CELESTENA GLOVER
Executive Officer

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Road, Suite 109 | Carson City, Nevada 89706
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
https://pebp.nv.gov

JOE LOMBARDO
Governor

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: January 26, 2024

Item Number: 10

Title: Proposed Changes to the Plan Year 2025 Master Plan Documents (MPDs)

SUMMARY

This report will go over the benefit changes and updates to the Master Plan Documents (MPD) and Summary of Benefits and Coverage for plan year 2025:

- Consumer Driven Health Plan Master Plan Document and Summary of Benefits and Coverage
- Low Deductible PPO Master Plan Document and Summary of Benefits and Coverage
- Exclusive Provider Organization Master Plan Document and Summary of Benefits and Coverage
- Dental Plan and Life Insurance Master Plan Document
- Health Reimbursement Arrangement Summary Plan Document
- Flexible Spending Account Master Plan Document
- Enrollment & Eligibility Master Plan Document
- Medicare Health Reimbursement Arrangement Master Plan Document
- Health and Welfare Wrap for Actives
- Health and Welfare Wrap for Retirees
- Section 125 Master Plan Document

Due to file size, to see red-lined changes please visit https://pebp.nv.gov/Meetings/current-board-meetings/ for digital, PDF copies of plan documents.

BACKGROUND

Throughout the plan year, several intricacies in the plan document verbiage are identified through various methods. Examples include a member notifying PEBP, an audit review, vendor inquiry, etc.

PEBP staff and its vendor partners, reviewed Master Plan Documents, Summary Plan Documents, and Summary of Benefits and Coverages. The proposed changes stem from input received from subject matter experts – some changes being simply housekeeping efforts, while others are regulatory and compliance matters.

REPORT

The lists and tables below will review housekeeping changes, Board approved changes, changes required per the Mental Health Parity and Addiction Equity Act, No Surprises Act, Plan Design changes, and other changes deemed necessary for board approval.

"HOUSEKEEPING" CHANGES

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

- Formatting.
- Removal of PEBP-specific one-time funding information for Health Savings Accounts and Health Reimbursement Arrangements.
- Updates to limitations per IRS requirements.
  - This includes increased Health Savings Account contribution limitations, the deductible floor the high-deductible health plan, and any other mandatory required changes.
- Plan year timeframe updated to 07/01/2024 through 06/30/2025.
- Updating the plan documents to reference PEBP's current web address: https://pebp.nv.gov/
- Required amendments to the plan documents throughout Plan Year 2024 were applied to the plan documents accordingly. Amendments incurred during Plan Year 2024:
  - Added language from bills passed in the 2023 Legislative Session.
  - Health Savings Account contribution limitations per IRS.
  - Under the Utilization Management section for "Impatient Admissions" – Remove "All" and "Same-day surgeries." Refer to the Outpatient and Physician Surgery category for outpatient and same-day surgery prior authorization requirements.
  - Preventative Services updated to align with USPSTF guidelines, NRS, and remove mammogram limitation language.
  - For Durable Medical Equipment, clarified listed examples.
  - Added NRS for Continuity of Coverage under the No Surprises Act.
  - For Pharmacy Benefits, added information for Diabetes Care Value.

    - For limitations and exclusions, added NRS citations and clarified limits for corrective appliances to "not medically necessary."
    - Updated contact information for Office of Consumer Health Assistance.
    - Updated Coordination of Benefits language to coincide with the Health and Welfare Wrap Plan Documents
- Updated Key Terms and Definitions to include NRS citations for Medically Necessary, Step Therapy, and Medical Management Techniques.
- Updated references to Nevada Revised Statute (NRS) or Nevada Administrative Code throughout documents:
    - Health benefits covered under NRS were cited in the MPD next to appropriate benefit language and hyperlinked to the legislative website.

Note: As bills from the 2023 Legislative Session are codified, the plan document may be updated mid-year to cite the appropriate statutory chapter.

BOARD REVIEWED AND PLAN DESIGN CHANGES

There are some changes the Board has already approved that are identified here. This includes other plan benefit changes that are contingent on the Board's approval in the prior agenda item.

#	Change Type	Proposed Change	Justification	Section
1	Reduction	Updated deductible as required for Health Savings Account to $1,600 for single tier coverage and $3,200 for spouse, children, and family tiers	Board approved on December 7, 2023	Consumer Driven Health Plan Master Plan Document
2	Enhancement	For Specialty Drugs part of the SaveOnSP program, the coinsurance applies (CDHP - 20%, PPO 30%, EPO 20%). For Specialty Drugs not part of the SaveOnSP program, the respective coinsurance applies with a copay limitation $100 minimum and a maximum of $250.	Board approved on December 7, 2023	Prescription Drug Benefit

#	Change Type	Proposed Change	Justification	Section
3	Enhancement	Under the Plans Prescription Drug Benefit, this will be added: UMR offers a Medical Pharmacy Coupon Program: For drugs administered in an inpatient setting, there is a "UMR Prescription Copay Maximizer Benefit" where a member may receive cost-share assistance. A UMR patient advocate will conduct outreach to members and introduce the UMR Prescription Copay Maximizer Program. The member can voluntarily enroll in to qualifying copay assistance programs. This may help the member with their cost-share for certain drugs. Please contact UMR for additional information or assistance.	UMR prescription Coupon Program	Prescription Drug Benefit
4	Enhancement	Reinstate Travel Benefit to allow for reimbursement up to GSA rates, with specifics documented in Exhibit A.	The TPA reports they are able to issue payment for travel reimbursements without cost-share. Due to this, PEBP will be able to manually report taxable income to the IRS and to member.	Schedule/Summary of Benefits

#	Change Type	Proposed Change	Justification	Section
5	Enhancement	For services requiring precertification's Outpatient and Physician Surgery: Added "When outpatient and physician surgery is performed at an In-Network, contracted ambulatory surgical center (ASC) by an In-Network, contracted physician, prior authorizations is not required. However, when services are not performed at an In-Network, contracted ASC, procedures will require prior authorization. This is commonly referred to as Site of Service. Examples of services that require prior authorization include, but are not limited to: [with list provided]"	The UM company reports that when outpatient and physician surgery is performed at an In-Network, contracted ambulatory surgical center (ASC) by an In-Network, contracted physician, the Plan and member receive significant savings. Adding this removes administrative barriers to services and assists with steerage.	Utilization Management
6	Removal	For services requiring precertification's Outpatient and Physician Continuing Care Services: Removed "Dialysis"	The UM company reports that this is redundant when performed at an In-Network facility.	Utilization Management

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT CHANGES

These changes are made in response to the Non-Qualitative Limitation analysis under the Mental Health Parity and Addiction Equity Act performed by the Actuary.

#	Change Type	Proposed Change	Justification	Section
7	Clarification	For Behavioral (Mental) Health Services, clarified sex counseling between individuals, so as not to exclude gender dysphoria.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
8	Clarification	For Behavioral (Mental) Health Services, separated hypnosis and hypnotherapy from Behavioral (Mental) Health Services exclusion to its own section.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
9	Clarification	For Weight Management, updated eating disorder and adjusted anorexia and bulimia as examples.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
10	Clarification	Moved "Hypnosis and Hypnotherapy" from "Behavioral Health Care Exclusions" to its own.	This should be a general plan exclusion and is moved to comply with MHPAEA's Non-Quantitative Treatment Limitation analysis.	Benefit Limitations and Exclusions
11	Clarification	Separated hypnosis and hypnotherapy to its own exclusion	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
12	Enhancement	For Alternative/Complimentary Health Care, added exception for chelation therapy for treatment of mental health.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions

#	Change Type	Proposed Change	Justification	Section
13	Enhancement	For Behavioral (Mental) Health Services, removed exclusion for attention deficit disorders.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
14	Enhancement	For Drugs, Medicines, Nutrition or Devices Exclusion, allowed exception to B-12 for Mental Health or Substance Abuse.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
15	Enhancement	For Other Benefit Exclusions, added exception for Mental Health and or Substance Abuse.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
16	Enhancement	For Other Benefit Exclusions, as related to milieu therapy inserted exception for Mental Health or Substance Abuse.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
17	Enhancement	For Other Benefit Exclusions, removed exceptions for sexual dysfunction.	For compliance with MHPAEA NQTL findings. This could be discriminatory when treating gender dysphoria or other mental health condition. This update will apply benefit based on medical necessity.	Benefit Limitations and Exclusions
18	Enhancement	For Other Benefit Exclusions, the exclusion for food addictions does apply when for Mental Health or Substance Use per MHPAEA.	For compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
19	Enhancement	For Rehabilitation Therapy (Inpatient or Outpatient), removed exclusion for condition of psychoneurotic origin; allowed exception for cognitive therapy.	Psychoneurotic origin is related mental health conditions and added enhancement for compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions

#	Change Type	Proposed Change	Justification	Section
20	Enhancement	Under Other Benefit Exclusions, removed the exclusion for "Except as otherwise provided in the Summary of Medical Benefits and Schedule of Medical Benefits, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment."	PEBP currently covers drugs when there is a prior authorization. This also may exclude treatments of gender dysphoria.	Benefit Limitations and Exclusions
21	Removal	For Cosmetic and Gender Dysphoria, removed references to "no coverage for travel costs"	Travel benefits are specifically and narrowly addressed. Removed for compliance with MHPAEA NQTL findings.	Benefit Limitations and Exclusions
22	Update	The word "Medical" was removed from various headings such as Exclusions Under the Medical Plan, Summary of Medical Benefits, etc.	For compliance with MHPAEA NQTL findings. PEBP coverages include non-medical benefits, such as mental health and substance use disorder.	Benefit Limitations and Exclusions
23	Enhancement	For Speech Therapy, remove exclusion for mental health	For compliance with MHPAEA NQTL findings.	Consumer Driven Health Plan
24	Enhancement	For Autism Spectrum Disorders, removed duplication of NRS 695G.1645.	For compliance with MHPAEA NQTL findings	Schedule/Summary of Benefits

#	Change Type	Proposed Change	Justification	Section
25	Enhancement	For Enteral Formulas and Special Food Products, included treatment for MH/SUD and removed $2,500 dollar maximum for MH/SUD	For compliance with MHPAEA NQTL findings.	Schedule/Summary of Benefits
26	Enhancement	For Habilitative and Rehabilitative Therapy, the visit limit of 90 visits between types of therapy per plan year will exclude Mental Health and Substance Use.	For compliance with MHPAEA NQTL findings.	Schedule/Summary of Benefits
27	Clarification	Under "Case Management" clarified that "Case management is a voluntary process administered by the UM company for PEBP benefits, including but not limited to, medical, behavioral health, mental health, substance use disorder, etc." Also, removed "medical" from "medical professionals"	For compliance with MHPAEA NQTL findings	Utilization Management
28	Clarification	Under Case Management, added "Case management is also available for a disability resulting from a mental health or substance use disorder diagnosis."	Language suggested per MHPAEA NQTL findings	Utilization Management
29	Clarification	Under Services Requiring Precertification: moved "partial residential programs" from "Inpatient" to "Outpatient"	For compliance with MHPAEA NQTL findings.	Utilization Management
30	Enhancement	For Habilitative and Rehabilitative Therapy, the visit limit of 90 visits between types of therapy per plan year will exclude Mental Health and Substance Use.	For compliance with MHPAEA NQTL findings.	Utilization Management

NO SURPRISES ACT CHANGES

During a review of the Master Plan Documents, some changes were noted to be required for compliance with the No Surprises Act.

#	Change Type	Proposed Change	Justification	Section
31	Clarification	Under Provider Network, clarified that there is an exception for emergency care.	Emergency care is subject to the No Surprises Act.	Description of In-Network and Out-of-Network
32	Clarification	Under Provider Network, included verbiage for how the Directories of Network Providers is maintained.	Provider network notification and maintenance is subject to the No Surprises Act.	Description of In-Network and Out-of-Network
33	Clarification	Under Provider Network, updated language to include PEBP leases a network of preferred providers (PPO) through a contract with a vendor who maintains such a network" and "The provider network is subject to change.	PEBP does not have direct contracts with Providers.	Description of In-Network and Out-of-Network
34	Removal	Under Provider Network: Removed "You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another In-Network provider."	This is redundant and technical change to comply with potential NSA findings.	Description of In-Network and Out-of-Network

OTHER CHANGES FOR MASTER PLAN DOCUMENTS

Listed are the plan document updates recommended for clarification, changes, updates, and additions to the plan documents.

#	Change Type	Proposed Change	Justification	Section
35	Clarification	Added exclusion for "Taxes: Sales taxes, unless specifically covered in the Plan. See also CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, Chapter 21, Section 2122.2.G."	As a government entity, PEBP is exempt from sales taxes. This is also addressed by CMS that sales taxes are not reimbursable.	Benefit Limitations and Exclusions
36	Clarification	For Cosmetic Services and Surgery and Gender Dysphoria, removed reference to no reimbursement for travel costs.	This is redundant as travel costs are narrowly construed to the specific benefits preapproved by the Board, and could be construed as targeting a benefit for exclusion.	Benefit Limitations and Exclusions
37	Clarification	For various exclusions, paragraph format was converted to a bullet point or list format.	This will reduce the run-on sentences which will make the language easier to read and understand.	Benefit Limitations and Exclusions
38	Clarification	Under Preventative Services, added "This plan is an IRS qualified High Deductible Health Plan and is required to comply with Section 223 of the Internal Revenue Code. Section 223 addresses preventative care benefits permitted to be provided by a high-deductible health plan not subject to cost-share.	As a high-deductible health plan, PEBP is required to follow IRS guidelines to maintain an HSA qualifying plan	Consumer Driven Health Plan Master Plan Document
39	Clarification	In HSA and HRA sections, addressed reference and link to IRS Publication 969, which provides further information.	The IRS Publication 969 addresses Health Savings Accounts.	Consumer Driven Health Plan Master Plan Document

#	Change Type	Proposed Change	Justification	Section
40	Clarification	Updated Corrective Appliances by breaking out Hearing aids to its own section.	Cleans up benefit language and aligns with the layout in other plan documents	Consumer Driven Health Plan Master Plan Document
41	Update	Under Highlights of the Plan, the bullet point was updated to include reference to prescription.	Lead Insurance Counsel review of plan document language	Consumer Driven Health Plan Master Plan Document
42	Clarification	For some instances where deductible, copayment/copay, and/or coinsurance is listed, this is replaced with "Cost-Share" which is defined in plan document.	Some plan documents refer to deductible or copays when they are not applicable for the respective document. "Cost-share" satisfies the plan intent.	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
43	Clarification	Moved the list of preventative services from a table to the body of the benefits and limitations. Removed duplicate items listed that are already in the body of the benefits and limitations.	The list of preventative services in the table was demonstrated as examples and directs readers to the websites of organizations governing preventative services. This move puts the language for the list and organizational information next to each other.	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization

#	Change Type	Proposed Change	Justification	Section
44	Update	In the Introduction, updated paragraph to "The Plan and this document are intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code (NAC) 287, and all other applicable provisions of Nevada Law. Additionally, PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA)."	Lead Insurance Counsel review of plan document language	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
45	Update	For instances where the document references "Exclusion" sections, this was updated to "Benefit Limitations and Exclusions."	To match renamed section of document	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
46	Update	For instances where the document references "Appeals Procedure" sections, this was updated to "Appeals."	To match renamed section of document	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
47	Update	Under Deductibles, an incomplete paragraph was noted and updated to end with "and other out of pocket costs."	Lead Insurance Counsel review of plan document language	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization

#	Change Type	Proposed Change	Justification	Section
48	Update	Under Provider Network, updated paragraph for continued medical treatment to "Pursuant to NRS 695G.164, if a member is receiving medical treatment from a provider whose In-Network status changes during the course of treatment, the member may continue to receive treatment with that provider at In-Network rates under certain circumstances. See more detailed explanation in PPO Network Health Care Provider Services section."	Lead Insurance Counsel review of plan document language	Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
49	Clarification	For basic life insurance coverage, added "Basic Life Insurance claim payouts are subject to resolution of any outstanding financial responsibilities (premiums or Health Reimbursement Arrangement funds) with PEBP or its vendors."	Member accounts have to be current with PEBP and vendors for premiums or HRA overpayments; otherwise, the claim may not be eligible for basic life insurance.	Dental Plan and Basic Life Insurance
50	Update	Added verbiage for Coordination of Benefits.	This adds some information for Coordination of Benefits to the reader and directs the reader to the Health and Welfare Wrap document for specific details.	Dental Plan and Basic Life Insurance
51	Clarification	Under Eligible Medical Expenses, added that when an individual changes from employee/retiree to dependent or vice versa, accumulators follow the individual.	There was some confusion on what happens to an individual's accumulators when they change status on a PEBP plan. Per TPA and Actuary, this is industry standard to have spent	Eligible Medical Expenses

#	Change Type	Proposed Change	Justification	Section
			dollars follow the individual during the plan year.	
52	Added	Added section for "Eligibility for Member of the Senate and Assembly."	This helps clarify that members of the legislature are not "employees" per NRS 287.045.	Enrollment & Eligibility MPD
53	Added	Added verbiage for Elected Officials throughout.	Elected Officials are not employees; however, are eligible for benefits.	Enrollment & Eligibility MPD
54	Added	After the Enrollment & Eligibility Events Quick Reference Table, added section for Examples of Timelines.	Per NRS 287.245 and IRS Section 125 rules, changes are prospective from date of notification. This example table clarifies impact of notification and retiree coverage issues.	Enrollment & Eligibility MPD
55	Added	For the Enrollment & Eligibility Events Quick Reference Table under "Permanent Guardianship of a Child to Age 19:" added "Coverage for other dependent(s) is effective on the first day of the month concurrent with or following notification."	Per NRS 287.245 and IRS Section 125 rules, changes are prospective from notification with limited exceptions.	Enrollment & Eligibility MPD

#	Change Type	Proposed Change	Justification	Section
56	Clarification	For the Enrollment & Eligibility Events Quick Reference Table under "Marriage or the establishment of Domestic Partnership:" Added "Participant shall enroll in coverage to add dependents."	Dependent coverage requires the primary participant to be enrolled.	Enrollment & Eligibility MPD
57	Clarification	For the Enrollment & Eligibility Events Quick Reference Table under "Newborn Child" and "Adoption of a Child or Placement for Adoption of a Child:" Added "Participant shall enroll in coverage to cover the newborn."	Dependent coverage requires the primary participant to be enrolled.	Enrollment & Eligibility MPD
58	Clarification	For the Enrollment & Eligibility Events Quick Reference Table under "Survivor of Police/ Firefighter killed in the line of Duty :" Added citation and "Eligible dependents may join the plan."	NRS Citation and allowance for adding qualified dependents.	Enrollment & Eligibility MPD
59	Clarification	For the Enrollment & Eligibility Events Quick Reference Table: Combined sections for "Employee or Retiree Death" and "Dependent Death"	These sections have the same requirements.	Enrollment & Eligibility MPD
60	Clarification	For the Enrollment & Eligibility Master Plan Document references to "Qualified Medical Child Support Order:" Included references to court orders. Added section for Court Orders	Court Orders can be valid orders per Department of Labor instructions on QMCSOs.	Enrollment & Eligibility MPD

#	Change Type	Proposed Change	Justification	Section
61	Clarification	For the Enrollment & Eligibility Master Plan Document, references which include "spouse/domestic partner, or other dependents" are updated to "eligible dependents."	Dependents are already defined to mean "dependent child(ren), spouse or domestic partner."	Enrollment & Eligibility MPD
62	Clarification	Under "Declining Active Employee Coverage:" Updated paragraph to bullet points and specified participant must furnish proof of other coverage. Additionally, included loss of PEBP benefits, including basic life insurance.	Per HIPAA, marriage is a Qualifying Life Event to add dependent to a plan. In order to remove the participant, we need proof of other coverage.	Enrollment & Eligibility MPD
63	Clarification	Under "Medicare Part B Premium Credit," added "Eligibility for the Medicare Part B Premium credit is subject to NRS 287.046."	Per NRS 287.046, retirees hired after 01/01/2012 do not receive Medicare Part B Premium Credit or other retiree benefits.	Enrollment & Eligibility MPD
64	Clarification	Under "When Coverage Begins," added "Retiree Coverage Information" and table reflecting coverage timelines for retirees	Demonstrate the enrollment requirements for retirees to maintain continuous coverage.	Enrollment & Eligibility MPD
65	Update	For the Enrollment & Eligibility Events Quick Reference Table under "Adoption of a Child or Placement for Adoption of a Child:" updated required supporting documents section.	This will align the quick reference table with the "Eligibility for Dependents" section in the Enrollment & Eligibility Master Plan Document.	Enrollment & Eligibility MPD
66	Update	For the Enrollment & Eligibility Events Quick Reference Table under "Notification Period:" updated language to refer to "within 60 days of the event date."	This section of the table had instances where language was different; however, meant the same thing. The update simplifies this.	Enrollment & Eligibility MPD

#	Change Type	Proposed Change	Justification	Section
67	Update	In the Enrollment & Eligibility Master Plan Document's Enrollment & Eligibility Events Quick Reference Table: removed erroneous bullet points, adjusted formatting for table.	The quick reference table was not uniform throughout.	Enrollment & Eligibility MPD
68	Clarification	Added introductory verbiage to FSA MPD: "There are three types of flexible spending accounts: A Health Care FSA, Limited-Purpose FSA, and Dependent Care FSA."	This introduction provides clarity for the reader.	Flexible Spending Account Master Plan Document
69	Clarification	For Introduction, added "PEBP's FSA benefits are subject to IRS Publication 969."	The IRS Publication 969 addresses Flexible Spending Account.	Flexible Spending Account Master Plan Document
70	Update	Updated FSA rollover and contribution limitations.	IRS released updated figures for Flexible Spending Accounts	Flexible Spending Account Master Plan Document
71	Added	Under "Miscellaneous" added information regarding reinstated employees.	Clarify HRA reinstatement to coincide with CDHP MPD where the HRA section addressed reinstated employees and their HRA funds.	Health Reimbursement Arrangement SPD
72	Clarification	For general information about HRA, added "HRA funds must be used on a prospective basis from the date of funding."	Members have tried to use HRA funds for claims prior to the HRA being established.	Health Reimbursement Arrangement SPD
73	Clarification	For Introduction, added "PEBP's HRA benefits are subject to IRS Publication 969."	The IRS Publication 969 addresses Health Reimbursement Arrangements.	Health Reimbursement Arrangement SPD

#	Change Type	Proposed Change	Justification	Section
74	Reduction	Remove PEBP-funded supplemental $300 Health Reimbursement Arrangement or Health Savings Account funding and related verbiage.	Voted on in December 5, 2022, Board Meeting, this benefit was for plan year 2024. This does not impact the Legislature's appropriated HSA/HRA funding.	Health Reimbursement Arrangement SPD, Consumer Driven Health Plan, Low Deductible PPO, and Exclusive Provider Organization
75	Clarification	For Cost-Sharing, added "Cost-Share" to the definition.	These words are used interchangeably.	Key Terms and Definitions
76	Update	For Durable Medical Equipment, updated definition layout and cited CMS.	Plan documents originally copied the definition from CMS; however, CMS has updated their definition of Durable Medical Equipment.	Key Terms and Definitions
77	Update	Update definition of Primary Care Physician to include Primary Care Doctor and definition under NRS 695G.060.	The definition originally had listed examples for providers. The citation to NRS enhances the definition.	Key Terms and Definitions
78	Clarification	Under Outpatient Rehabilitation and Habilitative Therapy Services it was clarified that "Outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) and is subject to cost-share for each therapy type."	This is a benefit clarification that was reported to Quality Control by auditors and the TPA due to confusing language. The plan language was found to be conflicting. This language clarifies the confusing language.	Low Deductible PPO and Exclusive Provider Organization
79	Clarification	Under Vision Care Services: clarified the exam is for preventative, screening exams. Clarified PEBP does not maintain a network specific to vision care.	This is in the CDHP, but not clarified in the LD or EPO plans.	Low Deductible PPO and Exclusive Provider Organization

#	Change Type	Proposed Change	Justification	Section
80	Clarification	"Outpatient Short-Term Rehabilitation Services" section heading updated to "Outpatient Rehabilitation and Habilitative Therapy Services"	This will match the benefit description section within the plan document.	Low Deductible PPO and Exclusive Provider Organization
81	Clarification	Under "Schedule of Medical Benefits" for "Durable Medical Equipment": updated section to refer the reader to the definition of DME	This helps align with the CDHP plan, which refers reader to Key Terms and Definitions.	Low Deductible PPO and Exclusive Provider Organization
82	Clarification	Under Other Medical Services, moved benefit description from Summary of Benefits to Schedule of Benefits	The plan design was in the improper location.	Low Deductible PPO and Exclusive Provider Organization
83	Change	Amend the term "Low Deductible" from the "Low Deductible PPO." The new name would officially be the "PPO Plan" with references to the "Low Deductible PPO" plan acceptable throughout the next plan year.	This plan currently has no In-Network deductible. Calling the plan a Low Deductible plan can be a misnomer and cause member confusion. Plan documents would be updated accordingly.	Low Deductible PPO Master Plan Document
84	Update	Update the plan language that references a legislative session to the appropriate NRS or NAC citation when available.	When bills from the 82nd legislative session are updated on the legislative website, the plan documents will be updated accordingly.	PEBP MPDs and SPDs as applicable.
85	Clarification	Correction for what preventative laboratory services are: removed "general health panel" and adjusted the examples to say "etc."	CTI noted this language is actually a service that is not a preventative service. Plan language caused confusion when the intent was to	Schedule/Summary of Benefits

#	Change Type	Proposed Change	Justification	Section
			demonstrate examples of a preventative laboratory service.	
86	Update	Update Clinical Trials to "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."	Lead Insurance Counsel review of plan document language	Schedule/Summary of Benefits
87	Added	For services requiring precertification's Inpatient Admissions: Added ""Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery."	The UM company reports that most procedures are in inpatient setting. Therefore, it is being added to the inpatient section.	Utilization Management
88	Added	For services requiring precertification's Inpatient Admissions: Added "Surgeries to treat Gender Dysphoria"	The UM company reports that most procedures are in inpatient setting. Therefore, it is being added to the inpatient section.	Utilization Management
89	Clarification	For Emergency Air Ambulance: Added reference to the No Surprises Act.	Emergency Air Ambulance has additional details in the Schedule of Medical Benefits.	Utilization Management

#	Change Type	Proposed Change	Justification	Section
90	Clarification	For How to request pre certification: Removed "Your or your" for who must call the UM company and changed to "Your provider…"	The UM company reports that Preauthorization's require sufficient medical records and supporting documentation that only Providers have; otherwise, the PA will deny, causing member abrasion. In the event a provider is unwilling to submit preauthorizations, the member can go to PEBP's Quality Control for assistance.	Utilization Management
91	Clarification	For Second Opinion: Added reference to PEBP's recommended second opinion provider, 2nd MD.	PEBP has a preferred Second Opinion Service listed in the Schedule of Medical Benefits.	Utilization Management
92	Clarification	For services requiring precertification's Inpatient Admissions: Clarified "Acute observation" was "Acute inpatient or observation."	UM company recommendation.	Utilization Management
93	Clarification	For services requiring precertification's Inpatient Admissions: Removed "all" from "Transplant including pre-transplant related services	UM company recommendation.	Utilization Management

RECOMMENDATION

Approve PEBP Staff's proposed travel benefit language in the attached Exhibit A.

Approve PEBP Staff's proposed language for UMR's Prescription Copay Maximizer Program in the attached Exhibit B

Approve the proposed changes for the Master Plan Documents for Plan Year 2025:

- Consumer Driven Health Plan Master Plan Document and Summary of Benefits and Coverage
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EXHIBIT A

Travel Benefit Explanations and Limitations

This Plan allows for the reimbursement of certain travel and lodging accommodation expenses consistent with Section 213(d) of the Internal Revenue Code and IRS Publication 502 for qualified medical expenses for the member and one additional person (travel companion). Travel expenses are covered when incurred in conjunction with the member's:

- Transplant or bariatric surgery.
  - This does not include pre-surgery appointments such as evaluations, testing, counseling, etc.
- Hip and knee total joint replacement surgery performed at an approved exclusive Nevada hospital/ ambulatory surgery facility when prior authorized by the utilization management company
  - This includes pre-surgery evaluations and
  - For one year after surgery for follow-up visits as required by the patient's surgeon; and
- Travel expenses related to an organ or tissue transplant or bariatric surgery scheduled or performed at a facility or other provider type that is not a Center of Excellence as determined by the Plan Administrator or its designee will not be covered.
  - Travel expenses related to an inpatient or outpatient surgery that is not determined to be a preferred hospital/ambulatory surgical facility by the UM company will not be covered. There are no exceptions.
- Travel for a participant located in a State with more restrictive access to abortion than Nevada, *see* NRS 422.250, to the nearest care center for abortion services covered under this Plan.

The plan reimburses for travel up to one year after services for follow-up visits as required by the patient's provider/surgeon. Travel expenses incurred on or after one year are not eligible for reimbursement.

If the travel companion has their own separate PEBP plan, travel expense reimbursement will not apply to the companion.

PEBP does not provide advance payment for travel expenses.

The Plan will reimburse up to the GSA rate for lodging, travel, meals, or actual expenses, whichever is less.

Pre-approval for travel expenses:

- Travel expenses must be pre-approved by PEBP or its designee
  - If the member is unable to obtain pre-approval because the organ or tissue transplant required immediate travel, the member may submit travel costs to PEBP or its designee after the transplant surgery.

Pre-approval will provide an estimation of your travel reimbursement based on GSA rates. A Travel Pre-Authorization form is available at pebp.nv.gov.

Submitting Travel Reimbursement form and receipts:

- Requests for travel expense reimbursement must be submitted to PEBP using the Travel Reimbursement form available at pebp.nv.gov.
- Travel Reimbursement forms and receipts must be submitted within 12 months of the date of the service.
    - The form must be completed, including the start and end times, destination, and purpose of trip
    - Must include original itemized receipts identifying the name(s) of the person(s) incurring the expense. If the travel includes a commercial airline flight, an itinerary attached for meal justification.

Reimbursement of eligible travel expenses, including any relating to a travel companion, will be payable to the primary participant.

Reimbursement will be based on actual expenses incurred and the actual number of days and travel times and may differ from the pre-approval estimation. The lessor of GSA rates or actual expenses will be used.

Meals will be reimbursed in accordance with the meals and incidental expense (M&IE) allowance. Receipts are not required for the M&IE allowance. Participants should refer to the GSA's website http://gsa.gov and the link "Per Diem Rates" for the most current rates.

Eligible Travel Expenses include:
This Plan follows the travel expense reimbursement guidelines established in Section 213(d) of the Internal Revenue Code, IRS Publication 502, and under the GSA rates based on region or locality.

- Method of transportation including personal car, airline, rental car, bus, taxi, etc. The least expensive method of transportation must be used.
    - Flight expenses for commercial air (regular coach rate).
    - Mileage reimbursement for personal vehicle (GSA non-medical mileage rate).
- Travel meals (for patient and travel companion only).
    - Reimbursement for meals while traveling will apply the GSA rate for the travel day for the first and last day of travel.
- Lodging accommodations (GSA rate)
    - For transplants, some Centers of Excellence facilities may have on-site or affiliated lodging services.
        - For required lodging, the plan will pay the lesser of the affiliated lodging or GSA rates, subject to verification of availability.

Travel expenses are not subject to cost-share (Deductible, copay, and/or Out-of-Pocket Maximum). Therefore, PEBP will issue appropriate reporting forms (form 1099, W2, etc.) for federal tax reporting purposes. You may be liable for taxes and must consult your tax professional for further assistance.

Excluded travel expenses:
The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved):

- Alcoholic beverages.
- Car maintenance.
- Vehicle insurance.
- Flight insurance.
- Cards, stationery, stamps.
- Clothing.
- Dry cleaning.
- Entertainment (cable televisions, books, magazines, movie rentals).
- Flowers.
- Household products.
- Household utilities, including cell phone charges, house cleaner, baby-sitter, or day care services.
- Kennel fees.
- Laundry services.
- Security deposits.
- Toiletries.
- Travel expenses related to a facility or provider that is not a certified Center of Excellence, exclusive hospital/ambulatory surgical facility, or outpatient infusion facility; and
- Travel expenses incurred on or after one year following services are not eligible for reimbursement.

<u>EXHIBIT B</u>

To be added in the plan documents under the prescription drug benefit:

UMR offers a Medical Pharmacy Coupon Program: For drugs administered in an inpatient setting, there is a “UMR Prescription Copay Maximizer Benefit" where a member may receive cost-share assistance. A UMR patient advocate will conduct outreach to members and introduce the UMR Prescription Copay Maximizer Program. The member can voluntarily enroll in to qualifying copay assistance programs. This may help the member with their cost-share for certain drugs. Please contact UMR for additional information or assistance.