is forthcoming, related to outcomes data collection and evaluation, as well as an updated self-compliance tool. PEBP should continue to evaluate the final rules and determine the impact on future MHPAEA compliance efforts.

State Findings

NRS 287.04335 directs that compliance with certain provisions in NRS and NAC is required to provide health insurance through a plan of self-insurance. Segal worked with PEBP to confirm the scope of review and identify the applicable State statutes subject to review. NRS 287.04335 was amended in the 2023 Nevada Legislature and made several changes applicable to PEBP.

PEBP should review the benefit requirements and new updates and make updates to the Master Plan Documents (MPDs) as necessary. PEBP should also confirm with UMR that it is administering the benefits according to the amendments made to NRS 287.04335.

Section 3. Federal Notices

Summary

Segal reviewed PEBP's compliance with Federal notices required by ACA, COBRA, HIPAA, No Surprises Act, and other Federal regulations.

- **Notice of Coverage Options in the ACA Marketplace**

  While this notice is an employer and not a PEBP requirement, PEBP provides this notice on its website. PEBP should ensure the notice is updated according to the new model notice released by HHS in 2024. Employers are required to distribute this notice within 14 days of date of hire. While PEBP is not the employer, PEBP may want to consider adding this notice into a new hire packet as discussed below.

- **Disclosure Notice Regarding Patient Protections Against Surprise Billing**

  PEBP posts this notice on its website under mandatory notices. PEBP should update this notice to the most current surprise billing model notice.

- **Qualified Medical Child Support Notice**

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

- **Notices for newly hired employees**

  In its review, Segal could not confirm whether PEBP provides certain notices upon initial enrollment. PEBP provides a new member welcome letter which contains a link to the PEBP website, where all plan documents, forms, and notices are contained. PEBP should consider a New Enrollee notice packet in addition to the annual notice packet, containing notices required to be distributed upon initial enrollment (ie: HIPAA special enrollment notice, HIPAA notice of privacy practices, CHIPRA, marketplace notice.) Alternatively, PEBP should consider amending its new member welcome letter to more clearly identify the location of any required initial notices.

Section 4. HIPAA Privacy Protections

Summary

The Department of Health and Human Services (HHS) recently issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes. PEBP should ensure the HIPAA Privacy Notice is provided upon enrollment in the plan.

- **Restrictions on use of PHI:** The final rule restricts covered entities (such as health plans healthcare clearinghouses or healthcare providers) and business associates from using or disclosing an individual's PHI for the purpose of conducting a criminal, civil or administrative investigation into or to impose criminal, civil or administrative liability on any person for the mere act of seeking, obtaining, providing or facilitating lawful reproductive healthcare. The final rule also restricts them from using PHI to identify any person for the purpose of conducting such investigation or imposing such liability.
- **Required Attestation:** When covered entities and business associates receive a request for PHI potentially related to reproductive healthcare, the final rule requires them obtain a signed written attestation from the person requesting the PHI that the use or disclosure is not for a prohibited purpose.
- **Revisions to Notices of Privacy Practices:** Covered entities must also amend Notices of Privacy Practices to include descriptions of the types of uses and disclosures prohibited under the final rule in sufficient detail for an individual to understand the rule. The final rule also requires revisions to Notices of Privacy Practices to address requirements under the Part 2 Rule for the Confidentiality of Substance Use Disorder Patient Records, published on February 16, 2024.

Effective Date: The effective date is June 25, 2024, with a general compliance deadline of December 23, 2024. Privacy notices must be updated by February 16, 2026.

Section 5. State Statute Review

Summary

NRS 287.04335 directs that compliance with certain provisions in NRS and NAC is required to provide health insurance through a plan of self-insurance. NRS 287.04335 was amended in the 2023 Nevada Legislature and made several changes applicable to PEBP. PEBP should review the benefit requirements and new updates and make updates to the Master Plan Documents (MPDs) as necessary. The following statutes were identified as areas PEBP may wish to clarify.

- **Telehealth**

NRS 695G.162 mandates that a plan must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means. PEBP's MPDs for the Low Deductible plan is unclear on whether the Plan provides telehealth coverage out-of-network. PEBP should clarify how out-of-network coverage is paid, and whether this complies with the State mandate.

- **Human immunodeficiency virus and hepatitis C**

NRS 695G.1705 mandates coverage for laboratory testing that is necessary for therapy that uses a drug to prevent the acquisition of human immunodeficiency virus (HIV) and any service to test for, prevent, or treat HIV or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist. PEBP should clarify the Plan provides for testing and other services for hepatitis C and HIV. Currently the MPDs state the Plan cover hepatitis C drugs. PEBP should also clarify coverage for drugs used for prevention of HIV.

- **Coverage for testing, treatment, and prevention of sexually transmitted diseases**

NRS 695G.1707 mandates that plans include coverage for testing for, treatment of and prevention of sexually transmitted diseases. The statute also mandates unrestricted coverage of condoms for insureds who are 13 years of age or older. NRS 695G.1714 mandates plans provide coverage for examination of person who is pregnant for certain diseases. The MPDs state the Plans provide for "counseling of sexually transmitted diseases" and ACA mandated preventive care services. The MPDs also contain an exclusion for condoms. These statutes above appear to mandate coverage above what the ACA preventive services mandate. PEBP should update the MPDs to clarify all coverage mandated by NRS 695G.1707 and NRS 695G.1714 is included. PEBP should also remove the exclusion for condoms. PEBP should confirm with UMR that coverage is provided according to the referenced State statutes.

- **Substance Use and Opioid Disorder Drugs**

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

- **Mandates for certain wellness benefits**

  NRS 695G. 1717 mandates coverage for certain wellness benefits, including hormone replacement therapy. PEBP should clarify that it covers hormone replacement therapy.

- **Emergency Prescription coverage during emergency or disaster declaration**

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

Appendix A. Summary of Findings – Federal

1. IRS Requirements

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Form W-2	Employers must report the cost of health coverage and Dependent Care Assistance Program and Health Flexible Spending Arrangement (FSA) benefits on an annual Form W-2, along with other information.	PEBP's Eligibility and Enrollment vendor TELUS Health/Lifeworks sends the necessary data for reporting on individual employee W-2s to the applicable state employers. PEBP has stated that neither PEBP nor Central Payroll have any concerns. No concerns noted during review.	None.	

2. ACA (Patient Protection and Affordable Care Act) Requirements

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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.	PY2025 SBCs provided: • PY2025 CDHP SBC Employee Family • PY2025 EPO SBC Individual Family • PY2025 Health Plan of Nevada HMO SBC • PY2025 LD PPO SBC Employee Family SBCs are posted on the PEBP website. SBCs are referenced in the annual Benefits Guide with a statement that the SBCs "are available by logging on to your E-PEBP Portal at www.pebp.state.nv.us or by calling PEBP and requesting a copy be mailed to you." No concerns with PEBPs distribution of SBCs noted.	None.	
Patient-Centered Outcomes Research Institute (PCORI) Fee	Plans and insurers pay fees to fund PCORI, which funds evidence-based research projects with the goal to advance quality of care. Fee is filed with IRS on Form 720. Payment is due 7/31 of calendar year immediately following last day of plan year to which fees apply. Applies through plan years ending before 10/01/29.	PEBP states it has paid its PCORI fee for 2023 and will pay PCORI fees for 2024 in the fourth quarter of PY 2025, when they are due. PEBP states that Health Plan of Nevada pays the PCORI fee for the HMO plan. PEBP is in compliance with PCORI fee.	None.	
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	Per the Eligibility MPD, Dependent children are covered through the end of the month in which they turn 26.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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).	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. No concerns noted with PEBPs coverage of dependent children.		
90-Day Waiting Period Rule	Plans must cover employees within 90 days of the date on which an employee is otherwise eligible.	Eligibility MPD states new hire employees are eligible for coverage on the first day of the month concurrent with or following the date of hire.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		PEBP is in compliance with the 90-day waiting period rule.		
No Rescission	Plans may not rescind coverage retroactively (with limited exceptions).	MPD discusses no retroactive rescission with limited exceptions. No concerns noted.	None.	
Preexisting Condition Exclusions	Plans may not have preexisting condition exclusions or limitations. Hidden preexisting conditions are also prohibited.	The Health & Welfare Wrap MPD states that PPACA group market (insurance) reforms that apply to all grandfathered and non-grandfathered group health plan Benefit Options under the Plan that are not exempt or excepted benefits under Section 2791 of the PHSA, including prohibition of preexisting condition exclusions under PHSA 2704. No pre-existing conditions were discovered during review.	None.	
No annual or lifetime dollar limits on Essential Health Benefits (EHBs)	Plans may not impose an annual or lifetime dollar limitation on EHBs. Plans may adopt a benchmark that excludes a benefit from EHB and have dollar limit on those benefits. One of the EHBs categories include pediatric vision services.	It does not appear that the PEBP plan imposes annual or lifetime dollar limitations on EHBs in the medical plan. However, the vision benefit within the medical plan includes a $100 limit for exams. This should be reviewed against the vision exam benefit as offered for children up to age 19. Additionally, the LD PPO MPD includes glasses benefit without distinction to age. The SBC states eyeglasses for children are not covered. This inconsistency needs to be clarified between the MPD and SBC and confirmed that the benefit complies with EHB rules.	Action Required: Review MPDs and SBCs for pediatric vision benefit offering for consistency and EHB.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		PEBP removed the dental maximum benefit for children up to age 19 in 2023.		
Preventive Care	Non-grandfathered group health plans must provide certain specified preventive health services without cost sharing.	Per the MPD: Preventive Care/Wellness Benefits are covered 100% in-network not subject to the deductible.	None.	
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). 2025 limits: $9,200 for an individual plan and $18,400 for a family plan before marketplace subsidies; maximum deductible is the same as the out-of-pocket maximum.	Per the MPD: 2024-2025 OOP maximums: Low PPO - $4,000/$8,000 (in-network) EPO - $5,000/$10,000 (in-network) See below for CDHP out-of-pocket maximums	None.	
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 – "Coverage for certain treatment received as part of a clinical trial or study for treatment of cancer or chronic fatigue syndrome will be provided subject to the requirements and limitations set forth in NRS 695G.173" The MPD sets out preauthorization requirements for clinical trials and defines approved clinical trials. No concerns noted.	None.	
Provider Nondiscrimination	Plans cannot discriminate against a health care provider acting within the scope of his or her license.	The Active Health and Welfare Wrap MPD has reference to provider non-discrimination under PHSA 2706 in the Compliance with Federal Group	Action Recommended: PEBP to review physician references in MPD and revise to Health Care Practitioner if appropriate.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		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."		
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"	PEBP removed the lifetime maximum for dependents to age 19.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	benefits are exempt from the HIPAA portability rules.			
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 (NAC 287.150) or an average of at least 130 hours per month as defined by the IRS are defined as full-time. The employers may have received the Employer Shared Responsibility Payment notice from the IRS. No concerns identified.	None.	
Minimum Value	Coverage must meet minimum value standard (60 percent)	SBCs state the plans meet minimum value.	None.	
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) (9.12% for 2023, and 8.39% for 2024). 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	PEBP uses the state of Nevada minimum wage for affordability. (Rate of Pay). Nevada minimum wage: $12.00 regardless of whether employer provides qualifying health coverage ($12.00 x 130 hours) = 1,560 $1560 x 8.39% = $130.88 The lowest cost employee only contributions per month is $55.26 for the CDHP PPO plan.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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 meets the affordability standard.		
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	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.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	previous reporting year are generally due to participants by 3/1 and filed with IRS by 3/31 if filed electronically (by 2/28 for paper filing). Employers filing more than 250 reporting forms are required to file electronically. Employers can use IRS Form 8809 for an automatic 30-day extension.			
Form 1095-C and Form 1094-C	Large employers (50 or more full-time employees, including equivalents), must provide full-time employees with Form 1095-C, documenting offer of coverage, and file all such forms with IRS (along with Form 1094-C transmittal). Forms for the previous reporting year are generally due to employees by 3/1 and filed with IRS by 3/31 if filed electronically (or 2/28 for paper filing). Employers filing more than 250 reporting forms are required to file electronically. Employers use IRS Form 8809 for an automatic 30-day extension of time.	PEBP works with 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.	None.	
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	The Plan does not require a designation of a primary care physician.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	regarding choice of health care professional and extended to grandfathered health plans.			
Notice of Coverage Options in the ACA Marketplace	Employer subject to the Fair Labor Standards Act required to provide new employees within 14 days of hire with notice about health insurance marketplaces, their options for health coverage, and information about premium tax credits, regardless of the employee's plan enrollment status or of part-time or full-time status. Note – this is an employer requirement, not a health plan requirement.	Included within the link here: Mandatory Notices (pebp.nv.gov/plans/mandatory-notices The website includes the 2022 version of the Marketplace notice. A new model notice was released early 2024.	Action Required: This is an employer requirement, however PEBP does include this notice on its website. PEBP should ensure the notice is updated according to the new model notice released by HHS in 2024.	
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.	None.	
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	MPD includes Section 1557 Notice. While pending litigation enjoined the application of Section 1557, we recommend inclusion of the notice while awaiting future guidance.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	participants/beneficiaries with a notice conveying information about §1557 nondiscrimination requirements in significant publications, communications, websites, and physical locations. The final rule was published in the federal register on May 6, 2024, with a general effective date of July 5, 2024. The final rule reinstated the application of 1557 and the tagline requirement to all covered entities.			

3. COBRA

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Initial or General Rights Notice	Provides basic information regarding COBRA and the rights and responsibilities of qualified beneficiaries to ensure they have the information they need before the occurrence of a qualifying event.	General notice provided. Notice is mailed to all new enrollees by eligibility unit.	None.	
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.	None.	
Notice of Unavailability of COBRA	Individuals who have sent the plan a qualifying event notice must be notified about why COBRA is not available. The notice must be provided within 14 days after the plan administrator is notified of the qualifying event.	Notice of Unavailability provided. PEBP stated it provides this notice as required.	None.	
Notice of Termination of COBRA	Qualified beneficiaries must be notified about early termination of COBRA. The notice is required as soon as practicable after the plan's determination that COBRA can be terminated prior to the applicable 18-, 36-, or 29-month period.	Notice of Termination example provided. PEBP states it provides this notice as required.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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. PEBP states it provides this notice as required. 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.	None.	

4. Health Insurance Portability and Accountability Act (HIPAA)

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
HIPAA Notice of Special Enrollment Rights	HIPAA requires group health plans to provide notice of special enrollment opportunities outside of the plans' regular enrollment periods in the following situations: • A loss of eligibility for other health coverage. • Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP); • The acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption; and • Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP. Notice must be provided on or before the date the participant is offered the opportunity to enroll in the plan.	Provided in Enrollment and Eligibility MPD under "HIPAA Special Enrollment Notice" and within Annual Notices. The Annual Notices were emailed to all Active and Retired PEBP members July 17, 2024.	Action Required: PEBP should ensure the HIPAA notice of Special Enrollment Rights is provided upon enrollment in the plan. See discussion in Section 3 above.	
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	Active Health and Welfare Wrap MPD states PPACA group market (insurance) reforms that apply to all grandfathered and non-grandfathered group health plan Benefit Options under the Plan that are not exempt or excepted benefits under Section 2791 of the PHSA including: • Prohibiting discrimination against Participants and beneficiaries based on a	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	coverage than an individual in a similar situation on account of any health factor.	health factor under PHSA 2705.		
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.	None.	
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)"	None.	
HIPAA Notice of Privacy Practices (NPP)	A notice to participants describing their rights, plan's legal duties with respect to Protected Health Information (PHI) and the plan's uses and disclosures of PHI must be included on the plan's website and provided upon enrollment. In general, any material revision to the notice must be provided within 60 days of the revisions. If a plan posts the revision on its website by the revision's effective date, then individual notices can be sent at the time of the next annual mailing. The notice must also be provided upon request. The Department of Health and Human Services (HHS) recently	The Privacy Notice – Disclosure and Access to Medical Information is located on the PEBP website (Mandatory Notices (state.nv.us) The Privacy notice was last updated July 2021.	Action Required: PEBP should ensure the new HIPAA Notice of Privacy Practices complies with the new rule by February 2026. PEBP should ensure the privacy notice is provided upon enrollment. See discussion in Section 3 above.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes.			
HIPAA Notice of Privacy Practices Reminder	Covered individuals must be notified at least once every three years of the availability of the NPP. Not required if the NPP is provided annually.	The Privacy Notice – Disclosure and Access to Medical Information is located on the PEBP website (Mandatory Notices (state.nv.us). The reminder notice is included in the Annual Notices were emailed to all Active and Retired PEBP members July 17, 2024.	None.	
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. The Department of Health and Human Services (HHS) recently issued a final rule that strengthens privacy protections for Protected Health Information (PHI) related to lawful reproductive healthcare. The rule requires covered entities, including group health plans, to modify privacy policies and procedures and prepare new Notices of Privacy Practices reflecting the changes.	Privacy and Security of Protected Health Information (PHI) policy – updated 08/20/2021	Action Required: PEBP should review HIPAA Privacy policies and procedures ensure they comply with the new rule.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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 08/20/2021	None.	
HIPAA Security Risk Analysis	HIPAA Security Rule requires covered entities to perform risk analysis as part of their security management processes, risk analysis should be an ongoing process, in which a covered entity regularly reviews its records to track access to e-PHI and detect security incidents, periodically evaluates the effectiveness of security measures put in place, and regularly reevaluates potential risks to e-PHI.	PEBP has conducted a security risk assessment through the use of the Security Risk Assessment Tool as provided through healthit.gov on September 11, 2024.	Action Recommended: PEBP should supplement 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.	
HIPAA Training	A covered entity must train all workforce members on its privacy and security policies and procedures, including the new rules regarding reproductive healthcare.	HIPAA Privacy and Data Security Training – conducted annually. PEBP keeps training attestations.	Action Required: PEBP should review HIPAA training materials and update for new provisions for reproductive healthcare.	
Breach of Unsecured PHI	Plan must file notice with HHS (and prominent media outlets) within 60 days of discovery if the breach affects 500 or more individuals. Plan must file annually with HHS if the breach affects fewer than 500 individuals, no later than 60 days after the end of calendar year.	Privacy and Security of Protected Health Information (PHI) policy – updated 8/20/2021. PEBP confirmed no breaches of PHI within this review period.	None.	
Business Associate Agreements (BAA)	A BAA is a required agreement between the covered entity (i.e.,	PEBP should continue to inventory current BAAs.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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.			

5. Medicare

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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 2024.	None.	
Creditable Coverage Disclosure to CMS	Provide written disclosure to CMS stating whether the plan's prescription drug coverage is, on average, at least as good as standard Medicare Part D coverage is due 60 days after beginning of the plan year (generally March 1 for a calendar year plan). Plan must also provide within 30 days of the plan's termination of drug coverage or change in creditable status of the plan. No penalty.	PEBP submits on CMS website every year. PEBP confirmed submission for PY 2024 and PY 2025.	None.	
Retiree Drug Subsidy Application	RDS application (along with retiree list and attestation) is due at least 90 days prior to the start of the plan year (typically October 3 for a calendar year plan, unless extended for 30 days until November 2). Reconciliation must be completed within 15 months after the end of the applicable plan year, unless 30-day extension.	The RDS is performed annually by PEBP. Data files are downloaded from TELUS and requested from ESI and HPN and reconciled with each other, then the reporting is completed on the CMS website and payment is requested.	None.	
Medicare Secondary Payer (MSP) Data Reporting	Plans (including HRAs with annual benefit levels of $5,000 or more as of the beginning of	Both UMR and ESI confirm they follow Section 111 guidelines	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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.			

6. Transparency – No Surprises Act

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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. PEBP is using the 2022 version of notice.	Action Required: PEBP should update notice to most current balance billing notice.	
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 confirmed that provider termination notices are sent to members. Patients under care are allowed to elect to continue benefits under the plan, with the treating provider and under the same terms and conditions for a period of 90 days (from date of notice) or earlier with the ending of continuing care from the provider. UMR's continuing care patient notice was provided.	None.	
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: 4. In-network rates 5. Out-of-network allowed amounts and	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/	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	6. Prescription drug negotiated rates Enforcement delayed until future rulemaking for prescription drug negotiated rate file.			
Insurance Identification Cards	For plan years beginning on and after 1/1/2022, Plans must include plan deductibles, out-of-pocket (OOP) maximums and consumer assistance contact information (phone number and website) in clear writing on any physical or electronic plan or insurance identification card.	PEBP has confirmed that UMR has updated the identification cards.	None.	
Prescription Drug Reporting (RxDC Report)	Under Section 204 (of Title II, Division BB) of the Consolidated Appropriations Act, 2021 (CAA), insurance companies and employer-based health plans must submit information about prescription drugs and health care spending.	PEBP response: ESI sends out an email to clients in Q1 to initiate the process of collecting data elements needed for the file submission on behalf of our clients who want ESI to be the reporting entity on their behalf. Once the file is sent, a confirmation email goes to the client. The file itself cannot be shared since this is an aggregated file that is sent. Files are sent annually. PEBP should continue to coordinate with its medical and PBM vendors to confirm filing status.	None.	
Gag Clause Attestation	Group health plans and health insurance issuers may not enter into an agreement with a provider, network, TPA or other service provider that would directly or indirectly restrict the plan or issuer from providing provider-specific cost or quality information to referring providers, the plan sponsor,	PEBP has stated they have worked with vendors for submission and will submit the new attestation by the required date.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	participants/ beneficiaries (or people eligible for coverage under the plan). Plans must provide by 12/31 an annual attestation to the government that they are in compliance with this section.			
No Surprises Act: Emergency Services	Effective for plan years beginning 1/1/2022, Plans must cover emergency services at non-participating facility, services/items provided by non-participating provider at a participating facility, or non-participating provider air ambulance services with the same participant cost-sharing whether the services are from a participating or non-participating provider or facility. Providers and facilities are banned from balance billing.	Per nv.doi.gov: The 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 has included language in its MPD to highlight when balance billing is not permitted under the No Surprises Act.	None.	
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 Response: UnitedHealth Group is committed to compliance with the laws and regulations applicable to its businesses. This includes requirements of the Consolidated Appropriations Act (CAA), Transparency in Coverage Rule and No Surprises Act. When participants log into their account on the UMR portal, they are able to access cost-sharing/price tool. It is not public facing and does require the member to be in their account.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		UMR is not aware of any concerns that have been reported regarding this tool to PEBP or UMR.		

7. 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

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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."	None.	
Preventive Services	CARES Act requires non-grandfathered group health plans and issuers to cover preventive services — 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.	None.	
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	The CDHP MPD highlights the plan will pay for telehealth services after the deductible is met, however provides a copay list for Doctors on Demand services before the deductible is	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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. 2023 CAA extended this safe harbor through December 31, 2024.	met. The Plan pays 80% after the deductible is met.		

8. Other Laws Affecting Group Health Plans

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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.	None.	
Americans with Disabilities Act of 1990, as amended ("ADA")	Under the ADA, workers with disabilities must have equal access to all benefits and privileges of employment that are available to similarly situated employees without disabilities. Prohibits exclusion from participation or denial of benefits in "services, programs or activities of a public entity." Website accessibility is a current litigation risk under the ADA.	Per the Health and Welfare Active MPD - To the extent applicable, the Plan shall comply with the Americans with Disability Act (ADA), including the requirement that any condition that substantially limits a major life activity will be considered a disability, even if the individual can offset or compensate for the disability with the mitigating measures such as hearing aids or artificial limbs. Website pages regarding ADA accessibility: Americans With Disabilities Act (adahelp.anv.gov)	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		Accessibility Information (adahelp.nv.gov)		
Family and Medical Leave Act of 1993 ("FMLA")	Employers must continue an employee's insurance coverage under the company's group health plan during FMLA leave, just as if the employee had worked continuously rather than out on leave. The employer may require employees on FMLA leave to pay their share of premium payments in any of the following ways: (1) Due at the same time as it would be made if by payroll deduction; (2) Due on the same schedule as payments are made under COBRA; (3) Prepaid pursuant to a cafeteria plan at the employee's option; (4) Using employer's existing rules for payment by employees on leave without pay provided that such rules do not require payment prior to the commencement of the leave of the premiums that will become due during a period of unpaid FMLA leave or payment of higher premiums than if the employee had continued to work instead of taking leave; or, (5) Another system voluntarily agreed to between the employer and the employee, which may include prepayment of premiums (e.g., through increased payroll deductions when the need for the FMLA leave is foreseeable).	Per the Eligibility and Enrollment MPD: "During FMLA leave, the employer must maintain the employee's health coverage under any employer group health plan on the same terms as if the employee had continued to work, regardless of whether the employee is on paid or unpaid leave." Per the Active Wrap plan document: "If a Participant fails to pay Participant Contributions during a Leave of Absence and the Plan Administrator in its discretion continues coverage under any Component Benefit in effect during such Leave of Absence, any unpaid Participant Contributions during such period will be collected in arrears through payroll deductions through the Cafeteria Plan, or as otherwise directed by the Plan Administrator upon the Participant's return to employment with the Employer or expiration of the Participant's Leave of Absence, as applicable."	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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.	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."	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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.			
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."	None.	
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 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	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		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 CDHP 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." LD PPO and EPO both state "Medically necessary maternity services for pregnant participants are covered, including prenatal and postpartum care, related delivery room and ancillary services and newborn care." "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."	None.	
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.	PEBP revised the Plan Year 2023 MPD to reflect enhancements in plan design for gender dysphoria treatment. Plan year 2025 MPD reflects these changes.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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).			
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. • 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	Per the Enrollment and Eligibility 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 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.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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.	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	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		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."		

9. Certain Required Notices

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Women's Health and Cancer Rights Act (WHCRA) Notice	Plans must provide a description of benefits under WHCRA both upon enrollment and annually thereafter.	PEBP's Annual Notices document includes Women's Health and Cancer Rights Act. The Annual Notices were emailed to all Active and Retired PEBP members July 2024. WHCRA language is included in the MPDs.	None.	
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 7/31/2024. https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra	PEBP's Annual Notices document includes CHIP Notice– Medicaid and Children's Health Insurance. The Annual Notices were emailed to all Active and Retired PEBP members July 2024.	None.	
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.	None.	
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.	None.	
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	PEBP does not have a wellness program.	N/A.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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.			
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 July 2024.	None.	
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	None. .	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		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."		
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	Action Required: PEBP should amend the following language to the MPD "You and the affected child will be notified if an order is received, *and a copy of the procedures is available free of charge upon request*."	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
		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.		

10. Cafeteria Plan, FSAs, HSA/HDHPs, HRAs

CAFETERIA PLAN

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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.	None.	
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.	None.	
Salary reduction agreement	Required for participant to pay for benefits on a pre-tax basis	Defined and referenced throughout Section 125 plan document.	None.	
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	Permitted mid-year events referenced in Status Change Elections; Special Enrollment; Other Election Changes section of the Section 125 plan document.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	• 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.			
Participants limited to current or former employees	Individuals who are self-employed, such as sole proprietors or partners in a partnership, and individuals who	Active Legislators pay 100% of their own contributions after tax. There are no subsidies.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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.			
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.	

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Maximum annual employee contribution election	For 2024: $3,200	The limit for calendar year 2024 is $3,200 for the medical FSA or the Limited Purpose FSA.	None.	
Employer contribution	An employer may match up to $500, regardless of whether or not the employee contributes to	No employer contributions to health FSA.	N/A.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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.			
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."	None.	
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.	The Plan does not permit a grace period.	N/A	
Carryover (optional)	Cannot have both a grace period and a carryover Maximum carryover amount indexed to 20 percent of the annual maximum election. For 2024 ($610); For 2025 ($640). Not applicable to DCFSA.	The Health Care FSA and Limited Purpose FSA permit a carryover of up to $640.	None	
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 - Claims for expenses incurred during the Plan Year must be submitted to the TPA by October 31st following the end of the Plan Year.	None.	
Significant cost or coverage changes	Does not apply to an election change with respect to a health	FSA MPD confirms this does not apply to the health FSA or	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	FSA (or on account of a change in cost or coverage under a health FSA).	limited purposes states the change applies when the cost charged to employee for a benefits package option significantly increases or decreases.		
Qualified medical expenses	Qualified medical expenses are those specified in the plan that are paid for care as described in Section 213 (d) of the Internal Revenue Code that are not otherwise reimbursed. See Pub. 502. Expenses incurred after December 31, 2019, for over-the-counter medicine (whether or not prescribed) and menstrual care products are considered medical care and are considered a covered expense.	Per the FSA MPD - Qualifying expenses are those expenses which are incurred by the taxpayer or their eligible dependents during the Plan Year for medical care as defined in Section 213(d) of the Internal Revenue Code, excluding all insurance premiums and long-term care expenses.	None.	
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 FSA MPD "When Do I Have to Turn in Paperwork" discusses substantiation.	None.	
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.	None.	
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.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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.	None.	
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." "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."	None.	
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.	None.	

DEPENDENT CARE FSA

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Eligibility	both parents working one spouse not working: generally, can qualify if (i) Job-related: the spending must	Per the FSA MPD: "Dependent Care FSA. To qualify for this account, both you and your spouse must be	Action Required: PEBP should clarify if the DCFSA is only open to employees enrolled in the	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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	gainfully employed (unless you are a single parent). If your spouse is a full-time student, actively looking for full-time employment, or disabled, you may also qualify if you meet strict IRS eligibility guidelines. The Dependent Care FSA covers expenses if you claim the person being cared for as a dependent on your income tax return and the person is either: • Younger than 13; or • Physically or mentally incapable of self-care and regularly spends at least eight hours a day in your household. Regularly does not mean daily, but frequently, on a regular basis. A DCFSA is an option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP), HMO, or EPO Plan that allows you to pay for dependent care expenses and lower your taxable income."	PEBP CDHP, HMO or EPO plans.	
Qualifying Individuals	A qualifying individual(s) who is: • A qualifying child who has not attained age 13; or	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	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	• 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 • 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.	dependent who is physically or mentally incapable of caring for himself or herself and who lives in your home at least 8 hours each day. The expenses may not be paid to a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent."		
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.	None.	
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."	None.	
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.	None.	
Qualifying Expenses	As set forth in the plan, payment for provision of services, which if paid for by the employee would	Per the FSA MPD: "Expenses necessary for you to be gainfully employed:	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	be considered, employment related expenses under I.R.C. § 21(b)(2). DCFSA-eligible expenses (i.e., expenses paid to enable the taxpayer to be gainfully employed) while the taxpayer is gainfully employed or is in active search for gainful employment. Expenses paid for household services and services for the care of a qualifying individual with respect to the taxpayer, but only if the expenses are incurred to enable the taxpayer to be gainfully employed. Expenses paid for household services performed in connection with the care of a qualifying individual. Expenses paid for the performance in and around the taxpayer's home of ordinary and usual services necessary to the maintenance of a household Expenses paid for services provided for the primary purpose of a qualifying individual's well-being and protection, including expenses for benefits which are incident 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	• 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."		

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	providing services for any of the individuals.			
Payments to Related Persons	No amount paid or incurred during the taxable year of an employee by an employer in providing dependent care assistance to such employee shall be excluded from income (a) if such amount was paid or incurred to an individual—(1) with respect to whom, for such taxable year, a deduction is allowable under section 151(c) (relating to personal exemptions for dependents) to such employee or the spouse of such employee, or (2) who is a child of such employee (within the meaning of section 152(f)(1)) under the age of 19 at the close of such taxable year.	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."	None.	
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	Per the FSA MPD "The TPA will review your claim, and if approved will reimburse you. Claim reimbursements are issued within one business day of the receipt of your claim up to the amount that you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from your payroll contributions. 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	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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	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."		
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.	None.	

Additional FSA Rules

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Cannot transfer funds between the two accounts	Cannot transfer funds between the Health FSA and the DCFSA.	PEBP's funds cannot be transferred between the Health FSA and the DCFSA.	None.	

Debit Cards

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Card limit	The use of the card is limited to the maximum dollar amount of	PEBP's debit card is limited to the maximum dollar amount of	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	coverage available in the employee's health FSA or HRA.	coverage available in the employee's health FSA or HRA.	.	
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)."	None.	
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	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 amount, provider, and time period (e.g., for an employee who pays a monthly fee for	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	claim amount (dollar amount spent for the service or item). In addition, the Health FSA sponsor may coordinate with an individual's insurance provider to use information provided in an explanation of benefits to substantiate a debit card charge without requiring more information.	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)."	None.	
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."	None.	
Use of Debit Card for DCFSA	An employer may use a payment card program to	PEBP uses the debit card for DCFSA.	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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.	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."		

HSA/HDHP

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
Only employees enrolled in a HDHP can enroll in the HSA		Per the CDHP MPD, "Employees may not establish or contribute to a Health Savings Account if any of the following apply: The employee is covered under other medical insurance coverage unless that medical insurance coverage: (1) is also a High Deductible Health Plan as defined by the IRS; (2) covers a specific disease state (such as cancer insurance); or (3) only reimburses expenses after the Deductible is met."	None.	
Annual limits	HSA Contribution Limit: 2024 2025	Per the MPD:	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	Self-only $4,150 $4,300 Family $8,300 $8,550 HSA Catch-up Contributions: Age 55 + $1,000 $1,000 HDHP Minimum Deductible: Self-only $1,600 $1,650 Embedded $3,200 $3,300 Family $3,200 $3,300 HDHP Maximum Out-of-pocket Expense Limit (deductibles, copayments, and other amounts, but not premiums) Self-only $8,050 $8,300 Family $16,100 $16,600	2024 HSA contribution: $4,150 / $8,300 HSA Catch Up Contribution: $1,000 HDHP Min. Ded. $1,600/$3,200 (ind./family) HDHP – OOP Max (in-network) $4,000/$6,850/$8,000 (ind/family member/family)		
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.	CDHP MPD: HSAs are employee-owned accounts, meaning the funds in the HSA remain with the employee and carry over from one year to the next.	None.	
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	Per the FSA MPD: "the FSA carryover will make you ineligible for the PEBP health savings account. To be eligible for the PEBP health savings account you may either elect to decline the carryover prior to the next Plan Year or switch your enrollment to the Limited Purpose FSA and carry over the unused funds to your new account."	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	carryover and waive the funds prior to the end of the FSA plan year (it is not generally permissible to decline a grace period, however). Employers may allow participants to choose whether to convert a carryover amount to a limited purpose health FSA, but a health FSA having a grace period is generally not permitted to offer each participant that choice (but may impose a mandatory conversion for all participants).			

HRAs

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
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: The HRA is funded solely by the Plan Administrator	None.	
Integrated HRA	Must be integrated with employer group health plan that meets the ACA's market reform requirements. HRAs so	Per the Active Wrap Plan Doc: "Health Reimbursement Arrangement is intended to be	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	integrated are deemed to comply with those requirements.	integrated for purposes of PPACA and related guidance."		
Retiree-Only HRA	Terminated/Retired employees only (limited to less than 2 active employees) Can reimburse their Medicare Part A, Part B and Part D premiums. Not subject to ACA market reforms but must satisfy: Reporting of minimum essential coverage (6055 reporting generally only for pre-Medicare retirees and dependents) and PCOR fee. For purposes of nondiscrimination testing, a key employee includes a retiree who was a key employee when he or she retired.	Per the Medicare HRA MPD: The HRA is provided to eligible retirees enrolled in a Medicare Plan through Via Benefits or who have Tricare for Life, and Medicare Parts A and B.	None.	
COBRA	Eligibility	Integrated HRA: can elect COBRA for HRA only if COBRA is elected for group health plan. COBRA is offered for the HRA.	None.	
COBRA	Premium	At the beginning of each plan year, the employer should calculate a reasonable premium for the HRA, both for single and family coverage. The IRS has defined two methods for determining the COBRA premium: the actuarial method and the past-cost method. PEBP does not charge an additional COBRA premium.	None.	
Coordination with Health FSA	While an employee can have both an HRA and an FSA at the same time, the same expense	Health Scope Benefits has confirmed that the participant signs an attestation including that the expenses are not	None.	

FEDERAL LAW	Requirement Overview	Materials Reviewed & Findings	Action Required	PEBP Response
	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.	eligible for reimbursement under any other health plan. The FSA and HRA SPDs state that if an employee has coverage under both the Health FSA and HRA, claims should be submitted to the health FSA first until that account is exhausted.		

Appendix B. Summary of Findings – State

STATE LAW	Description	Findings	Action Required	PEBP Response
Eligibility and Participation: Definition of "Dependent", "Participant" and "Domestic Partner" NAC 287.035 NAC 287.311 NAC 287.312 NAC 287.313 NRS 689B.035	• Dependent: defined. • Dependents: Enrollment and disenrollment. • Dependents: Eligibility of child of participant, spouse, or domestic partner. • Responsibility for final determinations concerning eligibility. • Required provision in certain policies concerning termination of coverage on dependent child.	MPD defines dependent child, domestic partner, and outlines eligibility. MPD defines participant and eligibility. MPD provides for provisions concerning termination of coverage of dependent children.	None.	
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.	None.	
Eligibility and Participation: Retirees NAC 287.530 NAC 287.540 NAC 287.542 NAC 287.544 NAC 287.546 NAC 287.548 NRS 287.023 NRS 287.047	• Coverage of retired person, spouse, domestic partner or surviving dependent. • Coverage of participating employee of State who reenrolls upon retirement or total disability, coverage of nonparticipating employee of State. • Coverage of participating employee of local	MPD outlines retiree eligibility and enrollment process.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	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.			
Eligibility and Participation: Seasonal Employees and	Retention by certain short-term state employees of membership	PEBP states that the employers report employee eligibility.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
Employees on a Biennial Plan NRS 287.0467	in and dependents' coverage under Program.			
Eligibility and Participation: Individual as Both Employee and Dependent NAC 287.520	Coverage of person qualified as both employee and dependent; change of status from employee to dependent.	Per the MPD: • Any spouse or domestic partner that is eligible for coverage as both a primary participant and a dependent shall be enrolled as a primary participant. • A child that is eligible as both a primary participant and a dependent may enroll as a primary participant or continue coverage as a dependent of a PEBP participant until age 26 years.	None.	
Eligibility and Participation: Surviving Spouse/ Dependents NAC 287.530 NRS 287.0475 NRS 287.0477	• Coverage of retired person, spouse, domestic partner or surviving dependent. • Reinstatement of insurance by retired public officer or employee or surviving spouse. Option of surviving spouse or child of police officer, firefighter or volunteer firefighter killed in line of duty to join or continue coverage under Public Employees' Benefits Program; notification; payment of costs for coverage; duration of eligibility.	MPD outlines surviving spouse/dependents eligibility. 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	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
		death of the police officer or firefighter.		
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 health insurance plan, the PEBP Plan reserves the right to coordinate benefits as stated in the Coordination of Benefits section of the PEBP Consumer Driven Health Plan, Low Deductible PPO Plan, and EPO Plan or HMO Evidence of Coverage Certificate (as applicable).	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	• Withdrawal from Program: Procedure; termination of coverage; limitation on reentry; eligibility of certain officers and employees after exclusion of group; liability of Program.	PEBP reports there are no opt-out plans maintained by local government agencies.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
Eligibility and Participation: Opt-out Plan Administration NAC 287.371 NAC 287.376	• Eligibility of officer or employee to join opt-out plan; ineligibility of officer or employee to continue participation in opt-out plan. Participation in Program by certain persons eligible for coverage under or participating in opt-out plan prohibited; exceptions.	PEBP reports there are no opt-out plans maintained by local government agencies.	None.	
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.	None.	
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 NRS 287.0475, a retired public officer or employee of the State, NSHE, a participating local government, or the surviving spouse thereof, may reinstate insurance during the open enrollment period if the retired public officer or employee did not have more than one period during which he	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
		or she was not covered under the PEBP Plan on or after October 1, 2011, or on or after the date of his or her retirement, whichever is later. Meaning, the above individuals will only have one opportunity to rejoin a PEBP Plan following retirement. In accordance with NRS 287.0475, a retired public officer or employee who retired from a nonparticipating local governmental agency or the surviving spouse thereof, may reinstate insurance during the open enrollment period through the Medicare Exchange or under the Public Employees' Benefits Program if eligible, if the retired public officer or employee (1) did not have more than one period during which he or she was not covered by insurance under the Program on or after October 1, 2011; (2) was enrolled in the Program as a retiree on November 30, 2008; and (3) is enrolled in Medicare Parts A and B at the time of the request for reinstatement. To enroll as a late enrollee, contact PEBP between April 15th and May 15th to request the retiree late enrollment form. All reinstatement applications are subject to the provisions of the Plan. Approved enrollment for reinstated retirees will become effective July 1st. Reinstated retirees are not eligible for basic life insurance coverage through the PEBP.		

STATE LAW	Description	Findings	Action Required	PEBP Response
		Requests for reinstatement must be completed through the submission of the required forms to the PEBP office not later than 31 days before the commencement of the plan year.		
Benefits Coverage: Oral Chemotherapy Parity NRS 695G.167 NRS 287.04335	• Plan covering treatment of cancer through use of chemotherapy: Prohibited acts related to orally administered chemotherapy. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs indicate that the health plans cover orally administered chemotherapy.	None.	
Benefits: Coverage: Services Provided Through Telehealth NRS 695G.162 NRS 287.04335	• Required provision concerning coverage for services provided through telehealth to same extent and in same amount as though provided in person or by other means; exception; prohibited acts. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	NRS 695G.152 requires plans to cover telehealth services to the same extent as though provided in person and by other means. The MPDs reflect that telemedicine is covered by Doctors on Demand, and alternatively, telemedicine is available from in-network providers is covered on the same basis as in-person services. The review cannot confirm from the LD plan language whether telehealth is covered out of network. The CDHP MPD reflects that telemedicine is covered at 80% in network, or 50% out of network, after the deductible has been met.	Action Required: PEBP should clarify whether telehealth services are provided out of network in the same manner as out of network in person coverage on the LD plan.	
Benefits: Coverage: Continued Medical Treatment	• Required provision in certain plans concerning coverage	MPDs reflect continuation of coverage provisions.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
NRS 695G.164 NRS 287.04335	for continued medical treatment; exceptions; regulations. Compliance with certain provisions required to provide health insurance through plan of self-insurance.			
Benefits Coverage: Autism Spectrum Disorders NRS 695G.1645 NRS 287.04335	• Required provision in plan for group coverage concerning coverage for autism spectrum disorders for certain persons, prohibited acts. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs reflect autism coverage with the same copay, deductible, and coinsurance provisions as other medical services covered by the plan	None.	
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.	MPDs do not require precertification for medically necessary emergency services provided at any hospital.	None.	
Benefits Coverage: Submission to step therapy protocol NRS 695G.1702 NRS 287.04335	Plan covering prescription drugs: Submission to step therapy protocol for drug to treat psychiatric condition prohibited in certain circumstances.	MPDs provide that prescription drugs that are prescribed to treat psychiatric condition are not subject to medical management techniques, such as step therapy	None.	
Benefits Coverage: Biomarker testing NRS 695G.1703 NRS 287.04335	• Required provision concerning coverage for biomarker testing for diagnosis, treatment, management and monitoring of cancer in certain circumstances; establishment of process to request	MPDs provide for biomarker testing, and provide for 24-hour urgent prior authorization limit, and 72 hour prior authorization limit.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	exception or appeal denial of coverage; time for responding to request for prior authorization.			
Benefits Coverage: Hepatitis C and HIV NRS 695G.1705 NRS 287.04335	Required provision concerning coverage for drugs, laboratory testing and certain services related to human immunodeficiency virus and hepatitis C; reimbursement of certain providers of health care for certain services; prohibited acts	NRS 695G.1705 requires coverage for any service to test for, prevent, or treat human immunodeficiency virus or hepatitis C. MPDs provide coverage for hepatitis C drugs, however, are silent on treatment or testing services for hepatitis C or human immunodeficiency virus.	Action Required: PEBP should clarify the Plan provides for testing and other services for hepatitis C and HIV. PEBP should clarify coverage for drugs used for prevention of HIV.	
Benefits Coverage: Sexually Transmitted Diseases NRS 695G.1707 NRS 287.04335	Required provision concerning coverage for testing, treatment and prevention of sexually transmitted diseases; required provision concerning coverage for condoms for certain insureds. .	NRS 695G.1707 appears to mandate coverage for more than what is on the ACA preventive service requirements. The Statute also mandates unrestricted coverage of condoms for insureds who are 13 years or older. MPD states the Plans provide for "counseling for sexually transmitted diseases" • Evidence-based items or services that have an "A" or "B" Recommendation by the United States Preventive Services Task Force (USPSTF) and Section 2713(a)(5)) of the 2015 Consolidated Appropriations Act. • With respect to women, such additional preventive care and screenings not described	Action Required: PEBP should update the MPDs to include all coverage mandated by NRS 695G.1707. PEBP should remove the exclusion for condoms.	

STATE LAW	Description	Findings	Action Required	PEBP Response
		under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. MPDs provide an exclusion for condoms.		
Benefits Coverage: BRCA gene NRS 695G.1712 NRS 287.04335	Required provision concerning coverage for screening, genetic counseling and testing related to BRCA gene in certain circumstances.	MPDs provide for coverage for: Genetic Testing, including o BRCA o Biomarker testing for the diagnosis, treatment, appropriate management, and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.	None.	
Benefits Coverage: Prohibition on Pre-Existing Conditions NRS 695G.155 NRS 287.04335	Managed care organization required to offer and issue plan regardless of health status of persons; prohibited acts; authority to include wellness program in plan that offers discounts based on health status under certain circumstances.	No pre-existing issues noted. MPD provides for domestic violence exceptions for any exclusions. MPDs do not list a wellness program.	None.	
Benefits Coverage: Required Provision Concerning Coverage for Human Papillomavirus Vaccine NRS 695G.171 NRS 287.04335	• Required provision concerning coverage for certain tests and vaccines relating to human papillomavirus, prohibited acts. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide coverage for HPV testing and vaccine.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
Benefits Coverage: Treatment Received as Part of a Clinical Trial or Study NRS 695G.173 NRS 287.04335	• Required provision concerning coverage for certain treatment received as part of clinical trial or study for treatment of cancer or chronic fatigue syndrome; authority of managed care organization to require certain information; immunity from liability. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide coverage for Experimental and/or Investigational Services as provided under NRS 695G.173.	None.	
Benefits Coverage: Required Provisions for Prescription Drugs Irregularly Dispensed for Synchronization of Chronic Medications NRS 695G.1665 NRS 287.04335	• Required provision in plan covering prescription drugs concerning coverage for prescription drugs irregularly dispensed for purpose of synchronization of chronic medications; prohibited acts; exception. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide provision concerning coverage for prescription drugs irregularly dispensed for the synchronization of chronic medications	None.	
Benefits Coverage: Required Provisions for Early Refills of Topical Ophthalmic Products NRS 695G.172 NRS 287.04335	• Plan covering prescription drugs: Denial of coverage prohibited for early refills of otherwise covered topical ophthalmic products. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide required provision concerning coverage for early refills of topical ophthalmic products.	None.	
Benefits Coverage: Required Provisions for Coverage for Prostate Cancer Screening NRS 695G.177	• Required provision in plans covering treatment of prostate cancer concerning	MPDs provide this benefit is covered as preventive care service.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
NRS 287.04335	coverage for prostate cancer screening; prohibited acts. Compliance with certain provisions required to provide health insurance through plan of self-insurance.			
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.	MPD provide that plans exclude a claim that involves an injury to which a contributing cause was the insured's commission of or attempt to commit a felony, except if as a result of a medical or behavioral health condition. This exclusion is permissible under NRS 695G.405.	None.	
Benefits Coverage: Sickle Cell Anemia Treatment NRS 695G.174 NRS 287.04335	• Required provision concerning coverage for management and treatment of sickle cell disease and its variants; plan covering prescription drugs required to provide coverage for medically necessary prescription drugs to treat sickle cell disease and its variants. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	MPDs provide for coverage for sickle cell disease. MPDs provide for coverage for prescription drugs to treat sickle cell disease.	None.	
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	Per the MPD - "Medically necessary maternity services for pregnant participants are covered."	Action Recommended: While the review did not note any exclusions, the LD Plan appears to have a gestational carrier definition, while the other plans do not. PEBP should clarify in the other plans the use	

STATE LAW	Description	Findings	Action Required	PEBP Response
	intended parent for purposes of plan. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	No exclusions for gestational carriers noted.	of the gestational carrier definition. .	
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.	No exceptions noted.	None.	
Benefits Coverage: Electronic Health Information NRS 439.581 to NRS 439.597 NRS 287.04335	• Certification for health information exchange required; disciplinary action for failure to comply with law; administrative fine for operating without certification; regulations • Limitations on use, release or publication of certain information; penalty for unauthorized access to electronic health record or health information exchange; establishment of complaint system. • Patient not required to participate in health	PEBP provided a copy of its PHI security procedures. Additionally, PEBP provided that PEBP staff, with exception of the Executive Officer and Quality Control (QC) staff, do not handle EHRs. PEBPs Executive Officer and QC I staff have access to vendor portals such as UMR and ESI in order to review claims for level 2 appeals. The claims data does not include diagnosis or medical notes; rather, it includes the providers name, the billed amount, and the CPT code for the procedure. In addition,	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	information exchange; notification to patient of breach of confidentiality of electronic health records or health information exchange; patient access to electronic health records. • Electronic health records, electronic signatures and electronically transmitted or retrieved health information deemed to comply with certain writing and signature requirements; information maintained or transmitted in electronic health record or retrieved by a health information exchange deemed to comply with certain confidentiality requirements; exception. Electronic transmission of health information: Exemption from state law concerning privacy or confidentiality of certain health information; ability of person to opt out of electronic disclosure of certain health information.	members may provide QC staff with copies of prior authorizations and appeal decision letter with health information as component of a compliant or an appeal. Lastly QC staff facilitate the External Review Process. As with complaints/appeals, QC staff may receive copies of prior authorizations, medical records, etc as a component of an external review. Health records are sent and received securely between PEBP and their various vendors.		
Contract Provisions: Vision Care NRS 686A.135 NRS 287.04335	Vision care: Prohibited provisions in contract between insurer and provider; insurer required to provide list of reimbursement rates to provider before entering contract; insurer required to disclose in policy pecuniary interest in supplier or provider; prohibited advertisements by insurer related to coverage; provider required to disclose pecuniary interest in supplier; use of in-	This section sets out certain prohibited contract provisions between insurers and providers. PEBP should operate due diligence in ensuring its vendors comply with contract prohibitions mandated by NRS 686A.135.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	network source or supplier not prohibited.			
Contract Provisions: Medicare Supplemental Policies NRS 687B.352 NRS 287.04335	Open enrollment period for Medicare supplemental policies required; prohibited acts; notice; treatment of Medicare supplemental policies purchased during open enrollment period for purposes relating to payment of commissions.	PEBP does not offer Medicare supplemental coverage. This section is not applicable.	None.	
Contract Provisions: Mental Health and Substance Abuse Payments NRS 687B.409 NRS 287.04335	Payments to out-of-network providers for treatment of mental health or alcohol or substance use disorder, assignment of benefits.	This section outlines certain mandates as to payments to out of network mental health and substance use providers. PEBP should continue its due diligence to ensure vendors are following NRS 687B.409 procedures for payments to out-of-network mental health and substance use disorder providers.	None.	
Contract Provisions: Dental Care NRS 687B.723 NRS 287.04335	Claim for dental care: Health carrier or administrator of health benefit plan prohibited from denying claim for which prior authorization has been granted; exceptions.	PEBP has not encountered any concerns regarding denial of claims after prior authorization was granted.	None.	
Claims: Dental Care NRS 687B.725 NRS 287.04335	Claim for dental care: Requirements and limitations related to recovery of overpayments.	No concerns noted. PEBP should continue its due diligence to ensure vendors are following overpayment procedures mandated by NRS 687B.725	None.	
Benefits Coverage: Inherited Metabolic Disease NRS 695C.1723 NRS 287.04335	Required provision concerning coverage for treatment of certain inherited metabolic diseases.	"Documentation to substantiate the presence of an inherited metabolic disease, including documentation that the product purchased is a special food	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
		product or enteral formula, may be required before the Plan will reimburse for costs associated with special food products or enteral formulas." – parity? MPD states there is coverage for enteral formulas for treatment of inherited metabolic diseases, with a $2,500 annual limit.		
Benefits Coverage: Authorization of Recommended and Covered Services NRS 695G.150 NRS 287.04335	Authorization of recommended and covered health care services required.	Per the MPD's, "The utilization management (UM) company is staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer utilization review services. The review includes a process to determine the medical necessity, appropriateness, location, and cost effectiveness of health care services. Depending on the service, a review may occur before, during, or after the services are rendered, including, but not limited to precertification/pre-authorization; concurrent and/or continued stay review; discharge planning; retrospective review; and case management." The Plans appear to comply with NRS 695G.150's requirements.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
Benefits Coverage: Prescription Coverage during Emergency Declaration NRS 695G.1635 NRS 287.04335	Plan covering prescription drugs: Required actions by managed care organization related to acquisition of prescription drugs for certain insureds residing in area for which emergency or disaster has been declared.	MPDs do not appear to contain language explaining coverage during emergency or disaster declaration. PEBP may already be providing coverage as required, however may wish to clarify procedures to obtain emergency prescription coverage, and limitations to this benefit.	Action Required: PEBP should consider adding language to the MPDs explaining procedure to obtain emergency prescription coverage during emergency or disaster declaration, and the geographic limitations to this benefit.	
Benefits Coverage: Step Therapy Cancer Protocols NRS 695G.1675 NRS 287.04335	Plan covering prescription drug for treatment of cancer or cancer symptom that is part of step therapy protocol: Managed care organization required to allow insured or attending practitioner to apply for exemption from step therapy protocol in certain circumstances; procedure for applying for and granting exemption.	Per MPD: "The Plan also complies with step therapy for treatment of cancer or cancer symptom that is part of step therapy protocol per NRS 695G.1675" The MPD does not provide for step therapy exemption procedures.	Action Recommended: While the MPD indicates that the Plan complies with this statute, PEBP should clarify step therapy exemption procedures in the MPD.	
Benefits Coverage: Examination of pregnant person for certain diseases NRS 695G.1714 NRS 287.04335	Required provision concerning coverage for examination of person who is pregnant for certain diseases.	The MPD's provide that the Plan provides for "Counseling for sexually transmitted infections (STI), HIV counseling and testing" as part of the preventive/wellness care services. The MPDs provide that the Plan covers ACA services for OB/GYN visits. The MPDs do not specifically specify whether testing for diseases referenced in NRS 695G.1714 are covered as part of maternity coverage.	Action Recommended: The Plan should clarify it provides coverage for testing for diseases references in NRS 695G.1714 during as part of maternity coverage, without prior authorization required.	

STATE LAW	Description	Findings	Action Required	PEBP Response
Benefits Coverage: Contraception and related health services NRS 695G.1715 NRS 287.04335	Required provision concerning coverage for drug or device for contraception and related health services; prohibited acts; exceptions.	MPDs provide coverage for tubal ligations. MPDs state "This Plan covers FDA approved contraceptive methods, including contraceptive injection or the insertion of a device at a hospital immediately after an insured gives birth, sterilization procedures, and patient education and counseling for women with reproductive capacity. The FDA requires the services to be "prescribed" by a physician even for over-the-counter methods. This Plan complies with the coverage requirements for contraception and related health services set forth in NRS 695G.1715."	None.	
Benefits Coverage: Drugs related to Substance and opioid use disorder NRS 695G.1719 NRS 287.04335	Required provision concerning coverage for certain drugs and services related to substance use disorder and opioid use disorder; reimbursement of pharmacists and pharmacies for certain services; prohibited acts.	MPDs state "The Plan provides benefits for substance use disorder including coverage for all drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone." The MPDs do not provide language for benefits for safe withdrawal from substance use disorder, including lofexidine.	Action Required: PEBP should amend the MPDs to clarify the Plan provides benefits for substance use disorder for all drugs approved by FDA to support safe withdrawal from substance use disorder, including, without limitation lofexidine. PEBP should clarify that the Plan does not subject these benefits to medical management techniques, other than step therapy.	
Benefits Coverage: Gender Dysphoria NRS 695G.1718	• Required provision concerning coverage for medically necessary treatment of conditions	MPDs state: "This Plan provides benefits to individuals seeking medically necessary services for the treatment of gender	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
NRS 695G.415 NRS 287.04335	relating to gender dysphoria and gender incongruence; restriction on refusal to cover certain treatments; authority of managed care organization to prescribe requirements for covering surgical treatments for minors; determination of medical necessity. • Managed care organization prohibited from discriminating against person with respect to participation or coverage on basis of gender identity or expression.	dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license." PEBP provides the coverage mandated by this statute.		
Benefits Coverage: Preventive and Wellness services, tests, and screenings NRS 695G.1717 NRS 287.04335	Required provision concerning coverage for certain services, screenings and tests relating to wellness, prohibited acts.	MPDs provide for the following coverage: • Breastfeeding support, supplies, and counseling • Screening for interpersonal and domestic violence • Counseling for sexually transmitted infections (STI), HIV counseling and testing • Screening for gestational diabetes • Prenatal care • Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination. • Evidence-based items or services that have an "A" or "B" Recommendation by	Action Required: PEBP should clarify it covers hormone replacement therapy.	

STATE LAW	Description	Findings	Action Required	PEBP Response
		the United States Preventive Services Task Force (USPSTF) and Section 2713(a)(5)) of the 2015 Consolidated Appropriations Act. • With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services guidelines including the American Academy of Pediatrics Bright Futures guidelines; and • With respect to women, such additional preventive care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. • Smoking/tobacco cessation • Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (tetanus, diphtheria, and pertussis -whooping cough)		

STATE LAW	Description	Findings	Action Required	PEBP Response
		This list incorporates most of the requirements under this statute. However, the MPDs are silent on coverage of hormone replacement therapy.		
Required provision concerning coverage for management and treatment of sickle cell disease and its variants 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.	MPDs provide that the plans cover "Medically necessary prescription drugs to treat sickle cell disease and its variants pursuant to the provisions of NRS 695G.174." and sickle cell disease on an outpatient basis. PEBP in compliance with State law.	None.	
Plan covering anatomical gifts, organ transplants or treatments or services related to organ transplants NRS 695G.176 NRS 287.04335	Plan covering anatomical gifts, organ transplants or treatments or services related to organ transplants: Prohibited acts by managed care organization if insured is person with disability.	No issues noted.	None.	
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: Payment of Premiums NAC 287.420 NRS 287.04385 NRS 287.044	• 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. • Payment of premiums or contributions to Program;	NAC 287.420 provides penalties to be assessed in the event of nonpayment by the participating public agency. PEBP provided its procedures for billing and collection of payments of non-state entities. No concerns were noted in review of billing and collection procedures.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	coverage of dependents; allocation of money paid to Program; establishment of Active Employee Group Insurance Subsidy Account.			
Funding Requirements: Direct Payment of Premiums for Retirees, LOAs Without Pay and LOAs due to Work Injury NAC 287.430 NAC 287.440 NAC 287.450 NAC 287.460 NRS 287.046 NRS 287.0439 NRS 287.0445	• Direct payment of premiums or contributions: Date due; cancellation of coverage. • Payment of premiums or contributions by retired officers and employees. • Employees on leave without pay: Conditions for payment of premiums or contributions by participating public agency; continuation of or eligibility for coverage or insurance; coverage and insurance upon return to full-time employment. • 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	A State agency that employs an individual who is on LWOP (other than FMLA leave) shall NOT pay any amount of the cost of premium or contributions for group insurance for that employee, unless the employee receives a minimum compensation of 80 hours in the month. An employee who is on approved LWOP may pay the full cost of premiums for their coverage and insurance to PEBP. An employee on LWOP is not eligible for coverage as a dependent of another PEBP covered participant.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	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.	PEBP has confirmed it has over and underpayment procedures in place, including assessments of underpayment penalties. No concerns noted.	None.	
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.	None.	
Claims and Appeals Procedures NRS 287.608 NAC 287.610 NAC 287.620 NAC 287.660 NAC 287.670 NAC 287.680 NAC 287.690 NRS 287.695 NRS 287.04335 NRS 689B.255	Coverage of person qualified as both employee and dependent; change of status from employee to dependent. • 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. No concerns noted with claims and appeals procedures as written.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	• Appeal of decision of Appeals Manager: Requirements; duties of Executive Officer or designee. • Request for external review. • Request for expedited review by Claims Administrator • Compliance with certain provisions required to provide health insurance through plan of self-insurance. 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	PEBP has confirmed they have a complaint resolution system to the Division of Insurance as noted in NAC 287.750.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
	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.			
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 NRS 287.04335	• Circumstances under which adverse determination may be subject to external review; exceptions. • Submission of complaint of covered person to independent review organization. • Annual report; requirements. Compliance with certain provisions required to provide health insurance through plan of self-insurance.	No exceptions noted.	None.	
PEBP Board Authority and Duties NRS 287.04062	• "Program Fund" defined. • Powers and duties.	No exceptions noted.	None.	

STATE LAW	Description	Findings	Action Required	PEBP Response
NRS 287.043 NRS 287.0487 NRS 287.04335 NRS 287.0434	• 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. Power to use assets, contract for services and charge and collect certain fees and payments. [Effective through December 31, 2025.]			
Taxable compensation reduction NRS 287.245	Employer may agree with employee to reduce taxable compensation; federal requirements prerequisite for operation of program; powers of Board of the Public Employees' Benefits Program.	No exceptions noted.	None.	
Local governmental agency may contract with Public Employees' Benefits Program NRS 287.025	Local governmental agency may contract with Public Employees' Benefits Program or other local governmental agency or participate as member of nonprofit cooperative association or corporation for group insurance, related medical services or health-related information.	PEBP confirmed several agencies contract with PEBP.	None.	