



Access.  
Quality.  
Affordability.



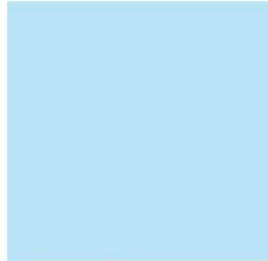
# CONSUMER DRIVEN HEALTH PLAN MASTER PLAN DOCUMENT

PLAN YEAR ~~2025~~2026

(EFFECTIVE JULY 1, ~~2024-2025~~ – JUNE 30, ~~2025~~2026)




NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM  
775-684-7000  
702-486-3100  
or 1-800-326-5496  
<https://pebp.nv.gov>



**Public Employees' Benefits Program**  
3427 Goni Road, Suite 109  
Carson City, Nevada 89706

## Table of Contents

<b>Table of Contents</b> .....	<b>ii</b>
<b>Amendment Log</b> .....	<b>vii</b>
<b>Welcome PEBP Participant</b> .....	<b>98</b>
<b>Introduction</b> .....	<b>119</b>
<i>Suggestions for Using this Document</i> .....	<i>1240</i>
<i>Accessing Other Benefit Information:</i> .....	<i>1340</i>
<b>Participant Rights</b> .....	<b>1412</b>
<i>You Participants have the right to:</i> .....	<i>1412</i>
<b>Summary of the CDHP Components</b> .....	<b>1513</b>
<i>Highlights of the Plan</i> .....	<i>1513</i>
<i>Deductibles</i> .....	<i>1614</i>
In-Network Individual Deductible .....	<i>1614</i>
Out-of-Network Individual Deductible .....	<i>1614</i>
In-Network Family Deductible .....	<i>1715</i>
Out-of-Network Family Deductible .....	<i>1715</i>
<i>Coinsurance</i> .....	<i>1715</i>
<i>Out-of-Pocket Maximums</i> .....	<i>1816</i>
In-Network Out-of-Pocket Maximums .....	<i>1916</i>
Out-of-Network Out-of-Pocket Maximum .....	<i>2016</i>
<b>Description of In-Network and Out-of-Network</b> .....	<b>2318</b>
<i>Provider Network</i> .....	<i>2318</i>
In-Network Provider Benefits.....	<i>2518</i>
Out-of-Network Provider Benefits .....	<i>2519</i>
<i>Other Providers</i> .....	<i>2519</i>
Out-of-Network Benefit Exceptions .....	<i>2619</i>
<i>Preferred Provider Organizations (PPO Network)</i> .....	<i>2721</i>
Service Area.....	<i>2721</i>
Directories of Network Providers.....	<i>2821</i>
<b>Eligible Medical Expenses</b> .....	<b>2923</b>
<i>A Person Whose Status Changes from Employee/Retiree to Dependent or from Dependent to Employee</i> .....	<i>2923</i>
<b>Non-Eligible Medical Expenses</b> .....	<b>3024</b>
<i>PPO Network Health Care Provider Services</i> .....	<i>3024</i>
<i>Out-of-Country Medical, Prescription and Vision Purchases</i> .....	<i>3125</i>
<b>Health Savings Accounts (HSA)</b> .....	<b>3327</b>

Table of Contents

*Active Employees Only*..... [3327](#)

*Health Savings Account Owner Identity Verification*..... [3528](#)

*HSA Contributions for Eligible Active Employees*..... [3529](#)

*Calendar Year 2024 HSA Contribution Limits* ..... [3529](#)

*Calendar Year 2025 HSA Contribution Limits* ..... [Error! Bookmark not defined.29](#)

**Health Reimbursement Arrangement (HRA)**..... [3730](#)

*Active Employees and Retirees* ..... [3730](#)

*Timely Filing of HRA Claims* ..... [3931](#)

**HRA Contributions for Eligible Active Employees and Retirees** ..... [3931](#)

**One-Time HSA or HRA Funding for Active State Employees** ..... [4133](#)

**HSA/HRA Contributions for Eligible State Active Employees**..... [4133](#)

**Utilization Management**..... [4234](#)

*Delivery of Services*..... [4335](#)

*Concurrent Review*..... [4335](#)

*Retrospective Review*..... [4435](#)

*Case Management* ..... [4436](#)

*Precertification (Prior Authorization) Process* ..... [4536](#)

        Services Requiring Precertification (Prior Authorization) ..... [4637](#)

        Services Not Requiring Precertification (Prior Authorization)..... [4839](#)

        How to Request Precertification (Prior Authorization) ..... [4939](#)

*Second Opinion*..... [4940](#)

        2<sup>nd</sup>.MD ..... [5141](#)

*Hospital Admission* ..... [5141](#)

        Emergency and Urgent Hospital Admission ..... [5141](#)

        Confinement in an Out-of-Network Hospital Following an Emergency Admission ..... [5242](#)

*Other Exceptions*..... [5342](#)

*Elective Knee and Hip Joint Replacement – Nevada Exclusive Hospitals and Outpatient Surgery Centers* ..... [5343](#)

*Inpatient or Outpatient Surgery* ..... [5443](#)

*Outpatient Infusion Services*..... [5443](#)

*Air Ambulance Services*..... [5444](#)

        Air/Flight Schedule Inter-Facility Transfer..... [5444](#)

        Emergency Air Ambulance ..... [5544](#)

*Gender Dysphoria*..... [5545](#)

*Health Care Services and Supplies Review*..... [5645](#)

*Failure to Follow Required UM Procedures* ..... [5645](#)

**Schedule of Benefits** ..... [5747](#)

## Table of Contents

<i>Acupuncture and Acupressure</i> .....	<u>5848</u>
<i>Allergy Services</i> .....	<u>5848</u>
<i>Ambulance</i> .....	<u>5848</u>
<i>Autism Spectrum Disorders Services</i> .....	<u>6150</u>
<i>Bariatric/Weight Loss Surgery</i> .....	<u>6254</u>
<i>Behavioral Health Services</i> .....	<u>6452</u>
<i>Blood Services for Surgery</i> .....	<u>6653</u>
<i>Chemotherapy</i> .....	<u>6654</u>
<i>Chiropractic Services</i> .....	<u>6754</u>
<i>Clinical Trials</i> .....	<u>6854</u>
<i>Corrective Appliances</i> .....	<u>6955</u>
<i>Diabetes Care Management Disease Program (DCM) (Enhanced Benefits)</i> .....	<u>7055</u>
<i>Diabetes Education Services</i> .....	<u>7257</u>
<i>Dialysis</i> .....	<u>7259</u>
<i>Durable Medical Equipment (DME)</i> .....	<u>7359</u>
<i>No Surprises Act</i> .....	<u>7460</u>
<i>Emergency Services</i> .....	<u>7460</u>
<i>Post Stabilization Services</i> .....	<u>7661</u>
<i>Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility</i> .....	<u>7662</u>
<i>Air Ambulance Services</i> .....	<u>7763</u>
<i>Payments to non-PPO Providers and Facilities</i> .....	<u>7863</u>
<i>External Review</i> .....	<u>7864</u>
<i>Continuity of Coverage</i> .....	<u>7864</u>
<i>Incorrect PPO Provider Information</i> .....	<u>7864</u>
<i>Enteral Formula and Special Food Product</i> .....	<u>7965</u>
<i>Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception</i> .....	<u>7966</u>
<i>Gender Dysphoria</i> .....	<u>8167</u>
<i>Genetic Counseling/Testing</i> .....	<u>8268</u>
<i>Hearing Aids</i> .....	<u>8669</u>
<i>Hinge Health</i> .....	<u>8670</u>
<i>Home Health Care and Home Infusion Services</i> .....	<u>8770</u>
<i>Hospice</i> .....	<u>8974</u>
<i>Hospital Services (Inpatient)</i> .....	<u>9072</u>
<i>Laboratory Outpatient Services</i> .....	<u>9173</u>
<i>Mastectomy and Reconstructive Services and Breast Reconstruction after Mastectomy</i> .....	<u>9374</u>
<i>Maternity and Newborn Services</i> .....	<u>9475</u>
<i>Nondurable Supplies</i> .....	<u>9676</u>
<i>Obesity Care Disease Management Program (Enhanced Benefits)</i> .....	<u>9676</u>

## Table of Contents

<i>Oral Surgery, Dental Services, and Temporomandibular Joint Disorder</i> .....	<u>10080</u>
<i>Outpatient Surgery Facility</i> .....	<u>10180</u>
<i>Physician and Other Health Care Practitioner Services</i> .....	<u>10281</u>
<i>Preventive Care/Wellness Benefits</i> .....	<u>10382</u>
<i>Radiation Therapy</i> .....	<u>10888</u>
<i>Real Appeal</i> .....	<u>10889</u>
<i>Rehabilitation Services (Cardiac, Physical, Occupational, and Speech Therapy)</i> .....	<u>10989</u>
<i>Second Physician Opinion</i> .....	<u>11190</u>
<i>2nd.MD (Second Opinion Service)</i> .....	<u>11191</u>
<i>Telemedicine</i> .....	<u>11191</u>
<i>Telehealth (other telemedicine providers)</i> .....	<u>11191</u>
<i>Skilled Nursing Facility (SNF) and Subacute Care Facility</i> .....	<u>11292</u>
<i>Transplant Services (Organ and Tissue)</i> .....	<u>11392</u>
<i>Travel Expenses</i> .....	<u>11493</u>
<i>Vision Screening Exam (Preventive)</i> .....	<u>11796</u>
<b>Schedule of Prescription Drug Benefits</b> .....	<b><u>11897</u></b>
<i>Prescription Drug Benefits</i> .....	<u>11897</u>
Preventive Drug Benefit Program.....	<u>12199</u>
Specialty Prescription Drugs.....	<u>121400</u>
Preferred Retail Pharmacy Network.....	<u>122400</u>
Smart90 Retail and Home Delivery Program.....	<u>122400</u>
.....	<u>123402</u>
SaveonSP Program.....	<u>124402</u>
Diabetes Care Value.....	<u>124403</u>
Diabetic Medications and Supplies.....	<u>124403</u>
Extended Absence Benefit.....	<u>124403</u>
Out-of-Country Emergency Medication Purchases.....	<u>125403</u>
Out-of-Network Pharmacy.....	<u>126404</u>
Other Limitations:.....	<u>126404</u>
<b>Benefit Limitations and Exclusions</b> .....	<b><u>127405</u></b>
<i>Expenses That Do Not Accumulate Toward <del>You</del> Out-of-Pocket Maximum</i> .....	<u>127405</u>
<i>Benefit Limitations</i> .....	<u>127405</u>
<i>Lifetime Maximum</i> .....	<u>128405</u>
<i>Exclusions Under the Plan</i> .....	<u>128406</u>
<b>Claims Administration</b> .....	<b><u>143419</u></b>
<i>How Benefits are Paid</i> .....	<u>143419</u>
<i>How to File a Claim</i> .....	<u>143419</u>
<i>Where to Send the Claim Form</i> .....	<u>146421</u>

Table of Contents

**Appeals**..... [147122](#)

*Discretionary Authority of PEBP and Designee*..... [147122](#)

*Claims and HRA Appeals*..... [147122](#)

    Written Notice of Adverse Benefit Determination ..... [147122](#)

    Level 1 Claim Appeal ..... [148123](#)

    Level 2 Claim Appeal ..... [150124](#)

    External Claim Review ..... [150125](#)

*Appealing a Utilization Management Determination* ..... [152125](#)

    Internal UM Appeal Review ..... [152126](#)

    External UM Appeal Review ..... [153127](#)

*Experimental and/or Investigational Claim/UM External Review* ..... [157128](#)

*Prescription Drug Review and Appeals*..... [157128](#)

    Clinical Coverage Review..... [158129](#)

    Administrative Coverage Review ..... [158129](#)

    Level 1 Appeal or Urgent Appeal..... [159130](#)

    Level 2 Appeal ..... [160131](#)

    External Reviews ..... [160131](#)

**Coordination of Benefits**..... [163133](#)

*Which Benefits are Subject to Coordination?* ..... [163133](#)

*Which Plan Pays First: Order of Benefit Determination Rules* ..... [164133](#)

*Coordination with Medicare*..... [167136](#)

*Coordination with Other Government Programs* ..... [169138](#)

**Subrogation and Third-Party Recovery** ..... [171139](#)

**Participant Contact Guide**..... [172140](#)

**Key Terms and Definitions** ..... [175143](#)

Amendment Log

Amendment Log

After this document is issued, it may be amended due to changes in the law or plan design. Any such amendments will be listed here and specify what sections have been amended and where the changes can be found.

**Formatted:** Font: (Default) +Body (Calibri), 14 pt

**Formatted:** Justified

**Formatted:** Font: +Body (Calibri)

Amendment Log

- ~~1. **May 10, 2024**— Amended telemedicine/Doctor on Demand section, pg. 83, to clarify listed amounts are before deductible has been met.~~
- ~~2. **May 10, 2024**— Deleted statement “Participants enrolled in the CDHP HRA who change plans during the Open Enrollment period to a plan without an HRA”, on page 30 due to all plans receiving HRA money, and HRA amounts carrying over for all active employees.~~

**Formatted:** Font: (Default) +Body (Calibri), 14 pt, Bold

**Formatted:** Justified, Space After: 0 pt



Welcome

## Welcome PEBP Participant Overview

Formatted: Font: (Default) +Body (Calibri), 14 pt

Formatted: Justified

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP is a group sponsor of health coverage which medical, vision, dental, and life insurance, in addition to flexible spending accounts, and other voluntary benefits. This series of benefits is referred to as a health plan. Throughout this document, "Plan" will be used to represent this document.

The Plan is available to all eligible state and local government employees, retirees, and their eligible dependents. All individuals on the Plan are referred to as "participants".

An eligible dependent is:

Formatted: Indent: Left: 0.25", Right: 0"

- natural child up to age 26,
- child(ren) of a domestic partner up to age 26 as long the domestic partnership is not terminated,
- stepchild up to age 26 if the marriage is not terminated
- legally adopted child up to age 26 or child placed in anticipation for adoption,
- a child under permanent guardianship up to age 26,
- child who qualifies for benefits under a Qualified Medical Child Support Orders (QMCSO) up to age 26. A QMCSO is a state court order that requires an employer to provide health coverage for a child of an employee as a component of a child support agreement.
- a domestic partner pursuant to NRS 122A.030 (the domestic partner is no longer eligible at termination of this partnership):
- a legal spouse. (A divorced spouse or legally separated spouse is not eligible)
- a child under guardianship (may be covered up to age 26 with some parameters. Guardianship is a legal arrangement that gives an adult the authority to care for a child when the child's parents are unable to do so. This arrangement gives the guardian responsibility for the child's health, welfare, and education.
- a disabled child. A determination by the Plan Administrator or its designee (after evaluation by a physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as intellectual disability, cerebral palsy, epilepsy, neurological disorder, or psychosis.

PEBP acts as the Plan Administrator which is the legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

All plans run on a Plan Year which is a 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits,

Welcome

Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

An independent Third-Party Claims Administrator (TPA) pays the claims for the medical, dental and vision benefits. An independent Pharmacy Benefit Manager pays the claims for prescription drug benefits. These are PEBP vendors.

**This document does not provide information on eligibility and enrollment, only the components of this health plan. PEBP offers medical, vision, dental, and life insurance, in addition to flexible spending accounts, and other voluntary benefits for eligible state and local government employees, retirees, and their eligible dependents.**

Formatted: Font: Bold  
Formatted: Centered

As a PEBP participant, you may access whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and plan requirements. These plans include the Consumer Driven Health Plan (CDHP), Exclusive Provider Organization Plan (EPO), Low Deductible PPO Plan, and the Health Plan of Nevada HMO Plan. You are also encouraged to research plan provider access and quality of care in your service area.

PEBP participants choosing this Plan should examine this document, the PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document, the Active Employee Health and Welfare Wrap Plan Document, the Retiree Health and Welfare Wrap Plan Document, the Section 125 Health and Welfare Benefits Plan Document, the Health Reimbursement Arrangement (HRA) Summary Plan Description (SPD), and the Enrollment and Eligibility Master Plan Document. These documents are available at <https://pebp.nv.gov/> or by calling PEBP.

Master Plan Documents are a comprehensive description of the benefits available to you. Helpful statutes and regulations are noted for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the Participant Contact Guide.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,

*Public Employees' Benefits Program*

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: 12 pt

Formatted: Font: (Default) +Body (Calibri), 12 pt

Introduction

Formatted: Font: (Default) +Body (Calibri), 14 pt

Master Plan Documents are a comprehensive description of the benefits available to participants. Relevant statutes and regulations are noted for reference. It is the participants responsibility to know and follow the requirements as described in PEBP’s Master Plan Documents.

This Master Plan Document describes the Consumer Driven Health Plan (herein after referred to the “Plan” or “CDHP”) benefits. This Plan offers In-Network and Out-of-Network benefits and is a self-funded plan administered by PEBP and governed by the State of Nevada. The Plan is available to eligible employees, retirees, and their eligible dependents participating in the Public Employees’ Benefits Program (PEBP).

This Master Plan Document describes the Consumer Driven Health Plan (CDHP). The CDHP Plan offers In-Network and Out-of-Network benefits and is a self-funded plan. This plan offers The benefits offered with the CDHP include medically necessary medical, behavioral health, prescription drug, vision, and dental coverage. Additional benefits include basic life insurance for active employees and eligible retirees. The medical, behavioral health, prescription drug, and vision benefits. Additional benefits include basic life insurance for active employees and eligible retirees. This document outlines medical, behavioral health, prescription drug and vision benefits.

are described in this document. For information regarding the dental and life insurance benefits, refer to the PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document.The CDHP provides a Health Savings Account (HSA) for eligible employees or a Health Reimbursement Arrangement (HRA) for eligible retirees and active employees who are ineligible for the HSA.

An independent Third-Party Claims Administrator pays the claims for the medical, dental and vision benefits. An independent pharmacy benefit manager pays the claims for prescription drug benefits.

The Plan and this document are intended to comply with Chapter 287 of the Nevada Revised Statutes (NRS), Chapter 287 of the Nevada Administrative Code (NAC), 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) of 1996 which is a federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

The Plan described in this document is effective **July 1, 2024**~~2025~~, and unless stated differently, replaces other CDHP medical and prescription drug benefit plan documents/summary plan descriptions previously provided to ~~you~~ participants.

The provisions of this document contain important information. It will help you understand and use the benefits provided by this Plan. You should review it and show it to members of your family who are or will be covered by the Plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan. Be sure to read the *Schedule of Benefits, Benefit Limitations and Exclusions*, and *Key Terms and Definitions* sections. Remember, not every expense you incur for health care is covered by this Plan.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. Members should keep informed of this document as the Plan is amended periodically. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

**Per NRS 287.0485 no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.**

Suggestions for Using this Document

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The *Table of Contents* provides you with an outline of the sections.
- The *Participant Contact Guide* helps you become familiar with PEBP vendors and the services they provide.
- The *Participant Rights* section describes your rights and responsibilities as a participant of this Plan.
- The *Key Terms and Definitions* section explains many technical, medical, and legal terms that appear in the text.
- The *Eligible Medical Expenses and Non-Eligible Medical Expenses, Summary of the CDHP Components, Schedule of Benefits, Schedule of Prescription Drug Benefits, Key Terms and Definitions*, and *Benefit Limitations and Exclusions* sections describe your benefits in more detail.
- The *Preventive Care/Wellness Services* section provides wellness information that can help you proactively manage your health.
- The *Utilization Management* section provides information on what health care services require prior authorization and the process to request prior authorization.
- The *Claims Administration* section describes how benefits are paid and how to file a claim.
- The *Appeals* section describes how to request a review (appeal) if you are dissatisfied with a claim decision.
- The *Coordination of Benefits* section describes situations where you have coverage under more than one health care plan, including Medicare.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Justified

[Accessing Other Benefit Information:](#)

~~You will also want to access the following documents for information related to~~Additional information regarding dental, life, flexible spending accounts, enrollment and eligibility, Consolidated Omnibus Budget Reconciliation Act (COBRA), third-party liability and subrogation, Health Insurance Portability and Accountability Act (HIPAA) and Privacy and Security and mandatory notices. ~~These documents are available~~ can be found in the following documents available -at <https://pebp.nv.gov/>.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO Plan Master Plan Document
- Low Deductible PPO Plan Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- Exclusive Provider Organization Plan Master Plan Document
- Exclusive Provider Organization Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description
- Health Reimbursement Arrangement Summary Plan Document

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Justified

Formatted: Font: 12 pt

Formatted: Font: 12 pt

## Participant Rights and Responsibilities

### Participant Rights

~~You~~ Participants have the right to:

- Participate with ~~your~~their health care professionals in ~~your~~their health care decisions and have ~~you~~their health care professionals ~~give you~~provide information about ~~you~~their condition and ~~your~~ treatment options.
- Receive the benefits for which ~~you~~they have coverage.
- Be treated with respect and dignity.
- Privacy of ~~your~~their personal health information, consistent with State and Federal laws, and the Plan's policies.
- ~~Receive information about the Plan's organization and services, the Plan's network of health care professionals and providers and your rights.~~
- ~~Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.~~
- ~~Make recommendations regarding the organization's participants' rights and responsibilities policies.~~
- Express, respectfully and professionally, any concerns ~~you~~participants may have about PEBP or any benefit or coverage decisions the Plan, or the Plan's designated administrator, makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing future treatment and be informed by ~~your~~their physician(s) of the medical consequences.

Formatted: Font: (Default) +Body (Calibri), 14 pt

Formatted: Justified

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: 12 pt

Formatted: Font: (Default) +Body (Calibri), 12 pt

Summary of the CDHP Components

Summary of the CDHP Components

Highlights of the Plan

The CDHP is a PEBP administered Preferred Provider Organization (PPO) High Deductible Health Plan which provides In-Network and Out-of-Network benefits. As a member, ~~you~~ participants receive coverage for many medically necessary services and supplies. This is an ~~open access~~ open-access PPO Plan and does not require a referral to see a specialist.

The Plan includes:

- Coverage statewide.
- Coverage ~~for participants residing~~ nationwide.
- Coverage worldwide for those residing or traveling outside of the United States.
- In- and Out-of-Network benefits.
- ~~Reimbursement for Eligible Medical Expenses described in this document (and as determined by the Plan Administrator) for participants residing permanently, part time, or while traveling outside of the United States. Refer to the Out-of-Country Medical, Prescription, and Vision Purchases section.~~
- ~~Coverage for eligible preventive care services at 100% when using In-Network providers. Refer to the Preventive Care/Wellness Services section for more information.~~
- Health care resources and tools ~~to assist you in making informed decisions about your and your family's health care services.~~ For more information log in to ~~you~~the E-PEBP member portal account at <https://pebp.nv.gov/>.

The CDHP is coupled with either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA).

Plan Year Deductibles and Out-of-Pocket Maximums					
	In-Network Deductible	In-Network Out-of-Pocket Maximum	Out-of-Network Deductible	Out-of-Network Out-of-Pocket Maximum	Out-
<b>Individual</b> (self-only coverage)	\$1,600	\$4,000	\$1,600	\$10,600	
<b>Family</b>	Family: \$3,200	Family: \$8,000 Individual family member: \$6,850	Family: \$3,200	\$21,200	
In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums are not interchangeable.					
The Deductibles and Out-of-Pocket Maximums accumulate separately for In-Network and Out-of-Network provider expenses. See Family Deductible explanation below.					

Formatted: Font: (Default) +Body (Calibri), 14 pt, Bold

Formatted: Font: (Default) +Body (Calibri), 14 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: Not Italic

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Justified

Formatted: Justified

Formatted: Justified

Formatted: Font: 12 pt

Formatted: Justified

Formatted Table

Formatted: Justified

Formatted: Justified

## Summary of the CDHP Components

### Deductibles

A deductible is an amount a participant may owe during a coverage period (usually one year) for covered health care services before the Plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles.

Formatted: Font: (Default) +Body (Calibri), 12 pt

The Plan Year Deductibles (combined medical and prescription drug) includes two tiers:

Formatted: Font: 12 pt

Formatted: Normal, Justified

- **Individual Deductible:** –Applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible:** Applies when two or more individuals are covered on the same Plan (e.g., Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductible may be met through a combination of *Eligible Medical Expenses* from covered family members.

Formatted: Right: 0"

The Individual and Family Deductibles start July 1<sup>st</sup> (the first day of the Plan Year) and reset the following Plan Year on July 1<sup>st</sup>. This Plan does not include a Deductible carryover or rollover provision.

Participants are responsible for paying Out-of-Pocket for eligible medical and prescription drug expenses that are subject to the Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service. During the Plan Year, you are responsible for paying for your eligible medical and prescription drug expenses (except eligible Preventive Services provided In-Network), including amounts exceeding the Plan's reference based pricing for hip and knee replacement, preauthorization penalties, and other out of pocket costs.

Formatted: Justified, Space After: 0 pt

### In-Network Individual Deductible

The In-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible is **\$1,600**. Participants are responsible for paying Out-of-Pocket for eligible medical and prescription drug expenses that are subject to the Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Formatted: Space After: 0 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Justified, Space After: 0 pt

Formatted: Highlight

### Out-of-Network Individual Deductible

The Out-of-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible for Eligible Medical Expenses received Out-of-Network is **\$1,600**. Participants are responsible for paying Out-of-Pocket for eligible medical (prescription

Formatted: Font: (Default) +Body (Calibri)

Formatted: Justified

Formatted: Highlight



## Summary of the CDHP Components

~~drugs are not covered Out-of-Network) expenses up to the Plan Year Deductible. Once the Individual Deductible is met, the Plan will pay its cost share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.~~

### In-Network Family Deductible

The In-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **\$3,200**. For a participant covered with one or more dependents, this Plan will pay benefits for eligible In-Network medical and prescription drug expenses for the entire family after the **\$3,200** Family Deductible is met. ~~The \$3,200 In-Network Family Deductible may be met by any combination of Eligible Medical Expenses from covered individuals in the family. The Family Deductible accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.~~

Formatted: Font: (Default) +Body (Calibri)

Formatted: Justified

Formatted: Highlight

Formatted: Highlight

### Out-of-Network Family Deductible

The Out-of-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **\$3,200**. For a participant covered with one or more dependents, this Plan will pay benefits for eligible Out-of-Network medical and vision (prescription drugs are not covered Out-of-Network) expenses for the entire family after the **\$3,200** Family Deductible is met. ~~The \$3,200 Family Deductible may be met by any combination of Eligible Medical Expenses from covered individuals in the family. The Family Deductible accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.~~

Formatted: Font: (Default) +Body (Calibri)

Formatted: Justified

Formatted: Highlight

Formatted: Highlight

### Coinsurance

Coinsurance ~~is the participants share of the cost of a covered service.~~

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Justified

In-Network: A participants share of the allowed amount for covered healthcare services. A member's share is usually lower for in-network covered services. This Plan pays 80%, participants pay 20%.

Formatted: Justified

Out-of-Network: This plan pays 50% of Out-of-Network provider (a non-participating provider, meaning the provider is not contracted with the PPO network), and participants are responsible for paying the remaining 50%.

Formatted: Space After: 0 pt

Out-of-Network providers can also bill participants directly for any difference between their billed charges and the Maximum Allowable Charge allowed by this Plan, except when prohibited by law.

### Copayment, Copay:

## Summary of the CDHP Components

The fixed dollar amount participants are responsible for paying out of pocket for a covered healthcare service. It is a form of cost sharing between a participant and the Plan.

Copays are usually set amounts and are typically paid at the time of service. is the percentage of costs that you and the Plan pay for Eligible Medical Expenses after your Deductible is met. If you receive covered health care services using a health care provider who is a participating provider of this Plan's PPO network, you will be paying less money out of your pocket. This Plan generally pays 80% of the In-Network provider's contract rate and you are responsible for paying the remaining 20%. If you use an Out-of-Network provider (a non-participating provider, meaning the provider is not contracted with the PPO network), the Plan benefit may be reduced to 50% of the Maximum Allowable Charge, and you are responsible for paying the remaining 50%. Out-of-Network providers can also bill you directly for any difference between their billed charges and the Maximum Allowable Charge allowed by this Plan, except when prohibited by law.

Formatted: Justified

Copayments apply as specifically stated in this document and are payable by the covered participant. Copayments do not apply to the Deductible but do apply to the Out-of-Pocket Maximum.

Formatted: Font: Font color: Auto

Formatted: Normal

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Body Text, Justified, Space After: 12 pt, Don't add space between paragraphs of the same style

Formatted: Font: Font color: Auto

### **Cost-Share or Cost Sharing:**

The amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under the plan.

### **Out-of-Pocket Maximums (OOPM)**

Formatted: Normal, Space After: 0 pt

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Justified, Space After: 0 pt

Formatted: Font: 12 pt

Formatted: Justified

This is the maximum amount a participant could pay during a Plan Year.

Once an Individual or Family satisfies the OOPM, the Plan will pay 100% of eligible medical and prescription drug expenses for the remainder of the Plan Year. The OOPM accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year. The accumulation of Allowable medical expenses toward the OOPM is based on the date the medical or prescription drug expense is received by the Plan and not on the date of services.

Only Allowable medical expenses that are subject to cost-sharing (Deductible, Copayments, and Coinsurance) will apply to the OOPM. The OOPM does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges, preauthorization penalties, amounts exceeding the Plan's allowable charge for hip and knee replacement and amounts billed by Out-of-Network providers that are payable and are greater

## Summary of the CDHP Components

~~than this Plan's Maximum Allowable Charge. This list is not all-inclusive and may not include certain services and supplies that are not listed here.~~

~~For this section only, references to the OOPM, Allowable medical expenses, Deductible and Coinsurance are specific to In-Network benefits.~~

Formatted: Justified

~~Once the OOP Maximum is met, the Plan will pay 100% of Eligible Medical Expenses (excluding Out-of-Network prescription drug expenses) for the remainder of the Plan Year. The OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year.~~

~~The accumulation of Eligible Medical Expenses toward the OOPM is based on the date the medical expense is received by the plan and not on the date of services.~~

~~The Family OOP Maximum (for Out-of-Network services only) can be met by one person or by a combination of Out-of-Pocket Eligible Medical Expenses from covered family members.~~

~~In- and Out-of-Network Maximums are not interchangeable and cannot be combined to reach the Plan Year OOP.~~

Formatted: Normal, Justified, Space After: 12 pt

Formatted: Font: 12 pt

### ~~In-Network Out-of-Pocket Maximums~~

Formatted: Font: (Default) +Body (Calibri)

~~The In-Network Out-of-Pocket Maximum (OOPM) is the maximum amount you participants will pay for In-Network eligible medical and prescription drug expenses during the Plan Year. The Out-of-Pocket costs you pay toward your Deductible and Coinsurance for Eligible Medical Expenses accumulate toward your OOPM. The OOPM for:~~

Formatted: Justified

- ~~• An Individual (covered as self-only) is \$4,000~~
- ~~• Family coverage (participant plus one or more covered dependents) is \$8,000~~
  - ~~○ The Family OOP Maximum includes a \$6,850 embedded "Individual Family Member" OOP Maximum. An Individual Family Member OOP Maximum means one single family member will not pay more than \$6,850 in the Plan Year for Eligible Medical Expenses.~~

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

Formatted: Right: 0"

Formatted: Highlight

~~Once an Individual or Family satisfies the OOP Maximum, the Plan will pay 100% of eligible medical and prescription drug expenses for the remainder of the Plan Year. The OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year. The accumulation of Eligible Medical Expenses toward the OOP Maximum is based on the date the medical or prescription drug expense is received by the Plan and not on the date of services.~~

~~Only Eligible Medical Expenses that are subject to cost sharing (Deductible, Copayments, and Coinsurance) will apply to the OOPM. The OOPM does not include premiums, cost-sharing for non-covered supplies and services, penalties for failure to get preauthorization, amounts exceeding the Plan's allowable charge for hip and knee replacement, expenses associated with denied claims, ancillary charges, and amounts billed by Out-of-Network providers that are payable and greater than this Plan's Maximum Allowable Charge. This list is not all-inclusive and may not include certain services and supplies that are not listed here.~~

## Summary of the CDHP Components

~~For this section only, references to the OOPM, Eligible Medical Expenses, Deductible and Coinsurance are specific to In-Network benefits.~~

### Out-of-Network Out-of-Pocket Maximum

The Out-of-Network Out-of-Pocket Maximum (OOPM) is the maximum amount ~~you~~ participants will pay for Eligible Medical Expenses (excluding prescription drugs) during the Plan Year. ~~The Out-of-Pocket costs you pay toward your Deductible and Coinsurance for Eligible Medical Expenses accumulate toward your OOPM. The OOPM for:~~

- Individual (covered as self-only) is **\$10,600**.
- Family coverage (participant plus one or more covered dependents) is **\$21,200**. (The Family coverage tier does not include an embedded Individual Family Member OOP Maximum.)
- Covered health services and billing for services use standards such as medically necessary, usual and customary, reasonable, and health care practitioner.

**Medically Necessary**; Health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

1. Provided in accordance with generally accepted standards of medical practice.
2. Clinically appropriate with regard to type, frequency, extent, location and duration.
3. Not primarily provided for the convenience of the patient, physician or other provider of health care.
4. Required to improve the specific health condition of an insured or to preserve the existing state of health of the insured; and
5. The most clinically appropriate level of health care that may be safely provided to the insured.

A medical or dental service or supply will be appropriate if:

- It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to health care expenses incurred in connection with the service or supply. The fact that a physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be medically necessary if the patient's illness or injury could safely and appropriately be

Formatted: Font: (Default) +Body (Calibri)

Formatted: Justified

Formatted: Highlight

Formatted: Highlight

Formatted: Right: 0"

Formatted: Normal, Right: 0", No bullets or numbering

Formatted: Font: 12 pt

Formatted: Font: +Body (Calibri), Bold, Underline

Formatted: Font: +Body (Calibri)

## Summary of the CDHP Components

diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility:

- The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

Once the OOP Maximum is met, the Plan will pay 100% of Eligible Medical Expenses (excluding Out-of-Network prescription drug expenses) for the remainder of the Plan Year. The OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year.

**Usual and Customary:** To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

Formatted: Font: Bold, Underline

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, subject to the Plan's Maximum Allowable Charge or negotiated fee schedule for any procedure, service, or supply, and whether a specific procedure, service or supply is usual and customary. Usual and customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, Average Wholesale Price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

**Reasonable:** Means charges for services or supplies which are necessary for the care and treatment of an illness or injury. The determination that charges are reasonable will be made by the Plan Administrator taking into consideration the following:

Formatted: Font: Bold, Underline

## Summary of the CDHP Components

- The facts and circumstances giving rise to the need for the service or supply.
- Industry standards and practices as they are related to similar scenarios; and
- The cause of the injury or illness necessitating the service or charge.

The Plan Administrator's determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities:

- (a) The National Medical Associations, Societies, and Organizations.
- (b) The Centers for Medicare and Medicaid Services (CMS).
- (c) Centers for Disease Control and Prevention; and
- (d) The Food and Drug Administration.

**Health Care Practitioner:** A healthcare practitioner is a licensed medical professional who is authorized to provide health care services. They may work in private practice, hospitals, clinics, and other health care settings. They may practice general medicine or specialize in a particular area. Individual state laws define the scope of practice for them. Note: This general statement includes primary care physicians, specialists, dentists, and an array of other licensed professionals.

**Formatted:** Normal, Indent: Left: 0.25", Hanging: 0.25", Right: 0.5", Space After: 0 pt

**Formatted:** Font: Bold, Underline

~~The accumulation of Eligible Medical Expenses toward the OOPM is based on the date the medical expense is received by the plan and not on the date of services.~~

~~The Family OOP Maximum (for Out-of-Network services only) can be met by one person or by a combination of Out-of-Pocket Eligible Medical Expenses from covered family members.~~

~~Only Eligible Medical Expenses that are subject to cost sharing (Deductible, Copayments, and Coinsurance) will apply to the OOP Maximum. The OOP Maximum does not include premiums, cost sharing for non-covered supplies and services, penalties for failure to obtain preauthorization, amounts exceeding the Plan's allowable charge for hip and knee replacement, expenses associated with denied claims, ancillary charges, and any amount that Out-of-Network providers bill and are payable that are greater than this Plan's Maximum Allowable Charge. This list is not all-inclusive and may not include certain services and supplies that are not listed here.~~

~~References to the Out-of-Network, OOP Maximum, Eligible Medical Expenses, Deductible and Coinsurance in this section are specific to Out-of-Network benefits.~~

~~In and Out-of-Network Maximums are not interchangeable and cannot be combined to reach your Plan Year OOPM.~~

## Description of In-Network and Out-of-Network Providers

Formatted: Font: (Default) +Body (Calibri), 10.5 pt, Font color: Auto

This plan uses a preferred provider organization (PPO) network which is a list of the doctors, hospitals, laboratories, and other health care providers that the Plan has a contract with to provide medical care for Plan members. These providers are called “network providers” or “In-Network providers.” Out-of-network providers are accessible if necessary. Network providers are not the Plan’s employees or employees of any Plan designee.

- **In-Network:** A provider who has a contract with the TPA and has agreed to provide services to participants of a plan. Participants will pay less if they see a provider in the network. Also called “preferred provider” or “participating provider.”
- **Out-of-Network:** A provider who doesn’t have a contract with the TPA to provide services. Participants will usually pay more to see an out-of-network provider than an in-network provider. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

This Plan includes a PPO network for members residing in-and outside-of Nevada. To locate an In-Network provider visit the PEBP website at <https://pebp.nv.gov/> or contact the third-party claims administrator. Information regarding the PPO network is also available in the *Participant Contact Guide* section of this document.

The TPA is responsible for managing network providers by confirming public information about the providers’ licenses and other credentials but does not guarantee the quality of the services provided. The plan includes network providers residing both in-and-outside of Nevada. In-Network providers, visit the PEBP website at <https://pebp.nv.gov/> or contact the TPA.

### Provider Types

- **Provider:** An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.
  - **Primary Care Provider:** A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps participants access a range of health care services.
  - **Specialist:** A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
  - **Facility:** An entity that provides health care or medical services. It is licensed by the regulatory authority having responsibility for the licensing under the laws of

## Description of In-Network and Out-of-Network

the jurisdiction in which it is located and is operated and equipped in accordance with applicable state law, and includes, but not limited to:

- Hospitals
- Surgical centers
- Birthing centers
- Inpatient rehabilitation centers
- Emergency rooms (freestanding)
- Skilled nursing facilities
- Residential treatment facilities
- Urgent care centers
- Imaging centers
- Independent laboratories
- Psychiatric day treatment centers
- Partial hospitalization centers
- Intensive outpatient centers
- Habilitation centers
- Radiation therapy centers

### Provider Network

~~PEBP leases a network of preferred providers (PPO) through a contract with a vendor who maintains such a network. For more information, see the *Participant Contact Guide*. In-Network providers are hospitals, physicians, medical laboratories, and other health care providers located within a “service area” who have agreed to provide health care services and supplies at negotiated discount fees. Network providers are not the Plan’s employees or employees of any Plan designee.~~

~~The contracted PPO Network is responsible for credentialing providers by confirming public information about the providers’ licenses and other credentials but does not assure the quality of the services provided.~~

~~Before obtaining services, you a participant should always verify the network status of a provider. A provider’s status may change. You can Participants may verify the provider’s status by calling the third-party administrator or on the PEBP website in the Find a Provider section. The provider listing is maintained and updated by the contracted network TPA.~~

~~The provider network is subject to change. It is possible that you might not be able to obtain specific services from an In-Network provider. Or you might find that an In-Network providers may not be accepting new patients. If a provider leaves the network or is otherwise not available, you participants must choose another In-Network provider to get In-Network benefits.~~

~~Do not assume that an In-Network provider’s agreement includes all Eligible Medical Expenses. Some In-Network providers agree to provide only certain covered expenses, but not all covered expenses. Some In-Network providers choose to be an In-Network providers for only some~~



## Description of In-Network and Out-of-Network

products and services. ~~You may contact the third-party administrator for assistance in choosing a provider or with questions about a provider's network participation.~~

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 a more detailed explanation in PPO Network Health Care Provider Services section. The TPA shall evaluate on a case-by-case basis.~~

### *In-Network Provider Benefits*

~~The Plan provides In-Network benefits when the services are provided by an In-Network provider and generally pays at a higher amount than Out-of-Network benefits. In-Network benefits are payable for covered Eligible Medical Expenses.~~

When a participant uses the services of a PPO network (In-Network) health care provider, the participant is responsible for paying the applicable cost-share (Deductible, Copay, and/or Coinsurance) on the discounted fees for medically necessary services or supplies, subject to the Plan's coverage, limitations, and exclusions.

~~If you receive medically necessary services or supplies from an In-Network provider, you will pay a lower cost than if you received those services or supplies from a health care provider who is not in the PPO network (Out-of-Network). In-Network providers have agreed to accept the Plan's payment (plus any applicable cost share you are responsible for paying) as payment in full. The In-Network health care provider generally deals with the Plan or its designee directly for any additional amount due.~~

### *Out-of-Network Provider Benefits*

Out-of-Network Eligible Medical Expenses are subject to applicable Deductibles and a Coinsurance rate of 50% of eligible billed charges and subject to the Plan's Maximum Allowable Charge, except when prohibited by law.

Out-of-Network health care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will pay benefits based on the Plan's Maximum Allowable Charge ~~(as defined in the Key Terms and Definitions)~~ on non-discounted medically necessary services or supplies, subject to the Plan's cost-share (Deductibles, Copay, and/or Coinsurance). ~~With exception of services subject to the No Surprises Act, Out-of-Network health care providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing). Balance billing for Eligible Medical Expenses can be avoided by using In-Network Providers.~~

### *Other Providers*

Participants with special medical conditions or complex medical conditions may be directed to an Out-of-Network provider by the TPA. In both cases, benefits will only be paid at the In-Network benefit level (subject to the Maximum Allowable Charge).

Formatted: Space After: 0 pt

Formatted: Normal

Formatted: Space After: 0 pt

## Description of In-Network and Out-of-Network

~~If you have a medical condition that the third-party administrator or the utilization management company believes needs special services, they may direct you to a provider identified by them. If you require certain complex covered services for which expertise is limited, the third-party administrator or the utilization management company may direct you to an Out-of-Network provider. In both cases, benefits will only be paid at the In-Network benefit level (subject to the Maximum Allowable Charge) if your covered expenses for that condition are provided by or arranged by the other provider as chosen by third-party claims administrator or the utilization management company.~~

Participants may obtain health care services from In-Network or Out-of-Network health care providers. Because providers are added and dropped from the PPO network periodically throughout the year, it is the participant's responsibility to verify provider participation before receiving services by contacting the third-party claims administrator at the telephone number or by visiting the provider network's website available at <https://pebp.nv.gov/>.

### *Out-of-Network Benefit Exceptions*

If there is no In-Network provider within 50 miles of ~~the participants home of record, participants may be eligible to receive benefits for certain Allowable medical expenses your home, you may be eligible to receive benefits for certain Eligible Medical Expenses~~ paid at the In-Network level, subject to the Plan's Maximum Allowable Charge (with exception of services subject to the No Surprises Act). Benefits that fall under this category must be approved prior to receipt of the care and are subject to any Plan Benefit Limitations and Exclusions set forth in this MPD.

~~If you~~Participants who are traveling outside ~~you~~the network and ~~you~~need non-emergency medical care, ~~you~~ should contact the third-party administrator at the telephone number appearing on ~~you~~the ~~r~~-medical identification card for assistance in locating the nearest In-Network provider.

### *Emergency Care*

~~The Plan provides benefits for emergency care when required for stabilization and initiation of treatment as provided by or under the direction of a health care provider. Eligible Medical Expenses that are provided as a result of emergent care are paid at the In-Network level, regardless of whether the provider is In-Network or Out-of-Network.~~

### *Confinement in an Out-of-Network Hospital Following an Emergency*

~~If you are confined in an Out-of-Network hospital after you receive emergency services, the utilization management company should be notified as soon as possible and must be notified within two business days at the latest. The UM company may elect to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If, after receiving required notice and providing informed consent, you choose to stay in the Out-of-Network hospital after the UM company determines a transfer is medically appropriate, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service.~~

## Description of In-Network and Out-of-Network

### *Other Exceptions*

~~If you receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out of Network provider while receiving services at an In Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the Eligible Medical Expenses at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge.~~

### *When Out-of-Network Providers May be Paid as In-Network Providers*

When a participant uses the services of an Out-of-Network provider for *Eligible Medical Expenses* in the circumstances defined below, charges by the Out-of-Network provider will be subject to the Plan's Maximum Allowable Charge (as defined in the *Key Terms and Definitions* section). Out-of-Network providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing).

- If a participant traveling to an area serviced by an In-Network provider experiences an urgent but not life-threatening situation and cannot access an In-Network provider, benefits may be paid at the In-Network benefit level for use of an Out-of-Network urgent care facility.
- In the event of a life-threatening emergency in which a participant uses an Out-of-Network urgent care.
- For medically necessary services or supplies when such services or supplies are not available from an In-Network provider within 50 driving miles of the participant's residence. This includes services provided for wellness/preventive, or a second opinion.
- Participant travels to an area not serviced by an In-Network provider within 50 miles.
- If a participant travels to an area serviced by an In-Network provider, the participant must use an In-Network provider to receive benefits at the In-Network benefit level.
- If there is a specialty not available inside the participant's eligible PPO network, benefits may be paid as In-Network.

Formatted: Right: 0"

### *Preferred Provider Organizations (PPO Network)*

~~A preferred provider organization (PPO) network is a list of the doctors, other health care providers, and hospitals that the Plan has a contract with to provide medical care for Plan members. These providers are called "network providers" or "In-Network providers."~~

~~This Plan includes a PPO network for members residing in and outside of Nevada. To locate an In-Network provider visit the PEBP website at <https://pebp.nv.gov/> or contact the third party claims administrator. Information regarding the PPO network is also available in the *Participant Contact Guide* section of this document.~~

### *Service Area*

~~A "Service Area" is a geographic area serviced by In-Network health care providers. If you and/or your covered dependent(s) live more than 50 driving miles from the nearest In-Network health care provider whose services or supplies are determined by the Plan Administrator or its designee as being appropriate for the condition being treated, the Plan will consider that you live outside the service area. In that case, your claim for medically necessary services or supplies from an Out-of-Network health care provider will be treated as if the services or supplies were provided In-Network, subject to the Maximum Allowable Charge.~~

Formatted: Space After: 0 pt

## Description of In-Network and Out-of-Network

### *Directories of Network Providers*

Participants are encouraged to confirm the In-Network participation status of a provider prior to receiving services.

A list of ~~PPO-In-Network~~ providers is available to ~~you~~ participants without charge by [contacting the TPA, visiting your member website from the Third-Party Administrator's website or by calling the phone number on your ID card.](#) The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

The online provider directory updates are made seven (7) days a week ~~for Sierra HealthCare Options (SHO) and Behavioral Healthcare Options (BHO) networks. UHC Choice Plus providers are available in the Find Care and Cost tool available 24/7 yearly updates.~~ The list of PPO providers is maintained and updated by the contracted network based on information supplied by Providers.

~~If a participant relies upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to claims, even if the provider was Out-of-network. If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.~~

Formatted: Space Before: 0 pt

## Eligible Medical Expenses

### Eligible Medical Expenses

~~You~~Participants are covered for expenses ~~you~~participants incur for most, but not all, medical services, and supplies. The expenses for which ~~you~~participants are covered are called *Eligible Medical Expenses*. ~~Eligible medical~~

~~expenses are limited to the covered benefits specified in the Schedule of Benefits and are:~~

~~• Determined by the Plan Administrator or its designee to be medically necessary (unless otherwise stated in this Plan), but only to the extent that the charges are usual and customary (U&C), provided in network, and/or do not exceed this Plan's Maximum Allowable Charge (as those terms are defined in the Key Terms and Definitions section).~~

~~• Not services or supplies that are excluded from coverage (as provided in the Benefit Limitations and Exclusions section).~~

~~Charges for services or supplies that do not exceed the Plan Year maximum benefits as shown in the Schedule of Benefits.~~

~~Medical expenses are any costs incurred in the prevention or treatment of injury or disease. Medical expenses include health and dental insurance premiums, doctor and hospital visits, co-pays, prescription and over-the-counter drugs, glasses and contacts, crutches, and wheelchairs, to name a few.~~

~~Eligible medical expenses are the maximum amount the Plan will pay for a covered health care service.~~

~~•~~  
Generally, the Plan will not reimburse ~~you~~ for all *Eligible Medical Expenses*. Usually, ~~you~~participants will have to pay some portion of costs, known as cost-sharing such as Coinsurance toward the amounts ~~you~~participants incur for *Eligible Medical Expenses*. However, once ~~you~~participants have incurred the Plan Year Out-of-Pocket Maximum cost for *Eligible Medical Expenses*, no further Coinsurance will apply for the balance of the Plan Year. There are also maximum benefits applicable to each participant.

~~The above is not all-inclusive. For more information regarding eligible medical expenses, see the Schedule of Benefits, Key Terms and Definitions, Benefit Limitations and Exclusions sections.~~

~~A Person Whose Status Changes from Employee/Retiree to Dependent or from Dependent to Employee~~

A person who is continuously covered on this Plan before, during, and after a change in status, will be given credit for portions of the medical, prescription drug and dental Deductibles previously met in the same Plan Year, including the benefit maximum accumulators (e.g., medical Out-of-Pocket Maximums, dental frequency maximums and annual benefit maximum) will continue without interruption.

**Formatted:** Normal, Right: 0", Don't add space between paragraphs of the same style, No bullets or numbering

**Formatted:** Normal, Right: 0", Space After: 0 pt, Don't add space between paragraphs of the same style, No bullets or numbering

## Non-Eligible Medical Expenses

Formatted: Font: Bold

~~Non-eligible medical expenses are ineligible for reimbursement, are expenses that are~~ excluded from the Plan, and do not accumulate towards ~~your participants~~ Deductible and Out-of-Pocket Maximum.

Formatted: Font: (Default) +Body (Calibri)

This Plan does not pay benefits equal to all the medical expenses ~~you may incurred~~. ~~You~~ Participants are responsible for paying the full cost of all expenses that are not *Eligible Medical Expenses*, including expenses that are:

- Not determined to be medically necessary (unless otherwise stated in this Plan).
- Determined to exceed this Plan's Maximum Allowable Charge.
- Expenses for medical services or supplies that are not covered by the Plan, including, but not limited to, expenses that exceed the PPO provider contract rate, services listed in the *Exclusions* section of this document and dental expenses.
- Benefits exceeding those services or supplies subject to limited overall maximums for each covered individual for certain *Eligible Medical Expenses*.
- Additional amounts ~~you participants~~ are required to pay because of a penalty for failure to comply with the Plan's utilization management requirements described in the *Utilization Management* section of this document. If ~~you participants~~ fail to follow certain requirements of the Plan's utilization management program, the Plan may pay a smaller percentage of the cost of those services, and ~~you participants~~ may have to pay a greater percentage of those costs. The additional amount ~~you participants~~ may have to pay is in addition to ~~you their~~ Deductibles or Out-of-Pocket Maximums described in the tables.
- *Preventive Care/Wellness Services* that are paid by the Plan at 100% do not accumulate towards the Out-of-Pocket Maximum.

This list is not all-inclusive and may include certain services and supplies that are not listed above.

Non-Eligible Medical Expenses do not accumulate toward the Plan Year Deductible or Out-of-Pocket Maximum as determined by the Plan Administrator for ~~you their~~ specific coverage tier. ~~You Participants~~ are responsible for paying these expenses out of ~~you their~~ own pocket.

~~For more information regarding Non-Eligible Medical Expenses, see the Benefit Limitations and Exclusions section.~~

### PPO Network Health Care Provider Services

~~If you receive medical services or supplies from an In-Network PPO provider, you will be responsible for paying less money out of pocket. Health care providers who are participating providers of the PPO network have agreed to accept the PPO network negotiated amounts in place of their standard charges for covered services. You are responsible for any applicable Plan Deductible and Coinsurance requirements as outlined in this document and are described in more detail in the Schedule of Benefits.~~

With exception of services subject to the No Surprises Act, Out-of-Network providers may bill the participant their standard charges and any balance that may be due after the Plan payment. It is the participant's responsibility to verify the In-Network status of a chosen provider.

**NOTE:** In accordance with [NRS 695G.164](#), [a provider who leaves the network may be reimbursed as an in-network provider if the provider agrees to these terms, coverage may continue until:](#)

- [The 120<sup>th</sup> day after the date the contract is terminated; or](#)
- [If the medical condition is pregnancy, the 90<sup>th</sup> day after:](#)
  - [The date of delivery; or](#)
  - [If the pregnancy does not end in delivery, the date of the end of the pregnancy.](#)

~~if you are seeing a provider that is In-Network and that provider leaves the network, and you are actively undergoing a medically necessary course of treatment, and you and your provider agree that a disruption to your current care may not be in your best interest or if continuity of care is not possible immediately with another In-Network provider, PEBP will pay that provider at the same level they were being paid while contracted with PEBP's PPO network, if the provider agrees. If the provider agrees to these terms, coverage may continue until: The 120th day after the date the contract is terminated; or~~

~~If the medical condition is pregnancy, the 90th day after:~~

~~The date of delivery; or~~

~~If the pregnancy does not end in delivery, the date of the end of the pregnancy.~~

#### Out-of-Country Medical, Prescription and Vision Purchases

##### Out-of-Country Medical, Prescription and Vision Purchases

This Plan provides ~~you with~~ coverage worldwide. Whether ~~you participants reside in the United States and~~ travel to a foreign country; or if ~~you reside~~ live outside of the United States permanently or on a part-time basis, ~~and require medical, prescription drug, or vision care services, you may be~~ they eligible for reimbursement of the cost of medical, prescription, and vision services.

~~Please contact this Plan's third party claims administrator and pharmacy benefit manager before traveling or moving to another country to discuss any criteria that may apply to a medical, prescription drug, or vision service reimbursement request.~~

Typically, foreign countries do not accept payment directly from the Plan. You Participants may be required to pay for medical and vision care services and submit ~~your~~ receipts to ~~this Plan's third party~~ the TYPA claims administrator for possible reimbursement. Medical and vision services received outside of the United States are subject to Plan provisions, coverage, limitations, exclusions, clinical review if necessary, and determination of medical necessity. The review may include application of pertinent Food and Drug Administration (FDA), and federal

Formatted: Font: Bold

Formatted: Space After: 0 pt

Formatted: Normal, Left

government agency responsible for the approval of prescription drugs and other medical services, regulations Out-of-country medication purchases are only eligible for reimbursement while traveling outside of the United States.

The ~~third-party claims administrator~~TPA may require a written notice ~~from you or your designated representative~~ explaining why ~~you received~~ the medical services from an out of country provider ~~were provided outside of the~~ and ~~why you were unable to travel to the~~ United States ~~for these services~~. This provision applies to elective and emergency services.

Prior to submitting receipts from a foreign country to ~~this Plan's third-party claims administrator~~the TPA, ~~you participants~~ must complete the following:

- Proof of payment from ~~you to~~ the provider of service (~~typically you may be a~~ credit card invoice).
- Itemized bill to include complete description of the services rendered and admitting diagnosis(es).
- Itemized bill must be translated to English.
- Reimbursement request converted to United States dollars.
- Foreign purchases of medical care and services are subject to Plan limitations such as:
  - Benefit coverage
  - Coinsurance and deductibles
  - Frequency maximums
  - Annual benefit maximums
  - Medical necessity
  - FDA approval
  - the Plan's Maximum Allowable Charge

The Plan administrator and the ~~third-party claims administrator~~TPA reserve the right to request additional information. If the provider will accept payment directly from the ~~claim's administrator~~TPA, ~~you must also provide the following~~they may be additional documents required.

- ~~Assignment of benefits signed by you or an individual with the authority to sign on your behalf such as a legal guardian or Power of Attorney (POA).~~

Once payment is made ~~to you or to the out-of-country provider~~, the Plan administrator and its vendors are released from any further liability for the out-of-country claim. The Plan administrator has the exclusive authority to determine the eligibility of all medical services rendered by an out-of-country provider. The Plan administrator may or may not authorize payment to ~~you participants~~ or to the out-of-country provider if all requirements of these provisions are not satisfied.

This Plan may provide certain benefits for travel assistance back to the United States.

Formatted: Space After: 0 pt



This Plan may provide benefits for the purposes of emergency medical transportation only. For more information, contact this Plan's third-party claims administrator listed in the *Participant Contact Guide*.

## Health Savings Accounts (HSA)

### Active Employees Only

The ~~Consumer-Driven Health Plan (CDHP)~~ is an IRS qualified High Deductible Health Plan. This means the CDHP complies with federal requirements regarding Deductibles, Out-of-Pocket Maximums, and certain other features. As a qualified High Deductible Health Plan, the CDHP is coupled with a Health Savings Account (HSA). A Health Savings Account is a tax-exempt account that ~~you participants~~ can use to pay or reimburse ~~yourself themselves~~ for certain medical expenses ~~you they~~ incur. For further information on Health Savings Accounts, see [IRS Publication 969](#).

HSAs are employee-owned accounts, meaning the funds in the HSA remain with the employee and carry over from one year to the next (i.e., will not be forfeited). Contributions to the HSA ~~grow are~~ tax free and are portable. When an employee retires or terminates employment, the employee retains the funds in the HSA. The employee can continue to use the funds in the HSA for health care and other qualified medical expenses after employment ends.

[Only active employees under this plan qualify for an HSA.](#) There are limits on the amount an eligible individual can contribute to an HSA based on the employee's coverage tier. For example, "self-only" or "Family" coverage:

- Self-only coverage means an eligible individual (employee).
- Family coverage means an eligible employee covering at least one dependent (whether that dependent is an eligible individual (for example, if the dependent has Medicare) if that other person is claimed on ~~you their~~ tax return and not claimed as a tax dependent on someone else's return.

~~You~~ [Participants](#) must be an eligible individual to qualify for an HSA. 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.
- ~~The~~ The employee is enrolled in Medicare.
- The employee is enrolled in Tricare.
- The employee is enrolled in Tribal coverage.
- The employee can be claimed as a dependent on someone else's tax return unless the employee is Married Filing Jointly.
- The employee or the employee's spouse has a Medical Flexible Spending Account (excludes Dependent Care or Limited Use Flexible Spending Accounts) that can reimburse the employee's medical expenses.

Formatted: Justified

Formatted: Font: 12 pt

## Health Savings Accounts

- The employee's spouse has an HRA that can be used to pay for the medical expenses of the employee.
- The employee is on COBRA; or
- The employee is retired.

If a participant loses eligibility to contribute to a Health Savings Account (HSA) for any reason, the participant is no longer eligible to contribute to an HSA, and contributions on the participants' behalf with discontinue. The participant retains all funds in their HSA at the time they lose eligibility.

~~If an employee loses eligibility to contribute to a Health Savings Account (HSA) for any reason, the Plan reserves the right to cease processing employee contributions to the HSA for the remainder of the Plan Year. If an HSA-ineligible employee elects to continue coverage in the Plan for the subsequent Plan Year, the employee will only be eligible to enroll in the Health Reimbursement Arrangement (HRA) to receive PEBP contributions as described below. The HSA third-party claims administrator reserves the right to verify Medicare eligibility with the Centers for Medicare and Medicaid Services (CMS).~~

Employees who wish to establish or contribute to an HSA should contact the HSA third-party claims administrator regarding eligibility requirements, consult with a tax professional or read the provisions described in IRS Publication 969.

Current CDHP participants who are eligible for the HSA will receive PEBP contributions during the first month of the new Plan Year. New hires receive a prorated contribution based on the ~~coverage effective date~~effective coverage dates and the number of months remaining in the Plan Year. HSA funds may not be used for a person who does not meet the IRS definition of dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether the dependent is covered under this Plan. In general, HSA funds may not be used to pay premiums. There are certain exceptions for retirees or former employees enrolled in a Plan offered under COBRA provisions.

HSA funds may only be used to pay, or reimburse expenses incurred after the HSA is established and can only be reimbursed if there are available HSA funds in the account.

HSA Bank, a division of Webster Bank, N.A., is the third-party claims administrator and custodian for the HSA. PEBP does not (i) endorse HSA Bank, a division of Webster Bank, N.A. as an HSA provider; (ii) limit an employee's ability to move funds to other HSA providers, (iii) impose conditions on how HSA funds are spent, (iv) make or influence investment decisions regarding HSA funds, or (v) receive any payment or compensation in connection with an HSA. PEBP HSA contributions and employee voluntary pre-tax payroll deductions will only be deposited to an HSA at HSA Bank, a division of Webster Bank, N.A. Employees may choose to establish an HSA with any HSA trustee or custodian and may transfer funds deposited into HSA Bank, a division of Webster Bank, N.A. account to another HSA account held by another trustee or custodian. However, PEBP will not pay any fees associated with any other HSA account including transfer fees.

## Health Savings Accounts

The IRS requires any person with an HSA to submit form 8889 with their annual income tax return.

### [Health Savings Account Owner Identity Verification](#)

Section 326 of the USA PATRIOT Act requires financial institutions to verify the identity of each employee who opens a Health Savings Account (HSA). If an employee's identity cannot be verified, the employee will be required to provide additional documentation to establish their identity. If additional verification is not provided within 90 days of the employee's HSA opening date, the HSA will be closed. Failure to comply with the identity verification requirement within the stated timeframe will result in the conversion from an HSA to a Health Reimbursement Arrangement (HRA) for the remainder of the Plan Year. The next opportunity to establish an HSA will be during the Open Enrollment Period for the subsequent Plan Year.

### [Contributions:](#)

[Current CDHP participants who are eligible for the HSA will receive PEBP contributions during the first month of the new Plan Year. New hires receive a prorated contribution based on the effective coverage and the number of months remaining in the Plan Year.](#)

[The annual contribution for HSA eligible active employees enrolled in the CDHP will be deposited on July 1, 2025.](#)

HSA Contributions for Eligible Active Employees	
Tier	Contribution
Active Participant (Employee/Retiree) Only	*\$ <del>600</del>

~~\*HSA contribution provided to HSA eligible active employees enrolled in the CDHP on July 1, 2024.~~

New hires ~~with benefits effective August 1, 2024, and later will~~ receive a pro-rated contribution based on their CDHP coverage effective date.

For **Plan Year 2026~~5~~**, dependents are not eligible for a PEBP HSA contribution. Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing from the CDHP with an HSA to the CDHP with a HRA or vice versa.

[Participants are limited to the total amount of contributions \(combined employee/employer\) in an HSA per year.](#)

Calendar Year 2024 HSA Contribution Limits	
Individual	Family (two or more HSA eligible family members)

Health Savings Accounts

**\$4,150**

**\$8,300**

Total contributions (combined employee/employer) cannot exceed the **2024-2025 calendar year limit, as determined by the IRS ([Revenue Procedure 2023-23](#))**.

To contribute the family maximum, the employee and at least one tax dependent must be covered on the CDHP Plan. The Family maximum applies regardless of whether two employees are married and enrolled in the CDHP and eligible for the HSA. Employees aged 55 years and older at the end of the tax year may contribute an additional **\$1,000** to the HSA.

## Health Reimbursement Arrangement (HRA)

This section provides summary information only regarding HRA's. PEBP's HRA benefits are subject to the provisions explained in IRS Publication 969. Refer to the HRA Summary Plan Description document on PEBP's website. For more detailed information regarding this important benefit, see IRS Publication 502 or contact the HRA third-party claims administrator listed in the Participant Contact Guide.

Formatted: Space After: 0 pt

HRA' available to active employees who are not eligible for an HSA, or who fail to establish an HSA. An HRA is also available to eligible retirees enrolled in the CDHP.

PEBP and its vendor require direct deposit for HRA reimbursements. PEBP's HRA benefits are subject to the provisions explained in IRS Publication 969. Also see the HRA Summary Plan Description document on PEBP's website.

### Active Employees and Retirees

This section provides summary information only. For more detailed information regarding this important benefit, see IRS Publication 502 or contact the HRA third-party claims administrator listed in the Participant Contact Guide.

The CDHP with an HRA is available to active employees who are not eligible for an HSA, or who fail to establish an HSA. An HRA is also available to eligible retirees enrolled in the CDHP.

Each Plan Year, PEBP contributions will be available for use through a CDHP HRA account established in the employee's or retiree's name. Funds in the CDHP HRA account may be used, tax-free, to pay for qualified medical expenses as defined by the IRS (see [IRS Publication 502](#)), other than premiums, including payment of Deductibles, Coinsurance, and other Out-of-Pocket qualifying healthcare expenses not covered by this Plan.

Participants are allowed the option annually, and at termination in the plan, to permanently opt-out of the HRA, and thereby forfeit any unused balance.

Formatted: Space After: 0 pt

### Contributions:

Contributions will be provided on July 1 of each plan year. Contributions for new hires will be prorated based on their CDHP coverage effective date.

### HRA Contributions for Eligible Active Employees and Retirees

<u>Employee/Retiree</u>	<u>Contribution</u>
<u>Participant Only</u>	<u>\$</u>

Direct deposit is required for HRA reimbursements.

Formatted: Space After: 0 pt

Use of HRA Funds:

The CDHP's HRA funds may only be used to pay or reimburse qualified Out-of-Pocket health care expenses incurred by the participant, the participants spouse, or the participants dependents who can be claimed on their annual tax return.:

- the participant;
- the participant's spouse; or
- participant's dependent(s) who could be claimed on the participant's annual tax return.

Formatted: Normal, Right: 0", No bullets or numbering

CDHP HRA funds may not be used for a person who does not meet the IRS definition of a qualified tax dependent, including many domestic partners, children of domestic partners, and or older dependents children who cannot be claimed on the participant's annual tax return, regardless of whether PEBP provides coverage for the dependent.

The entire annual PEBP base contribution for Plan Year 2025 will be available for use at the beginning of the Plan Year, and for new hires, the entire prorated contribution will be available the month after hire on or about July 1, 2024 (subject to certain limitations). Participants who initially elect PEBP coverage after July 1, 2024, will receive a pro-rated base contribution for the participant based upon the coverage effective date and the months remaining in the Plan Year. Participants cannot contribute to a CDHP CDHP HRA. If the annual funds in the CDHP HRA are exhausted, neither PEBP nor the participant will contribute any additional funds.

Participants are allowed the option annually, and at termination in the plan, to permanently opt-out of the HRA, and thereby forfeit any unused balance.

Formatted: Space After: 12 pt

Any funds remaining in the CDHP HRA at the end of the Plan Year will carryover (i.e., will not be forfeited) and will be available for use in the following Plan Year. Unlike a Flexible Spending Account (FSA), participants cannot be reimbursed from funds that are not yet available in the CDHP HRA. Any reimbursement from the CDHP HRA will be the lesser of the available CDHP HRA balance or the claim amount paid to the provider.

Retirees who transition coverage to the Via Benefits Medicare exchange will forfeit any remaining funds in their CDHP HRA account and will start over with a Via HRA.

Active employees who retire and who are not Medicare age (typically at age 65 years) can maintain the balance of their CDHP HRA account at retirement if:

- They are eligible to enroll in and continue coverage under a PEBP plan; or
- Continue coverage under COBRA.

- If a participant elects COBRA coverage, the HRA account will remain in place until COBRA coverage is terminated.

In the case of a retroactive coverage termination, any funds used from the CDHP HRA for expenses that are incurred after the date of coverage termination will be recovered by PEBP through the collection process.

Retirees who have a CDHP HRA balance and who transition to the Medicare Exchange will forfeit any remaining funds in the HRA on the last day of coverage under the Plan.

The death of an active employee or retiree will cause any remaining funds in the HRA to be forfeited on the first day following the date of death.

**Timely Filing of HRA Claims**

In accordance with [NAC 287.610](#), claim requests must be submitted to the ~~third-party claims TPA administrator~~ within one year ([12 months](#)) from the date of service that the claim is incurred. No plan benefits will be paid for any claim requests submitted after this period.

[The one year \(12 months\) from the date of service that the claim is incurred is also required for participants who lose coverage or pass away.](#)

~~When your HRA-eligible coverage ends, you will have one year from the date your coverage ends to file a claim for reimbursement from your HRA for eligible claims incurred during your coverage period in accordance with [NAC 287.610](#), dependent on the date of service. CDHP HRA funds may not be used to pay premiums.~~

HRA Contributions for Eligible Active Employees and Retirees	
Employee/Retiree	Contribution
Participant Only	*\$600

~~\*HRA contribution provided to eligible active employees and retirees enrolled in this Plan on **July 1, 2024**. For **Plan Year 2025**, dependents are not eligible for PEBP HRA contributions. New hires effective **August 1, 2024**, and later receive a pro-rated contribution based on their CDHP coverage effective date.~~

Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing from the CDHP with an HSA to the CDHP with a HRA or vice versa.

Formatted: Space Before: 6 pt

Reinstated employees who return to active employment within the same Plan Year and who re-enroll in the CDHP HRA shall have their remaining HRA fund balance reinstated. Reinstated employees who re-enroll in the CDHP HRA more than one year after termination are not eligible for reinstatement of HRA balance reinstatement. ~~No additional prorating of HRA funds is~~

Health Reimbursement Arrangement

~~available to reinstatements unless the reinstated employee is eligible for additional prorated funding due to adding new dependent(s).~~



## One-Time HSA or HRA Funding for Active State Employees

There is additional funding for the HSA or HRA for active, state employees enrolled in a PEBP plan on July 1, 2024.\*

The entire one-time contribution for **Plan Year 2025** will be available for use at the beginning of the Plan Year on or about **July 1, 2024** (subject to certain limitations, above).

<b>HSA/HRA Contributions for Eligible State Active Employees</b>	
<b>Tier</b>	<b>One-Time Contribution</b>
<b>Legislature Appropriated One-Time Contribution</b>	
State Active Employee Only	\$300
State Active Employee + Spouse/Domestic Partner	\$400
State Active Employee + Child(ren)	\$400
State Active Employee + Family	\$500

\*One-time contribution provided to eligible active, State employees enrolled in a Plan on **July 1, 2024**. State employees who initially elect PEBP coverage after **July 1, 2024**, will receive a pro-rated base contribution based on the tier and the coverage effective date and the months remaining in the Plan Year.

Legislatively approved enhancements, such as HSA/HRA funding and enhanced basic life insurance amounts may be subject to change in subsequent plan years.

## Utilization Management

Utilization management (UM) is a process that reviews the use of medical services and resources to ensure they are medically necessary and meet quality standards. The goal of UM is to reduce unnecessary services and control costs while still providing patients with the care they need.

Formatted: Normal

Formatted: Font: 12 pt

Formatted: Font: 12 pt

UM is a key component of cost management in healthcare. It's run by or on behalf of medical service purchasers, such as insurance providers, and affects hospitals, medical staff, insurers, and patients.

A Utilization Management (UM) program is included in this Plan that is designed to help control increasing health care costs by avoiding unnecessary services, directing participants to more cost-effective treatments capable of achieving the same or better results and managing new medical technology and procedures.

Utilization Management is conducted by an independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professionals, operating under a contract with the Plan to administer the Plan's utilization management services. Utilization management services (sometimes referred to as UM services, UM, utilization review services) include concurrent review, or retro review and case management.

Formatted: Font: +Body (Calibri), 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

~~The Plan is designed to provide you and your eligible dependents with financial protection from significant health care expenses. To enable the Plan to provide coverage in a cost-effective way, it has a Utilization Management (UM) program designed to help control increasing health care costs by avoiding unnecessary services, directing participants to more cost-effective treatments capable of achieving the same or better results, and managing new medical technology and procedures. If you follow the procedures of the Plan's UM program, you may avoid some Out-of-Pocket costs.~~

~~The Plan's UM program is administered by an independent professional UM company operating under a contract with the Plan. The name, address and telephone number of the UM company appears in the *Participant Contact Guide* section. The health care professionals at the UM company focus their review on the medical necessity of hospital stays ~~and the~~including medical necessity, ~~appropriateness,~~ and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM company has been given discretionary authority by the Plan administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of the Plan.~~

The UM program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document, PEBP's *Active Employee Health and Welfare Wrap Plan*, and *Retiree Health and Welfare Wrap Plan* documents.

For example, benefits would not be payable if ~~your~~ eligibility for coverage ended before the services were rendered, or if the services were not covered, either in whole or in part, by an exclusion in the Plan.

~~Even if your physician recommends surgery, hospitalization, confinement in a skilled nursing or sub-acute facility, or your physician or other provider proposes or provides any medical service or supply, the recommended services or supplies are not automatically considered medically necessary for purposes of determining coverage under the Plan.~~

PEBP, the ~~third-party claim administrator~~ TPA, and the UM company are not engaged in the practice of medicine and are not responsible for the outcomes of health care services rendered (even if the health care services have been authorized by the UM company as medically necessary), or for the outcomes if the patient chooses not to receive health care services that have not been authorized by the UM company as medically necessary.

When reviewing services for ~~appropriateness of care and~~ medical necessity, the UM company uses guidelines and criteria published by nationally recognized organizations, along with medical judgement of licensed health care professionals.

#### Delivery of Services

~~You~~ Participants are entitled to receive medically necessary medical care and services as specified in this Plan's *Schedule of Benefits*. These include medical, mental health, behavioral health, surgical, diagnostic, therapeutic, and preventive services. These services, although not all-inclusive are those that generally:

- Are provided In-Network and Out-of-Network,
- Are performed or ordered by a participating provider,
- Require a prior authorization according to the utilization management and quality assurance protocols, if applicable.

~~If a precertification is required and you do not obtain the required precertification, the service may not be covered, even if the service is medically necessary.~~

#### Concurrent Review

Concurrent Review is defined as a managed care program (a cost control measure to avoid unnecessary services or services that are costlier than other that can achieve the same result) designed to ensure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the utilization management company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility.

In practice, this is a continued stay review or an ongoing assessment of health care currently being provided inpatient, specifically a hospital or skilled nursing facility. Concurrent review (sometimes referred to as a continued stay review) is the ongoing assessment of health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or skilled nursing or sub-acute facility. When you are receiving medical services in a hospital or other

Formatted: Font: 12 pt

Formatted: Font: 12 pt

~~inpatient facility, t~~The UM company monitors ~~your-an inpatient~~ stay by contacting ~~your~~ physicians or other providers to ~~assure~~ensure that continuation of medical services in the facility is medically necessary. The UM company will also help coordinate ~~your~~ medical care with other healthcare benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services, or advising ~~your~~the physician or other providers of various options and alternatives for ~~you~~their medical care available under this Plan.

When or if an inpatient stay is found not to be medically necessary and care could be safely and effectively delivered in another environment (such as through home health care or in another type of health care facility), the facility and/or physician will be notified. This does not mean that a participant must leave the hospital, but if they choose to stay, expenses incurred after the notification will be their responsibility.

Formatted: Font: 12 pt

If an inpatient stay is determined not to be medically necessary, no benefits will be paid on any related hospital, medical or surgical expense.

~~If at any point, your stay is found not to be medically necessary and care could be safely and effectively delivered in another environment (such as through home health care or in another type of health care facility), you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, expenses incurred after the notification will be your responsibility. If your hospital stay is determined not to be medically necessary, no benefits will be paid on any related hospital, medical or surgical expense. You may also appeal the determination (refer to the *Appealing a Utilization Management Determination* section).~~

Formatted: Font: 10.5 pt

Formatted: Left, Space After: 4 pt

#### Retrospective Review

Retrospective Review is defined as a review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are UCR and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule.

~~Retrospective Review is the review of health care services after they have been provided to determine if those services were medically necessary.~~The Plan will pay benefits only for those days or treatment that would have been authorized under the utilization management program.

#### Case Management

Case management in healthcare is a coordinated and individualized approach to the management of a participant's health and social care needs. It is a voluntary process administered by the UM company. Its professionals work with the ~~patient, participant, their~~ the patient's family, caregivers, providers, the ~~third-party claims administrator~~TPA, and the Plan Administrator or its designee to coordinate a quality, timely and cost-effective treatment program. Case management services are particularly helpful when ~~the patient~~a participant needs complex, costly and/or high-technology services, or when assistance is needed to guide ~~the~~

~~patient~~ participant through a maze of potential providers. Case management is available for sickle cell disease and its variants, see [NRS 695G.174](#), as well as for a disability resulting from a mental health or substance use disorder diagnosis, among other conditions.

The case manager will work directly with ~~your~~ a physician, hospital, and/or other provider to review proposed treatment plans and to assist in coordinating services and obtaining discounts from providers as needed. From time to time, the case manager may confer with ~~your~~ physicians or other providers and may contact ~~you or your~~ participant or their family to assist in making plans for continued health care services or obtaining information to facilitate those services.

The case manager will be available at any time to answer questions, make suggestions or offer information.

Formatted: Font: 12 pt

~~You, your family, or your physician may call the case manager at any time to ask questions, make suggestions or offer information. The case manager can be reached by calling the UM company at the telephone number shown in the *Participant Contact Guide* section or on the PEBP website at <https://pebp.nv.gov/>.~~

Precertification (Prior Authorization) Process

Formatted: Font: 10.5 pt

Prior authorization is a decision by the Plan, through the UM Company, that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "prior authorization." This Plan requires preauthorization for certain services before they are provided. An exception is emergency services/treatment.

Formatted: Left, Space After: 4 pt

Formatted: Space After: 0 pt

Formatted: Normal

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Preauthorization isn't a promise that health insurance will cover the cost of health care services.

Formatted: Font: 12 pt

~~Precertification or prior authorization review is a procedure administered by the UM company to assure health care services meet or exceed accepted standards of care. In certain cases, as set forth below, in practice, for a benefit to be covered, the UM company must approve and/or pre-certify the service. ~~If a precertification is required and you do not obtain the required precertification, the benefits may be reduced, even if the service is medically necessary.~~ The UM company uses nationally recognized guidelines and criteria as standard measurement tools to determine whether benefits are approved and/or pre-certified.~~

Formatted: Font: 12 pt

Formatted: Space After: 0 pt

~~Precertification~~ Prior authorization also includes the determination of whether the admission and length of stay in a hospital or skilled nursing or sub-acute facility, surgery or other health care services are medically necessary and if the location of service is high quality and ~~low~~ est cost.

~~A precertification is required for referrals to physicians and providers for certain services. Benefits listed in this Plan may be subject to precertification requirements and concurrent or retrospective review depending upon the circumstances associated with the services. Refer to the Services Requiring Precertification section below for more information.~~

## Utilization Management

Failure to obtain ~~precertification~~prior authorization may result in ~~your~~ benefits being reduced or denied. Participants are ultimately responsible for ensuring prior authorization is obtained as necessary.  
~~(see the Failure to Follow Required Utilization Management Procedures in this section).~~

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Space After: 0 pt

Services Requiring ~~Precertification~~Prior authorization (*Prior Authorization*)

### *Inpatient Admissions*

- Acute inpatient or observation
- Long-Term Acute Care
- Rehabilitation
- Behavioral Health
- Transplant including pre-transplant related expenses
- Skilled Nursing facility and sub-acute facility
- Residential Treatment Facility—Inpatient Residential Treatment and partial residential treatment programs for Mental Health and Substance Use Disorders~~and partial residential treatment programs~~
- Hospice (inpatient/outpatient) exceeding six (6) months.
- Obstetric – (~~precertification~~prior authorization only required if days exceed 48 hours for vaginal delivery or 96 hours for a C-section)
- Intraoperative Neuro Monitoring
- Surgeries ~~to treat~~for treating Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery

### *Outpatient and Physician – Surgery*

~~When outpatient and physician surgery is performed at an In-Network, contracted ambulatory surgical center (ASC) by an In-Network, contracted physician, prior authorization is not required. However, when services are not performed at an In-Network, contracted ASC, procedures will require prior authorization. Examples of services that require prior authorization include, but are not limited to:~~

Formatted: Normal

- Back Surgeries and hardware related to surgery
- Total and remaining Hip and Knee Surgeries
- Biopsies (excluding skin, colonoscopy and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Frenectomy
- Oophorectomy, unilateral and bilateral
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)

- Balloon sinuplasty
- Surgeries to treat Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery
- Sleep apnea related surgeries, limited to:
  - Radiofrequency ablation (Coblation, Somnoplasty)
  - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic) and reconstruction surgery
- Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Varicose vein surgery/sclerotherapy
- Any procedure deemed to be Experimental and/or Investigational (provider must indicate on the pre-certification request that the service/procedure is Experimental and/or Investigational and/or part of a clinical trial).
- Intraoperative Neuro Monitoring
- Prophylactic surgery

When outpatient and physician surgery is performed at an In-Network contracted ambulatory surgical center (ASC) by an In-Network contracted physician, prior authorization is not required. The physician will obtain prior authorization.

However, when services are not performed at an In-Network, contracted ASC, procedures will require prior authorization. The physician's prior authorization may not be accepted in this case. This is commonly referred to as a Site of Service.

*Outpatient and Physician – Diagnostic Services*

- Advanced high-tech imaging services (for example, CT, PET, SPEC, MRI, etc.)
- Capsule endoscopy
- Genetic testing including:
  - BRCA
  - Biomarker testing for ~~the diagnosis~~ diagnosis, treatment, ~~appropriate case~~ management, and ongoing monitoring of cancer when such biomarker testing is supported by the medical and scientific evidence.
    - Requests for ~~precertification~~ prior authorization for biomarker testing will be responded to within 72 hours after receipt, or within 24 hours if the provider indicates the request is urgent.

*Outpatient and Physician – Continuing Care Services*

- Applied Behavior Analysis (ABA) Therapy for Medical, Mental Health, and substance use disorder
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Chemotherapy

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted: Indent: Left: 0.25", No bullets or numbering

Formatted: Normal, No bullets or numbering

Formatted: Space After: 0 pt, No bullets or numbering

## Utilization Management

- Oral Chemotherapy to be reviewed by Pharmacy Benefit Manager
- Radiation Therapy
- Oncology and transplant related injections, infusions, and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric Oxygen
- Home Health Care
- Durable Medical Equipment exceeding \$1,000
  - prior authorization is based on overall cost to the plan and/or purchase price, not the amount billed for monthly rental. DME rental to purchase in accordance with Medicare guidelines.
- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables and infusions excluding services reviewed by the PBM
- Intensive Outpatient Programs, including partial hospitalization programs
- Sickle Cell Disease
- Vein Therapy
- Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a visit limit of 90 visits between the types of therapy per Plan Year.

- ~~Visit limits will not apply to medically necessary treatment of mental health or substance use disorder.~~ Outpatient Treatment for Mental Health and Substance Use Disorders (generally follows an inpatient stay). Visit limits will not apply to medically necessary treatment of mental health or substance use disorder.



### ~~Services Not Requiring Precertification (Prior Authorization)~~

Prior authorization is not required for ~~medically necessary~~ emergency services when a medical condition that manifests itself by symptoms of such severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the participant;
- Serious jeopardy to the health of an unborn child;
- Serious impairment of a bodily function; or
- Serious dysfunction of any bodily organ or part.

The ~~UM company~~ TPA must be notified of an emergency hospital admission within one business day so the UM company can conduct a *concurrent review*. ~~Your~~ The physician or the hospital should call the UM company to initiate the concurrent review. Even though a ~~precertification~~ prior authorization may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding UM, such as concurrent review.

Formatted: Indent: Left: 0.5", No bullets or

Formatted: Right: 0.5", Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri)

Formatted: No bullets or numbering

Formatted: Indent: Left: 1", Space After: 0 pt, No bullets or numbering



*How to Request ~~Precertification~~ (Prior Authorization)*

~~It is your responsibility to ensure that precertification occurs when it is required by the Plan. Any penalty or denial of benefits for failure to obtain precertification is your responsibility, not the provider's. Your~~ The physician must ~~call~~ contact the UM company ~~at the telephone number shown in the Participant Contact Guide~~ to request ~~precertification~~ prior authorization. Calls for elective services should be made at least 15 calendar days before the expected date of service or may be subject to the benefit reduction listed in the *Utilization Management* section. The UM company will require the following information:

- The employer's name;
- Employee's name;
- Patient's name, address, phone number and Social Security Number or PEBP unique ID;
- Physician's name, phone number or address;
- The name of any hospital or outpatient facility or any other provider that will be providing services;
- The reason for the health care services or supplies; and
- The proposed date for performing the services or providing the supplies.

The UM company will review the information and provide a determination to ~~you~~ the participant, ~~your~~ the physician, the hospital or other provider, and the ~~third-party claims administrator~~ TPA as to whether the proposed health care services have been determined to be medically necessary. Additionally, the UM company may approve medical necessity but not site of care. In these circumstances, the UM company will provide approved alternate locations to the caller. While industry and accreditation standards require a preauthorization determination within 15 calendar days for a non-urgent case, the UM company will usually respond to ~~you~~ the physician or other provider by telephone within (5) five business days of receipt of the request. The determination will then be confirmed in writing.

~~If the hospital admission or medical service is determined not to be medically necessary, the participant and/or the physician will be given recommendations for alternative treatment.~~

Formatted: Font: 12 pt

~~Participants are responsible for ensuring prior authorization is obtained.~~

Formatted: Font: 12 pt

~~If your hospital admission or medical service is determined not to be medically necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal (refer to the *Appealing a Utilization Management Determination* section).~~

Centers of Excellence Benefit (Voluntary)

Formatted: Space After: 0 pt

~~A center of excellence is a team, facility, or entity that provides leadership, research, best practices, support, and training for a specific area. Centers of excellence can identify resources that can be shared amount groups, increasing efficiency, consistency, and improvement.~~

Formatted: Default Paragraph Font

Formatted: Normal

Formatted: Font: (Default) +Body (Calibri), 12 pt, Font color: Auto

Formatted: Font: 12 pt

Formatted: Default Paragraph Font

Formatted: Normal

## Utilization Management

Participants in the CDHP have access to the Centers of Excellence Benefit, which is a special surgery benefit that provides access to Centers of Excellence and concierge services. Through the Centers of Excellence Benefit, participants have access to specialized providers and facilities selected for their expertise in selected procedures, as well as assistance with travel, communication, and other non-medical matters relating to those procedures.

Currently, participants may use the Centers of Excellence Benefit for procedures such as:

- Total, partial, and revision hip and knee replacement surgery
- Spinal fusion surgery
- Bariatric (weight loss) surgery
- Other orthopedic and spine procedures (e.g., hand, wrist, elbow, shoulder, ankle, foot)
- Cardiac (heart) surgery
- Oncology

~~This benefit generally pays all eligible expenses after the CDHP participant satisfies the applicable deductible.~~ For details of how this benefit works, covered expenses, and limitations and disclosures, please see the Centers of Excellence Wrap Plan Document online at <https://pebp.nv.gov/>.

The vendor currently coordinating the Centers of Excellence Benefit, Carrum Health, will determine if a member is eligible to participate in the benefit, and this determination is separate from the Utilization Management process described elsewhere. If ~~you~~ participants would like to use the Center of Excellence Benefit, please contact Carrum Health.

### Second Opinion

~~Second Opinion is a consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving medical service.~~

The ~~utilization management~~UM company may authorize a second opinion upon ~~your~~ request in accordance with this Plan. Examples of instances where a second opinion may be ~~appropriate~~ applicable include:

- ~~Your~~A physician has recommended a procedure ~~and you are~~that a participant is unsure whether the procedure is necessary or reasonable;
- ~~You have~~A participant has questions about a diagnosis or plan or care for a condition that threatens substantial impairment or loss of life or bodily functions;
- ~~You are~~A participant is unclear about the clinical indications about ~~you~~their condition;
- A diagnosis is in doubt due to conflicting test results;
- ~~You~~A physician is unable to diagnose ~~you~~a condition; and
- A ~~current~~ treatment plan ~~in progress~~ is not improving ~~you~~a participant's medical condition within a reasonable period.

Formatted: Space After: 0 pt

Formatted: Normal

Formatted: Font: 12 pt

Formatted: Normal

## Utilization Management

A participating provider, including ~~your~~ primary care physician, may notify the UM company on ~~your behalf~~ to obtain ~~precertification~~prior authorization (prior authorization) for the services described in Services Requiring ~~Precertification~~Prior authorization (Prior Authorization).

### *2nd.MD*

2nd.MD is PEBP's preferred second opinion Service. ~~See benefits in the Schedule of Benefits, below, for additional information.~~

### Non-Emergency Hospital Admission

~~You are responsible for ensuring the UM company is notified at least 5 (five) business days before an inpatient admission to obtain pre-certification. —~~Prior authorization is required for all non-emergency hospital admissions due to elective surgeries.

~~Your~~The physician or ~~other~~ provider ~~may shall~~ notify the UM company a minimum of 5 business days before the hospital admission, but it is ultimately your responsibility to make sure they are notified. The UM company will review the physician/provider's recommendation and treatment plan to determine the level of care and place of service.

If the UM company denies the ~~precertification~~prior authorization for hospital admission as not covered or determines that the services do not meet the UM company's medical necessity criteria, the Plan's ~~third party administrator~~TPA will only pay benefits for inpatient that has been pre-certified, ~~and/or~~.

~~You are required to obtain a precertification before you obtain services for inpatient elective surgeries. If you do not follow the required UM process,~~ benefits for the elective surgeries and inpatient hospital stays may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network surgery expenses. Expenses related to the penalty will not be counted to meet ~~you~~the Out-of-Pocket Maximum, if applicable.

Formatted: Font: (Default) +Body (Calibri)

Formatted: Default

Participants are responsible for ensuring prior authorization is obtained.

Formatted: Space After: 0 pt

### *Emergency and Urgent Hospital Admission*

Emergency and Urgent Hospital Admissions include complications of pregnancy.

Participants are not required to obtain prior authorization before receiving emergency care. However, the UM company must still be notified within 24 hours, the next business day, or as soon as reasonable after admission so the UM company can conduct a concurrent review. A family member, friend, or hospital staff may notify the UM company on a participant's behalf, if they are unable to.

Formatted: Justified

Even though prior authorization may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding utilization management, such as concurrent review.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

~~Failure to notify the UM Company may result in reduced benefits. This provision applies to both In-Network and Out-of-Network providers. Expenses related to the penalty will not be counted to meet the Out-of-Pocket Maximum.~~

Formatted: Font: 12 pt

~~The UM company may determine whether it is suitable to transfer a participant to an In-Network hospital as soon as it is medically necessary to do so. If a participant chooses to stay in the Out-of-Network hospital after the date the UM company decides a transfer is medically necessary, the Plan will pay allowable medical expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge.~~

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

~~You are not required to obtain a precertification before you obtain services for a medical emergency. However, the UM company must still be notified within 24 hours, the next business day, or as soon as reasonable after admission so the UM company can conduct a concurrent review. If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times, they must receive notification as soon as reasonably possible after the admission or you may be subject to reduction or denial of benefits as provided by the Plan.~~

- ~~• Emergency Hospital Admission: Admission for hospital confinement that results from a sudden and unexpected onset of a condition that requires medical or surgical care. In the absence of such care, you could reasonably be expected to suffer serious bodily injury or death. Examples of emergency hospital admission include, but are not limited to, admissions for heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal injuries, and other acute conditions.~~
- ~~• An urgent hospital admission means an admission for a medical condition resulting from injury or serious illness that is less severe than an emergency hospital admission but requires care within a short time, including complications of pregnancy.~~

~~Even though a precertification may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding utilization management, such as concurrent review.~~

~~If you do not Failure to follow the required UM process, benefits payable for the services may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network medical expenses. Expenses related to the penalty will not be counted to meet the Out-of-Pocket Maximum.~~

#### No Surprises Act:

~~A federal law that shields people from paying unexpected medical bills when participants accidentally or unknowingly get treatment from an out-of-network provider. The No Surprises Act bans surprise billing in a few situations, including receiving emergency services at an out-of-network facility and receiving non-emergency services at an in-network hospital, but with an out-of-network provider. Confinement in an Out-of-Network Hospital Following an Emergency Admission. **No Surprises Act** means the federal No Surprises Act (Public Law 116-260, Division BB).~~

This is also referred to as balance billing. Balance billing is the difference between what a medical provider charges for a treatment or service, and what a health insurance plan covers.

Formatted: Font: 12 pt

~~Please refer to the No Surprises Act section of this document for claims subject to that Act. For all other confinements, if you are confined in an Out-of-Network hospital after you receive emergency services, the UM company must be notified within 24 hours, the next business day, or as soon as reasonable after admission. The UM company may determine it is appropriate to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the UM company decides a transfer is medically appropriate, the Plan will pay Eligible Medical Expenses at the Out-of-Network benefit level, subject to the Plan's Maximum Allowable Charge if the continued stay is authorized by the UM company and determined to be a covered service.~~

Formatted: Normal

#### Other Exceptions

If ~~you~~ participants receive ancillary services such as an x-ray, laboratory services, or anesthesia services from an Out-of-Network provider while receiving services at an In-Network inpatient or outpatient facility (such as an outpatient surgery center), the Plan will cover the Eligible Medical Expenses at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge.

#### Elective Knee and Hip Joint Replacement – Nevada Exclusive Hospitals and Outpatient Surgery Centers

~~P~~recertification Prior authorization is required; the UM company will review the request based on surgery type, medical necessity, covered benefits, provider quality, cost, and provider location.

Due to cost variations for elective knee and hip joint replacement performed in Nevada, the third-party claims administrator has identified exclusive providers who meet the Plan's cost threshold for routine knee and hip replacement procedures. The exclusive provider list can be found on the PEBP website.

If ~~you~~ participants choose a provider on the exclusive list, ~~you~~ participants will potentially reduce ~~you~~ the out-of-pocket costs in accordance with the standard plan benefits.

However, if ~~you~~ participants choose to use a non-exclusive provider, the Plan will pay benefits in accordance with its cost threshold or Maximum Allowable Charge. ~~You~~ Participants may be subject to balance billing for any amount exceeding this Plan's cost threshold. Amounts exceeding the Plan's established threshold will not apply to ~~you~~ the ~~r~~-Deductible (if applicable) or Out-of-Pocket Maximum.

### Inpatient or Outpatient Surgery

~~You~~[Participants](#) are responsible for ensuring that the UM company is notified at least 5 (five) business days before elective inpatient or outpatient surgery is performed to ensure that it is covered.

~~You~~[A](#) physician or other provider may notify the UM company, but it is ~~you~~[participants](#) responsibility to make sure they are notified. The UM company will review the physician's recommended course of treatment to ensure the requested treatment meets established medical necessity criteria and protocols.

The claims administrator will only pay benefits for inpatient or outpatient surgery that is pre-certified, and the services/supplies are a covered benefit.

### Outpatient Infusion Services

~~Precertification~~[Prior authorization](#) is required for outpatient infusion services. The UM company will review the request based on covered benefits, medical necessity, provider quality, cost, and location. If ~~you~~[participants](#) choose to receive ~~your~~ infusion at a non-exclusive hospital or infusion center, ~~you~~[participants](#) will be responsible for any amount that exceeds this Plan's Maximum Allowable Charge. Amounts exceeding this Plan's established cost threshold will not apply to ~~you~~[their](#) annual Deductible or Out-of-Pocket Maximum.

### Air Ambulance Services

This Plan provides coverage for emergency air ambulance and inter-facility patient air transport if there is a life-threatening situation, or the service is deemed medically necessary by the UM company. The air ambulance services are subject to cost-share (Deductible, Copay, or Coinsurance) if applicable.

See the Utilization Management section for air ambulance ~~precertification~~[prior authorization](#) requirements.

### *Air/Flight Schedule Inter-Facility Transfer*

All inter-facility transport services require ~~precertification~~[prior authorization](#). The UM company may discuss with the physician and/or hospital/facility the diagnosis and the need for inter-facility patient transport versus alternatives. Failure to obtain ~~a~~[precertification](#)[prior authorization](#) may result in a reduction or denial of benefits for charges arising from or related to flight-based inter-facility transfers. Non-compliance penalties imposed for failure to obtain a ~~precertification~~[prior authorization](#) will not be included as part of the annual out-of-pocket maximum.

Inter-facility transport may occur if there is a life-threatening situation, or if the transport is deemed medically necessary. The following conditions apply:

- Services via any form of air/flight for inter-facility transfers must be pre-certified before transport of the participant to another hospital or facility, and the

participant is in a hospital or other health care facility under the care or supervision of a licensed health care provider; and

- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

*Emergency Air Ambulance*

This Plan provides coverage for emergency air ambulance transportation for participants whose medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness/injury. Air ambulance transportation must meet the following criteria:

- Services via any form of air/flight for emergency air ambulance; and
- The patient's destination is an acute care hospital; and
- The patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health; or
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

See *Ambulance* section for details on plan benefits and coverage.

Gender Dysphoria

The Plan provides benefits for treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders.

The participant or their physician should contact the UM company to begin the process toward surgical intervention to treat gender dysphoria.

This service is provided by the UM company and will be initiated upon the first call for prior authorization.

Case management services are available for gender dysphoria.

~~The Plan provides benefits for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders.~~

~~The participant or their physician must contact the UM company to begin the process toward surgical intervention to treat gender dysphoria. The initial contact will include:~~

- ~~Notification to the participant that the precertification process begins with the initial contact to the UM company.~~

Formatted: Space After: 0 pt  
Formatted: Normal  
Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

- ~~• Advising participants of providers who specialize in this type of treatment.~~

~~This service is provided by the UM company and will be initiated upon the first call for a precertification. Case management services are particularly helpful for a participant or their covered dependent who is receiving complex medical services for medical conditions such as gender dysphoria. Your assigned case manager nurse will provide you with assistance addressing any concerns you may have about issues such as continuity of care or finding providers or a provider who specializes in gender dysphoria.~~

#### Health Care Services and Supplies Review

~~A participating provider, including a primary care physician, may notify the UM company to obtain prior authorization (prior authorization) for the services and supplies.~~

~~The Plan will pay for covered health care services and supplies only if authorized as outlined above. The Plan does not cover any health care services or supplies that do not meet medically necessary criteria and protocols.~~

~~A participating provider, including your primary care physician, may notify the UM company on your behalf to obtain precertification (prior authorization) for the services described in *Services Requiring Precertification (Prior Authorization)*.~~

~~Non-participating providers may not know the UM company to obtain precertification for services. In such a case, you must confirm that the UM company pre-certified the service to assure that it is covered.~~

~~The Plan will pay for covered health care services and supplies only if authorized as outlined above. The Plan will not pay for any health care services or supplies that are not covered services or do not meet medically necessary criteria and protocols.~~

#### Failure to Follow Required UM Procedures

~~If you do not follow the required precertification review process described in this section, benefits payable for the services you failed to receive a precertification may be reduced by 50% of the Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network *Eligible Medical Expenses*. Expenses related to the penalty will not apply to your Plan Year Deductible or Out-of-Pocket Maximum. If you wish to appeal a decision made by the UM company, refer to the *Appealing a UM Determination* section.~~



## Schedule of Benefits

To determine the benefit limitations for any health care service or supply, review the Summary of Benefits listed in this section.

Formatted: Font: 12 pt

Formatted: Normal, Justified, Space After: 12 pt

Formatted: Font: (Default) Calibri, 12 pt

~~The Schedule of Benefits provides a description of benefits, including certain limitations under this Plan.~~ Covered services must be medically necessary and are subject to exclusions and limitations as described herein. ~~Precertification~~Prior authorization is required for many services. Plan benefit limitations apply to certain benefit categories and out-of-network charges are not covered unless otherwise specified in this document.

~~When the Plan Administrator determines that two or more courses of treatment are substantially equivalent, the Plan Administrator reserves the right to substitute less costly services or benefits for those that this Plan would otherwise cover.~~

*~~Example: If both inpatient care in a skilled nursing facility and intermittent, part-time nursing care in the home would be medically appropriate, and if inpatient nursing care would be less costly, this Plan could limit coverage to the inpatient care. This Plan could limit coverage to inpatient care even if this means extending the inpatient benefit beyond the quantity provided in the Schedule of Benefits.~~*

~~The fact that a participating provider prescribed, ordered, recommended, or approved a service, treatment, or supply does not necessarily make it a covered service or medically necessary.~~

The Schedule Summary of Benefits should be read in conjunction with the Benefit Limitations and Exclusions and Key Definitions Terms and Definitions. The Explanations and Limitations may not include every limitation. For more information relating to a specific benefit, refer to Utilization Management (for any precertificationprior authorization requirements), Exclusions, Key Terms and Definitions and other sections that may apply to a specific benefit.

All claims must be submitted within twelve (12) months of the date of service to be considered for payment.

~~The following services are covered services when provided by a professional.~~

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Acupuncture and Acupressure	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p><b>Explanations and Limitations</b> Acupuncture and Acupressure</p> <p><a href="#">A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.</a></p> <ul style="list-style-type: none"> <li>Covered if performed by a licensed provider acting within the scope of their license. <a href="#">Where licensing is not required, must be certified by the National Certification Commission for Acupuncturists (NCCA).</a></li> <li>Supporting documentation establishing medical necessity will be required after 20 visits in a Plan Year.</li> <li>Maintenance services are not a covered benefit.</li> </ul>		
Allergy Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible, or 110% of the Medi-Span Average Wholesale Price (AWP) after Plan Year Deductible
<p><b>Explanations and Limitations</b> Allergy Services</p> <ul style="list-style-type: none"> <li><a href="#">Covered when performed by a licensed provider acting within the scope of their license.</a></li> <li><del>Allergy services are covered only when ordered by a physician.</del></li> <li>Allergy <a href="#">services include</a> -sensitivity testing (<del>including skin patch or blood tests such as Rast or Mast</del>); Desensitization and hypo-sensitization, <a href="#">allergy antigen solution, and allergy shots.</a> (<del>allergy shots given at periodic intervals</del>); <del>Allergy antigen solution.</del></li> </ul>		
Benefit Description	In-Network	Out-of-Network
Ambulance		
<b>Ground Ambulance</b>	Plan pays 80% after Plan Year Deductible	Play pays 80% of Maximum Allowable Charge after Plan

Formatted: Justified

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Ambulance		
Air Ambulance	Plan pays 80% after Deductible	Year Deductible Plan pays 80%, subject to the No Surprises Act.

**Explanations and Limitations**  
Ground and Air Ambulance Services

Formatted: Font: 12 pt

Ground Ambulance Services: A ground ambulance is a vehicle or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Formatted: Font: 12 pt

Formatted Table

Air Ambulance Services: An air ambulance A medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

~~In the event of a life-threatening emergency in which a participant uses a ground ambulance, the deductibleDeductibles, coinsurance, and accrual of the Out of Pocket Maximum are the same for In-Network and Out-of-Network providers. However, benefits for Out-of-Network providers are subject to the Plan's Maximum Allowable Charge, which is 140% of the Medicare Allowable rate. Because Out-of-Network providers do not have a contract with this Plan's provider network, they may bill the member for any amount exceeding the benefits paid.~~

Formatted: Font: 12 pt

Formatted: Font: 12 pt

For example, if ~~youparticipants~~ have already met ~~youther~~ deductible for the plan year, ~~youparticipants~~ use a ground ambulance during an emergency, the out-of-network provider bills \$2,000 for the ride but the Medicare Allowable rate for that ambulance ride is \$1,000:

Formatted: Font: 12 pt

Formatted: Font: 12 pt

The Out-of-Network Ground Ambulance Provider Bills	\$2,000
The Plan Pays 80% of \$1,000 × 140%	\$1,120

The Out-of-Network Provider May Bill ~~YouParticipants~~ For \$ 880

Formatted: Font: 12 pt

These amounts are for illustrative purposes only; the difference between what an out-of-network Provider bills for a ground ambulance ride and the Medicare Allowable rate for that ride varies. Please direct questions about any balance billed by the Provider to the Provider.

~~Covered services: Air Ambulance Services: In the event of a life-threatening emergency in which a participant uses an Out-of-Network provider, benefits will be paid at the In-Network benefit level. Out-of-Network providers may not balance bill the member.~~

Formatted: Font: 12 pt, Underline

Formatted: Font: 12 pt, Not Bold

- ~~Life threatening emergency by or in conjunction with first responders. Does not require prior authorization. This includes an accident which is an unforeseen event that is not work related, resulting from an external or extrinsic source.~~

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Ambulance		
<p><del>Transfer to another facility if deemed necessary. Requires prior authorization. Transportation by a professional ground ambulance to a local hospital or transfer to the nearest facility having the capability to treat the condition.</del></p> <p><del>Air Ambulance (fixed wing/rotary) Inter Facility Transfer</del></p> <ul style="list-style-type: none"> <li><del>Inter facility patient air transport, for participants if there is a life threatening situation or it is deemed to be medically necessary.</del></li> <li><del>Air ambulance for scheduled inter facility transfers must be prior authorized before transport via any form of flight (fixed wing/rotary) to another hospital or facility.</del></li> <li><del>Failure to obtain a precertification may, at the discretion of the Plan Administrator or its designee, result in a reduction or denial of benefits for charges arising from or related to inter facility patient transport via any form of flight.</del></li> <li><del>Non-compliance penalties imposed for failure to obtain precertification will not apply to the Plan Year Deductible or Out-of-Pocket Maximum.</del></li> </ul> <p>o As part of the <del>precertification</del><u>prior authorization</u> review, the Plan Administrator retains the discretionary authority to limit benefit availability to alternative providers of flight-based inter-facility patient transport if a provider fails to comply with the terms of the Plan, or the proposed charges exceed the maximum allowable charge in accordance with the terms of this Plan.</p>		
<p><del>Air Ambulance (fixed wing/rotary) Emergency</del></p> <ul style="list-style-type: none"> <li><del>Includes coverage for e</del>Emergency air ambulance transportation when a medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness/injury.</li> <li><del>Emergency air ambulance services must meet the following criteria:</del> <ul style="list-style-type: none"> <li>o The patient's destination is an acute care hospital, and</li> <li>o The Patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health, or</li> <li>o Inaccessibility to ground transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.</li> </ul> </li> <li>The Plan Administrator retains <del>the discretionary</del><u>discretionary</u> authority to limit benefit availability for air emergency ambulance and/or inter-facility patient transfer when a provider fails to comply with the terms of this Plan, except where provided by the No Surprises Act.</li> </ul>		
<p><del>See the Utilization Management section for air ambulance precertification requirements.</del></p>		

Formatted: Font: 12 pt, Not Bold

Formatted: List Paragraph, Space Before: 6 pt, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at:

Formatted: List Paragraph, Left, Right: 0", Space Before: 0 pt

Formatted: Left, Indent: Left: 0.5", Right: 0", No bullets or numbering

Formatted: Font: 10.5 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Indent: Left: 0.35", No bullets or numbering

Formatted: Font: 12 pt

Formatted: Font: 12 pt, Highlight

Formatted: Font: 12 pt

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Autism Spectrum Disorders Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p align="center"><b>Explanations and Limitations</b> Autism Spectrum Disorders Services</p> <p><u>Autism Spectrum Disorder is a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the <i>Diagnostic and Statistical Manual of Mental Disorders</i> published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined.</u></p> <ul style="list-style-type: none"> <li><u>The Plan covers screening for and diagnosis of autism spectrum disorders and treatment of autism spectrum disorders for <del>covered individuals</del> individuals under the age of 18, or if enrolled in high school, until they reach age 22.</u></li> <li><u>Subject to copayment, deductible, and coinsurance.</u></li> <li><u>Must have and follow a treatment plan.</u></li> </ul> <p>Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.</p>		

- Formatted: Font: +Body (Calibri)
- Formatted: Justified
- Formatted: Space After: 0 pt, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
- Formatted: Space After: 0 pt
- Formatted: paragraph, Right: 0.09", Space After: 12 pt, Font Alignment: Baseline

<u>Benefit Description</u>	<u>In-Network</u>	<u>Out-of-Network</u>
<u>Applied Behavior Analysis</u>	<u>Plan pays 80% after Plan Year Deductible</u>	<u>Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible</u>
<p align="center"><u><b>Explanations and Limitations</b></u> <u>Applied Behavior Analysis (ABA)</u></p> <p><u>ABA is any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or registered behavior technician.</u></p> <ul style="list-style-type: none"> <li><u>Subject to copayment, deductible, and coinsurance.</u></li> <li><u>Must have and follow a treatment plan.</u></li> <li><u>Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.</u></li> </ul>		
Benefit Description	In-Network	Out-of-Network

- Formatted: Space After: 0 pt, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
- Formatted: Font: 9 pt
- Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
- Formatted: Space After: 0 pt, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Schedule of Benefits

<u>Benefit Description</u>	<u>In-Network</u>	<u>Out-of-Network</u>
<u>Applied Behavior Analysis</u>	<u>Plan pays 80% after Plan Year Deductible</u>	<u>Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible</u>
<p><u>Explanations and Limitations</u>  <u>Applied Behavior Analysis (ABA)</u></p> <p><u>ABA is any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or registered behavior technician.</u></p>		
Bariatric/Weight Loss Surgery	Plan pays 80% after Plan Year Deductible	Not Covered
<p><b>Explanation and Limitations</b>                      Bariatric/Weight Loss Surgery</p> <p>Bariatric weight loss surgery benefits, pre-and post-surgery, are available only when performed at an In-Network Bariatric Surgery Center of Excellence facility <u>which is a provider that has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP-),</u> by an In-Network surgeon and ancillary providers.</p> <p><del>The third-party claims administrator will determine the In-Network Bariatric Surgery Center of Excellence facility. It is the participant’s responsibility to ensure that bariatric surgery services providers are In-Network and facilities chosen to provide services are In-Network. Participants <u>can may</u> verify the network status of any provider, including a facility, by calling the <u>third party claims administrator TPA.</u> <u>For more information regarding Bariatric Surgery Centers of Excellence, see the Key Terms and Definitions.</u></del></p> <p>Participants are limited to one obesity related surgical procedure of any type in an individual’s lifetime while covered under any PEBP-sponsored self-funded plan. <del>For example, a participant cannot have lap band surgery on a PEBP-sponsored self-funded plan and then subsequently seek benefits for gastric bypass on this Plan.</del></p> <p>▲</p> <p>If a participant has started any type of program to meet the pre-surgery criteria outlined below with an Out-of-Network provider (including a facility), those services will not meet the Plan’s mandatory <del>precertification</del><u>prior authorization</u> requirements. For the Plan to consider <del>your</del> bariatric surgery at the In-Network benefit level; <del>you</del><u>participants</u> will have to begin the <del>precertification</del><u>pre-certification</u> process again with the <del>appropriate</del><u>proper</u> In-Network providers.</p>		

Formatted: Font: 12 pt

Formatted: Font: +Body (Calibri)

Formatted: Font: 11.5 pt

Schedule of Benefits

<u>Benefit Description</u>	<u>In-Network</u>	<u>Out-of-Network</u>
<u>Applied Behavior Analysis</u>	<u>Plan pays 80% after Plan Year Deductible</u>	<u>Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible</u>

Explanations and Limitations  
Applied Behavior Analysis (ABA)

ABA is any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or registered behavior technician.

Lap band adjustments are covered for up to 12 months following surgery. The participants must be compliant with their post-surgical plan as verified by the UM company.

Lap band adjustments after 12 months require review by the UM company and prior authorization.

For lap band adjustments, the Plan will consider any adjustments made in the immediate 12 months following surgery if the participant remains compliant with their post-surgical support group meetings as verified by the UM company. Any adjustments to the lap band after the first 12 months post-surgery will be subject to precertification.

**Clinical criteria for weight loss surgeries is managed by the UM Company.**

Travel Expenses:

This Plan provides reimbursement of certain costs associated with travel and lodging accommodations for the member and one additional person (spouse/domestic partner, family member or friend) when associated with bariatric/weight loss surgery and performed at a Center of Excellence that is located 50 or more miles from the member's residence. For travel expense benefits, refer to the *Travel Expenses* benefit section.

Expenses incurred for travel and lodging accommodations for bariatric/weight loss surgery not performed at a Center of Excellence are not covered.

Formatted: paragraph, Indent: Left: 0", Right: 0.09", Font Alignment: Baseline

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<i>Behavioral Health Services</i> Mental Health and Substance Abuse	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

**Explanations and Limitations**  
Behavioral Health Services

A behavioral health condition is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause.

A behavioral health practitioner is a psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a master's degree, or other provider who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Services, including room and board, given by a behavioral health treatment facility or area of a hospital that provides behavioral or mental health or substance abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the illness that is identified under the DSM code is considered a behavioral health treatment for the purposes of this Plan.

Behavioral health services payable by this Plan include:

- Inpatient admission: Treatment in a hospital or mental health facility for intensive mental health care. Requires prior authorization.
- Partial hospitalization: This is an alternative to inpatient care. It is a structured outpatient program that provides intensive psychiatric care. Requires prior authorization.
- Intensive outpatient program: A structured treatment program for mental health and substance use disorders. Requires prior authorization.
- Psychological testing: A standard way to measure a person's mental and behavioral characteristics. Testing is used for diagnosis and developing treatment plans. May require prior authorization.
- Detoxification: Set interventions to manage acute intoxication and withdrawal. Requires prior authorization.

Formatted: Font: (Default) Calibri, 12 pt

Formatted: Font: Not Bold

Formatted: Font: Font color: Black

Formatted: Font: 11.5 pt

Formatted: Default, Space After: 12 pt, Don't add space between paragraphs of the same style



Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<p><i>Behavioral Health Services</i></p> <p>Mental Health and Substance Abuse</p>	<p>Plan pays 80% after Plan Year Deductible</p>	<p>Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible</p>
<p style="text-align: center;"><b>Explanations and Limitations</b></p> <p style="text-align: center;">Behavioral Health Services</p> <p><del>Precertification is required for inpatient admissions, including residential treatment facilities, outpatient partial hospitalization programs, and partial residential treatment programs.</del></p> <p><del>Services and supplies for treatment of alcoholism, chemical dependency or drug addiction are covered. Care must be provided by licensed/credentialed providers—such as hospitals or residential treatment programs for inpatient care, and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care.</del></p> <p><del>Behavioral health services payable by this Plan include:</del></p> <ul style="list-style-type: none"> <li><del>• Outpatient visits</del></li> <li><del>• Acute inpatient admission</del></li> <li><del>• Partial day treatment</del></li> <li><del>• Partial hospitalization</del></li> <li><del>• Intensive outpatient program</del></li> <li><del>• Day treatment</del></li> <li><del>• Psychological testing</del></li> <li><del>• Detoxification</del></li> </ul> <p><del>The following behavioral health practitioners are payable under the Plan: psychiatrist (MD or DO), psychologist (Ph.D.), Masters’ prepared counselors (e.g., MSW), licensed associate in social work, social worker, independent social worker, or clinical social worker, as well as any licensed provider providing covered services and acting within the scope of their license.</del></p> <p>The Plan provides benefits for intermediate levels of care for behavioral health disorders and/or chemical dependency disorders in parity with medical or surgical care of the same level. If the Plan provides benefits for a skilled nursing facility for medical or surgical treatment, the Plan will provide equal behavioral health disorder and/or chemical dependency disorder benefits for intensive outpatient therapy, partial hospitalization, residential treatment, <u>and</u> inpatient treatment.</p> <p><del>The provider must be licensed or approved by the state in which the services are provided. Care must be provided by licensed, eligible providers—such as hospitals or residential treatment programs for inpatient care and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care. Precertification is required for inpatient and outpatient care in a facility.</del></p> <p>Outpatient prescription drugs for behavioral health are payable under the prescription drug benefits. <del>For information regarding precertification requirements, benefits, and exclusions, refer to the Utilization Management, Key Terms and Definitions, and Exclusions sections.</del> <u>Mental health office visits</u></p>		

**Formatted:** Default, Space After: 12 pt, Don't add space between paragraphs of the same style

**Formatted:** Space After: 0 pt

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<i>Behavioral Health Services</i> Mental Health and Substance Abuse	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p align="center"><b>Explanations and Limitations</b> Behavioral Health Services</p> <p><u>are not covered under this benefit. They do not require prior authorization, there are no limitations, and they have the same copay requirement as a primary care physician.</u></p>		

Benefit Description	In-Network	Out-of-Network
Blood <u>Transfusions Services for Surgery</u>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p align="center"><b>Explanations and Limitations</b> Blood Transfusions</p> <p><u>A blood transfusion is the use of donated blood for the purposes of surgeries, injuries, diseases, or bleeding disorders.</u></p> <p><u>Services include blood products, blood transfusions, and equipment for its administration. Includes autologous blood donations.</u></p> <p><u>Services must be ordered by a physician and may be administered as a component of, or during surgery, or in a free-standing facility. Prior authorization may be required in certain circumstances.</u></p> <ul style="list-style-type: none"> <li><u>Blood transfusions, blood products and equipment for its administration.</u></li> <li><u>Services are covered only when ordered by a physician.</u></li> <li><u>Expenses related to autologous blood donation (patient's own blood) are covered.</u></li> </ul>		

Formatted: Justified, Indent: Left: 0"

Formatted: Left

Formatted: No bullets or numbering

Benefit Description	In-Network	Out-of-Network
Chemotherapy	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge or 110% of the Medi Span AWP, after Plan Year Deductible
<p align="center"><b>Explanations and Limitations</b> Chemotherapy</p> <p><u>Chemotherapy is the treatment of a disease or cancer by the use of chemical substances.</u></p>		

Formatted Table

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Normal, Left, Indent: Left: 0"

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<p><del>Services include c</del>Chemotherapy drugs and supplies administered under the direction of a physician in a hospital, health care facility, physician’s office or at home. <u>Must be prior authorized. Covered when ordered by a physician; chemotherapy must be pre-certified by the UM company.</u></p> <p><u>Outpatient prescription drugs for chemotherapy are payable under the prescription drug benefits.</u></p> <ul style="list-style-type: none"> <li><del>See prescription benefits for orally administered chemotherapy drugs:</del></li> <li><del>Patients</del><u>Participants</u> undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year (excluding sales tax).</li> </ul>		
<p>Chiropractic Services</p> <p>Office visit and spinal manipulation services</p>	<p>Plan pays 80% after Plan Year Deductible</p>	<p>Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible</p>
<p style="text-align: center;"><b>Explanations and Limitations</b></p> <p style="text-align: center;">Chiropractic Services</p> <p><u>Chiropractic services must be medically necessary by meeting the following:</u></p> <ol style="list-style-type: none"> <li><u>1) participant has objective medical findings of a neuro-musculoskeletal disorder, and</u></li> <li><u>2) A treatment plan has been established including treatment and discharge goals.</u></li> </ol> <p><u>Services are covered if performed by a person who holds the degree of Doctor of Chiropractic (DC) and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal column (vertebrae); and who acts within the scope of his or her license.</u></p> <ul style="list-style-type: none"> <li><u>Services are limited to 20 visits per Plan Year.</u></li> <li><u>Maintenance services are not covered.</u></li> <li><u>Refer to Radiology Services for X-Rays and other types of testing.</u></li> <li><u>Outpatient prescription drugs for neuro-musculoskeletal disorders are payable under the prescription drug benefits.</u></li> </ul> <ul style="list-style-type: none"> <li><del>Services are covered if performed by a licensed provider acting within the scope of their license.</del></li> <li><del>Limited to a maximum of 20 visits per Plan Year.</del></li> <li><del>Maintenance services are not a covered benefit.</del></li> </ul> <p><del>X-rays performed in conjunction with chiropractic services are payable under the Radiology Services section of this Schedule of Benefits.</del></p>		

Formatted Table

Formatted: No bullets or numbering

Formatted: Font: 12 pt

Formatted: Normal, Left, Right: 0", No bullets or numbering, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

Formatted: Not Highlight

Formatted: Justified

Formatted: Font: +Body (Calibri)

Formatted: Font: +Body (Calibri)

Formatted: Font: +Body (Calibri)

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Justified, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Left, Indent: Left: 0"

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<a href="#">Clinical Trials/Experimental or Investigative Services</a>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b></p> <p style="text-align: center;"><a href="#">Clinical Trials/Experimental or Investigative Services</a></p> <p><a href="#">A clinical trial involves a test and one or more human subjects and is subject to the requirements of the Food and Drug Administration (FDA).</a></p> <p><a href="#">Experimental services refer to services, procedures, drugs, or equipment that is not considered standard medical care for a condition and have not been proven effective. A service, procedure, drug, or equipment may be approved for one condition but not another. General criteria for experimental or Investigative Services if at least one of the following is met.</a></p> <ul style="list-style-type: none"> <li><a href="#">• The intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or</a></li> <li><a href="#">• Available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or</a></li> <li><a href="#">• The intervention is not proven to be as safe or effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or</a></li> <li><a href="#">• The intervention does not improve health outcomes; or</a></li> <li><a href="#">• The intervention is not proven to be applicable outside the research setting.</a></li> </ul> <p><del><a href="#">A clinical trial is the process for testing new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases.</a></del></p> <p>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 <a href="#">NRS 695G.173</a>, and <a href="#">coverage for experimental or investigative services is set forth in NRS 695G.275.</a></p> <ul style="list-style-type: none"> <li><a href="#">• <u>Precertification must be obtained from the UM company</u>Prior authorization is required.</a></li> <li><a href="#">• <u>May require UM interventions.</u></a></li> </ul>		

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: +Body (Calibri)

Formatted: Justified

Formatted: Font: +Body (Calibri), Not Bold

Formatted: Font: +Body (Calibri)

Formatted: Font: +Body (Calibri), Not Bold

Formatted: Font: +Body (Calibri)

Formatted: Font: +Body (Calibri), Not Bold

Formatted: Font: +Body (Calibri)

Formatted: Font: +Body (Calibri), Not Bold

Formatted: Font: +Body (Calibri)

Formatted: Justified

Formatted: Font: (Default) Calibri, 12 pt

Formatted: Normal, Left, Right: 0", Line spacing: single, No bullets or numbering

Formatted: Font: Bold, Underline

Formatted: Font: Bold, Underline

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Corrective Appliances		
Prosthetic & Orthotic Devices, other than dental	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b></p> <p style="text-align: center;"><u>Prosthetic &amp; Orthotic Devices, other than dental</u></p> <p><u>The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or device) and Prosthetic Appliance (or device).</u></p> <ul style="list-style-type: none"> <li>• <u>Must be medical necessary and ordered by a physician.</u></li> <li>• <u>Glasses, contact lenses, hearing aids and durable medical equipment are referred to in other sections.</u></li> </ul> <p><del>• Coverage is provided for certain corrective appliances that are medically necessary and FDA approved. This Plan pays for the purchase of standard models at the option of the Plan. There is coverage for repair, adjustment, or servicing of the device or, replacement of the device due to a change in the covered person's physical condition that makes the original device no longer functional or if the device cannot be satisfactorily repaired.</del></p> <ul style="list-style-type: none"> <li><del>• Prosthetics such as limbs and ocular; orthotics such as casts, splints and other orthotic devices used in the reduction of fractures and dislocations; colostomy or ostomy (Orthotic) supplies, hearing aid* (with limitations, see Hearing Aids section).</del></li> <li><del>• Plan allows up to \$120 for one set of lenses (contacts or frame type) for the treatment of glaucoma or when required following cataract surgery. This includes soft lenses or sclera shells intended as corneal bandages for patients without the lens of the eye (aphakic).</del></li> </ul> <p><del>Corrective appliances are covered only when ordered by a physician or health care practitioner. Orthopedic shoes and foot orthotics are not a covered benefit unless the shoe or foot orthotic is permanently attached to a brace.</del></p> <p><del>*Hearing aids: To help determine what prosthetic or orthotic appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Key Terms and Definitions section.</del></p>		

Formatted: Font: 12 pt, Not Bold  
Formatted: Right: 0.31", Space Before: 0.3 pt

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: (Default) +Body (Calibri), 11.5 pt, Bold, Font color: Auto

Formatted: Left, Indent: Left: 0.5"


Formatted: No bullets or numbering

Formatted: Default, Left, Right: 0", Space After: 6 pt

Schedule of Benefits

Benefit Description	In-Network		Out-of-Network
<b>Diabetes Care Management Disease Program (DCM) (Enhanced Benefits)</b>			
Office Visits	Two office visits covered at 100% per Plan Year, not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<b>Laboratory Test</b> (must be performed using a free-standing non-hospital-based laboratory)	Two routine lab tests covered at 100% per Plan Year, not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
	Preferred Retail Network Retail 30-Day Supply	<b>Smart90 Retail or ESI Home Delivery</b> 90-Day Supply	
<b>Preferred Generic</b>	\$5 Copay	\$15 Copay	Not covered
<b>Preferred Brand</b>	\$25 Copay	\$75 Copay	Not covered
<b>Non-Preferred Brand</b>	100% copay		Not covered
<b>Diabetic Supplies</b> (test strips, insulin syringes, alcohol pads, and lancets)	<b>ESI Home Delivery Pharmacy:</b> 90-Day Supply \$50 Copay per supply item or the lessor of actual cost		Not covered
<b>Blood Glucose Monitor</b>	<b>ESI Home Delivery:</b> \$0 Copay (limited to one per Plan Year)		Not covered
<b>Explanations and Limitations</b>			
Diabetes Care Management Disease program (enhanced benefits)			
<p>The Diabetes Care Management (DCM) program is a voluntary opt-in disease management program that provides enhanced benefits to participants diagnosed with diabetes, and who are enrolled in and <del>actively engaged-meeting the goals of in</del> the program. Benefits provided under the DCM program are not subject to deductible if determined to be preventive under the ACA and IRS guidelines. To enroll:</p> <ul style="list-style-type: none"> <li>Obtain the DCM form by logging into the E-PEBP Portal at <a href="https://pebp.nv.gov/">https://pebp.nv.gov/</a>, or contact the third-party claims administrator to request the DCM enrollment form. Complete the required information and have <del>you a</del> physician sign the form. Send the form to the third-party claims' administrator for processing.</li> <li>The effective date of the DCM program will begin on the first day of the month following the third-party claims administrator's receipt and processing of the DCM enrollment request.</li> </ul>			

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Diabetes Care Management Disease Program (DCM) (Enhanced Benefits)		
<ul style="list-style-type: none"> <li>To continue receiving the DCM enhanced benefits, a new DCM form must be completed annually, at the start of, or prior to, the new plan year. This form must be signed by both <a href="#">you</a> <del>participants</del> and <del>your</del> physician and submitted to the third-party claims' administrator for processing.</li> </ul> <p>Enrolled DCM participants must comply with the following requirements to receive <del>the</del> <del>enhanced</del> <del>enhanced</del> benefits:</p> <ul style="list-style-type: none"> <li>Complete two office visits each Plan Year for a primary diagnosis of diabetes with <del>you</del> <del>a</del> primary care physician or endocrinologist.</li> <li>Comply with the diabetes <del>medications as</del> <del>medications</del> prescribed by <del>your</del> physician.</li> <li>Complete the <del>appropriate-necessary</del> laboratory testing as ordered by <del>your</del> physician.</li> <li>Must remain compliant with <del>your</del> physician's prescribed treatment plan in the Diabetes Care Management program.</li> </ul> <p>Enhanced In-Network benefits in the DCM Program include:</p> <ul style="list-style-type: none"> <li>Two physician office visits per Plan Year are paid at the 100% benefit level when billed with a primary diagnosis of diabetes (additional office visits are subject to deductible and coinsurance).</li> <li>Two routine laboratory hemoglobin (A1c) blood tests are paid at the 100% benefit level per Plan Year (additional lab services are subject to deductible and coinsurance).</li> <li>Diabetes-related medications, such as insulin and Metformin, are eligible for copayments listed in the DCM Pharmacy Benefits and not be subject to the Plan Year Deductible.</li> <li>One glucose monitor, per Plan Year at \$0 copayment available through the Pharmacy Benefit Manager.</li> <li>Diabetic supplies including test strips, lancets, insulin syringes and alcohol pads are eligible for purchase for the lessor of a \$50 copay per 90-day supply item, or the cost of the item, when coordinated through the Pharmacy Benefit Manager's Home Delivery program.</li> <li>Copayments for Tier 1 (Generic) and Tier 2 (Preferred Brand) drugs apply to the Plan Year Deductible and Out-of-Pocket Maximum.</li> <li>Copayments made while enrolled in the DCM program apply to the Plan Year Deductible and Out of Pocket Maximum.</li> </ul> <p> Laboratory services must be performed at an independent (non-hospital-based laboratory) to be covered by this Plan. Refer to the Laboratory Outpatient Services section in the Schedule of Benefits.</p> <p>Other limitations:</p> <ul style="list-style-type: none"> <li>Diabetes Medications: Preferred Retail Network Pharmacies, Smart90 Retail, and <del>Express</del> <del>Scripts</del> <del>the</del> Home Delivery Program requirements apply. Refer to the <i>Schedule of Prescription Drug Benefits</i> for coverage limitations, cost implications and details regarding these programs.</li> </ul>		

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<a href="#">Diabetes Care Management Disease Program (DCM) (Enhanced Benefits)</a>		
<ul style="list-style-type: none"> <li>Participants who are not enrolled or non-compliant in the DCM Program receive the standard CDHP benefits. The effective date of the return to the standard CDHP benefits will be the first day of the month following the non-compliance determination by the third-party claims administrator.</li> <li>Specialty medications are not eligible for enhanced benefits under this program and are subject to the standard CDHP benefits.</li> <li>This Plan does not coordinate prescription drug benefits.</li> <li>Medications purchased at Out-of-Network pharmacies are not covered under this Plan.</li> </ul>		
<i>Diabetes Education Services</i>	This Plan pays 80% after Plan Year Deductible	Not Covered
<p style="text-align: center;"><b>Explanations and Limitations</b> Diabetes Education Services</p> <ul style="list-style-type: none"> <li>Diabetes training and education services are payable when requested by a physician and are medically necessary for the self-care and self-management of a person with diabetes. Services must be provided by a certified diabetes educator or a health care practitioner. Included in this benefit is retraining due to new techniques for the treatment of diabetes or when there has been a significant change in the person's clinical condition or symptoms that <del>requires</del><a href="#">require</a> modification of self-management techniques.</li> <li>Some diabetic supplies are payable under the <i>Prescription Drug</i> section of this document. Please contact the prescription drug Plan Administrator for more information.</li> <li>This Plan pays enhanced benefits for participants enrolled <del>in and actively engaged in the Diabetes</del><a href="#">Diabetes</a> Care Management (DCM). For information regarding the DCM program and the enhanced benefits, refer to the Disease Management section and to the <i>Schedule of Benefits</i> for the Diabetes Care Management Program.</li> </ul>		

Benefit Description	In-Network	Out-of-Network
<i>Dialysis</i>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b> Dialysis</p> <p><a href="#">Dialysis is a treatment that replicates the kidney's functions and cleans waste from blood for individuals with kidney disease or failure.</a></p> <ul style="list-style-type: none"> <li>Hemodialysis or peritoneal dialysis and supplies.</li> <li>Covered when ordered by a physician and administered in a hospital, health care facility, and</li> </ul>		

Formatted: Normal, Left  
Formatted: Font: 12 pt



Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<p>physician's office or at home. Outpatient, inpatient or home dialysis must be prior authorized by PEBP's utilization management company.</p> <p>• See the <a href="#">Utilization Management information</a>.</p>		
Benefit Description	In-Network	Out-of-Network
Durable Medical Equipment (DME)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b> Durable Medical Equipment (DME)</p> <p><u>DME is equipment which can withstand repeated use, used for a medical purpose, used when someone is sick or injured, used at home, and expected to last at least three (3) years. Some items like wheelchairs may last a lifetime.</u></p> <ul style="list-style-type: none"> <li>• <u>Durable medical equipment includes (but is not limited to) apnea monitors, augmentation devices, blood glucose monitors, blood pressure monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.</u></li> <li>• <u>All DME must be medically necessary and ordered by a physician.</u></li> <li>• <u>Prior authorization is required when cost is expected to exceed \$1,000.</u></li> <li>• <u>Repair or maintenance of standard models at the option of the Plan to include equipment maintenance agreements. Repair, adjustment or servicing or medically necessary replacement of the DME due to a change in the covered person's physical condition, or if the equipment cannot be satisfactorily repaired.</u></li> <li>• <u>Certain DME may be rented, and rental of DME is subject to Medicare guidelines.</u></li> </ul> <p><del>• DME requires precertification by the UM company when the cost is expected to exceed \$1,000.</del></p> <p><del>• Rental of DME will be subject to Medicare guidelines concerning rental to purchase criteria.</del></p> <p><del>• Repair or maintenance of standard models at the option of the Plan to include equipment maintenance agreements.</del></p> <p><del>○ Repair, adjustment or servicing or medically necessary replacement of the DME due to a change in the covered person's physical condition, or if the equipment cannot be satisfactorily repaired.</del></p> <p><del>• DME, including but not limited to, insulin pumps, insulin supplies, oxygen, equipment, and supplies required for its administration, is covered only when its use is medically necessary, and it is ordered by a physician or health care practitioner.</del></p> <p>Certain blood glucose monitors are covered under this Plan. In-Network, the Plan pays 80% after the Plan Year Deductible.</p>		

Formatted: Indent: Left: 0.35", Space After: 0 pt, Don't add space between paragraphs of the same style

Formatted: No bullets or numbering

Formatted: Font: 12 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 11.5 pt

Formatted: List Paragraph, Space After: 0 pt, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Right: 0.1", Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Left

Formatted: No bullets or numbering

Formatted: No bullets or numbering

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<p>Participants enrolled <del>in and actively engaged</del> in the Diabetes Care Management Program are eligible to receive one glucose monitor each Plan Year at no cost in accordance with the DCM Program requirements, refer to the <i>Diabetes Care Management Disease Program</i> section.</p> <p><del>Rental to purchase following Medicare guidelines for certain lifelong DME. Examples of lifelong durable medical equipment include, but are not limited to, CPAP and BiPAP machines, and electric wheelchairs. Please check with PEBP's third party claims administrator or utilization management company for assistance. Contact the third party claims administrator for the purchase of certain DME such as breast pumps.</del></p> <p><del>See the Exclusions section related to corrective appliances and durable medical equipment. To help determine what durable medical equipment is covered, see the definition of "Durable Medical Equipment" in Key Terms and Definitions, below.</del></p>		

Formatted: Highlight

Benefit Description	In-Network	Out-of-Network
Emergent and Urgent Care Services		
<b>Emergency Room</b>	Plan pays 80% after Plan Year Deductible	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible
<b>Urgent Care Services</b>	Plan pays 80% after Plan Year Deductible	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible

**Explanations and Limitations**  
Emergent and Urgent Care Services

*Emergency Services*

**Emergency Services** means the following:

An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services ~~are covered~~ is defined as immediate medical attention for a medical or mental health condition.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that would result in any of the following: (1) placing the person's health (or, with respect to a pregnant person, the health of the pregnant person or unborn

Formatted: Heading 3, Subsection, Left, Space After: 0 pt

Formatted: Table - List Number, t1, Indent: Left: 0.25", Hanging: 0.25"

Formatted: Font: (Default) +Body (Calibri)

Formatted: Justified

Formatted: Font: +Body (Calibri)

Formatted: Space Before: 0 pt

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<p>child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.</p>		
<p>A mental health condition is an emergency medical condition when it meets the requirements of the paragraph above or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true: The person is an immediate danger to themselves or to others, or the person is immediately unable to provide for or use food, shelter, or clothing due to the mental disorder.</p>		
<p>Urgent care is the middle ground between a primary care physician and an emergency room and is for medical conditions that require prompt attention but not serious enough to meet the definition of an emergency. No prior authorization is needed and both in-out-of-network providers will be reimbursed at the in-network rate. Deductibles, coinsurance, and out-of-pocket maximums apply.</p>		
<p><del>Without the need for a prior authorization determination, even if the services are provided out-of-network;</del></p> <p><del>Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility, as applicable, with respect to the services;</del></p> <p><del>Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities;</del></p> <p><del>Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO provider or a PPO emergency facility;</del></p> <p><del>By calculating the cost-sharing requirement for out-of-network Emergency Services consistent with the requirements of the federal No Surprises Act; and</del></p> <p><del>By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by a PPO provider or a PPO emergency facility.</del></p>		
<p><del>Your cost sharing amount for Emergency Services from Non-PPO Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount (QPA).</del></p>		
<p>This Plan complies with the federal No Surprises Act, which provides patients who receive emergency services at hospitals, independent freestanding emergency departments, and air ambulances with certain protections against surprise medical bills. In addition, the law protects patients who receive emergency services from out-of-network providers at in-network facilities. Members receiving such</p>		

Formatted: Font: +Body (Calibri)

Formatted: Justified, Space Before: 0 pt

Formatted: Justified

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<p>services will only be responsible for paying their in-network cost sharing and cannot be balance billed by the provider or facility for emergency services.</p>		
<p><a href="#">No prior authorization is required but participants must contact the UM Company within 24 hours of admission.</a></p>		
<p><i>Post Stabilization Services</i></p>		
<p>Emergency Services furnished by an <del>out-of-network provider or out-of-network</del> emergency facility (regardless of the department of the hospital in which such items or services are furnished) also includes post stabilization services and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:</p>		
<ul style="list-style-type: none"> <li>• The provider or facility determines <del>that whether</del> the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; and</li> <li>• The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges <del>for your</del> treatment and any advance limitations that the Plan may put on <del>your</del> treatment, of the names of any in-network providers at the facility who are able to treat <del>you participants</del>, and <del>that you</del> may elect to be referred to one of the participating providers listed; and</li> <li>• The participant or beneficiary gives informed consent to continued treatment by the nonparticipating provider, acknowledging that the participant or beneficiary understands that continued treatment by the nonparticipating provider may result in greater cost to the participant or beneficiary.</li> </ul>		
<p><i>Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility</i></p>		
<p>With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by an out-of-network provider at an in-network facility, the items or services are covered by the plan:</p>		
<p>With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider;</p>		
<p>By calculating the cost-sharing requirements consistent with the federal No Surprises Act; and</p>		
<p>By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an in-network provider.</p>		
<p>Non-emergency items or services performed by an out-of-network provider at an in-network facility will be covered based on out-of-network coverage if:</p>		

Formatted: Table - Bullet,tb1, Indent: Left: 0.25", Right: 0.5", Space Before: 6 pt

Formatted: Right: 0", Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Right: 0", Space Before: 0 pt, Bulleted + Level: 1 + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Justified

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<ul style="list-style-type: none"> <li>○ At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for <del>your</del> treatment and any advance limitations that the Plan may put on <del>your</del> treatment, of the names of any in-network providers at the facility who are able to treat <del>you</del> participants, and that <del>you</del> participants may elect to be referred to one of the in-network providers listed; and</li> <li>○ The participant or dependent gives informed consent to continued treatment by the out-of-network provider, acknowledging that the participant or beneficiary understands that continued treatment by the out-of-network provider may result in greater cost to the participant or beneficiary.</li> </ul> <p>The notice and consent exception does not apply to Ancillary services <u>which are services that are supplemental to support a diagnosis and treatment</u>, and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the out-of-network provider satisfied the notice and consent criteria, and therefore these services will be covered:</p> <ul style="list-style-type: none"> <li>○ With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider,</li> <li>○ With cost-sharing requirements calculated consistent with the federal No Surprises Acr, and</li> <li>○ With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by an in-network provider.</li> </ul> <p><del>Your</del> The cost sharing amount for Non-emergency Services at in-network facilities by out-of-network providers will be based on the lesser of billed charges from the provider or the Qualifying Payment Amount.</p> <p><u>Air Ambulance Services</u></p> <p><del>If you receive air ambulance services that are otherwise covered by the Plan from an out-of-network provider, your cost-sharing requirement will be the same as if the services had been furnished by an in-network provider, and your payments will count toward your in-network deductible and network out-of-pocket maximum. In general, you cannot be balance billed for air ambulance services.</del></p>		

Formatted: Table - Bullet,tb1, Space After: 12 pt

## Schedule of Benefits

### *Payments to Out-of-Network Providers and Facilities*

The Plan will make an initial payment or notice of denial of payment for emergency services, non-emergency services at in-network facilities by out-of-network providers, or air ambulance services within 30 calendar days of either receiving a clean claim from the out-of-network provider or the date the plan receives the information necessary to decide the claim.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing required under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

Formatted: Space Before: 0 pt

### *External Review*

An adverse benefit determination related to an emergency service, non-emergency service provided by an out-of-network provider at an in-network facility, or air ambulances services covered under the No Surprises Act is eligible for External Review. Please see the *External Review* section further information.

Formatted: Space After: 0 pt

### *Continuity of Coverage Care*

Continuity of Care is a process that allows a participant to continue using the same provider for a period of time after enrolling in a new plan. This is for participants who have complex medical conditions, which are conditions that affect multiple body systems or has multiple systems.

Formatted: Font: (Default) +Body (Calibri), Not Italic, Font color: Auto

#### If this occurs:

Formatted: Normal

~~If you are a Continuing Care Patient, and the contract with your in-network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:~~

- ~~You Participants~~ will be notified in a timely manner of the contract termination and of ~~you their~~ right to elect continued transitional care from the provider or facility; and
- ~~You Participants~~ will be allowed up to ninety (90) days of continued coverage at in-network cost sharing to allow for a transition of care to an in-network provider.

Consistent with [NRS 695G.164](#), the Plan provides coverage for continued medical treatment for a medical condition from a provider of health care whose contract with the insurer is terminated during active medically necessary treatment. Unless excepted, this is until the later of:

- The 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 45th day after
  - o The date of delivery; or
  - o If the pregnancy does not end in delivery, the date of the end of the pregnancy.

### *Incorrect Provider Information*

A list of in-network providers is available ~~to you by visiting on~~ PEBP's website or by calling the phone number on ~~your the participant~~ ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice. If ~~you participants~~ obtain and rely upon incorrect information

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<p>about whether a provider is an in-network provider from the Plan or its administrators, the Plan will apply in-network cost-sharing to <del>your</del><u>the</u> claim, even if the provider was out-of-network.</p>		

Benefit Description	In-Network	Out-of-Network
<p>Enteral Formula and Special Food Products</p>	<p>Plan pays 80% after Plan Year Deductible; with benefit limitations</p>	<p>Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; with benefit limitations</p>
<p style="text-align: center;"><b>Explanations and Limitations</b> Special Food Product and Enteral Formula</p> <p>The Plan covers enteral formulas and special food products <a href="#">which are specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease.</a></p> <p><a href="#">These products are</a> for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after both, of amino acid, organic acid, carbohydrate, or fat.</p> <p>There is a \$2,500 maximum benefit per Plan Year for special food products for the treatment of an inherited metabolic disease. The maximum does not apply to coverage of special food products prescribed or ordered in connection with a mental health diagnosis.</p> <p>Documentation to substantiate the presence of an inherited metabolic disease, including documentation that the product purchased is a special food product or enteral formula, may be required before the Plan will <del>reimburse for</del><u>reimburse</u> costs associated with special food products or enteral formulas.</p>		

Benefit Description	In-Network	Out-of-Network
<p>Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception</p>	<p>Plan pays 80% after Plan Year Deductible</p>	<p>Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible</p>
<p style="text-align: center;"><b>Explanations and Limitations</b> Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception</p>		

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<p>Only diagnostic procedures for fertility and infertility are payable for the employee and spouse/domestic partner. Diagnostic procedures for fertility and infertility are subject to the Plan Year Deductible.</p> <p>The Plan does not cover the treatment of fertility or infertility. Please see the <i>Benefit Limitations and Exclusions</i> section, and in particular, the subsections for drugs, medicines, and nutrition; fertility and infertility; maternity services; and sexual dysfunction services, for more details.</p> <p>Procedures related to sexual dysfunction may be covered. See the <i>Benefit Limitations and Exclusions</i> section of this document for more information.</p> <p>Coverage is provided for vasectomies and tubal ligations. Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals are excluded.</p> <p>Male surgical sterilization is subject to the Plan Year Deductible and Coinsurance.</p> <p><a href="#">Condoms are covered under this plan for individuals aged 13 and above.</a>  <del><a href="#">Male contraception such as condoms are not covered under this Plan.</a></del></p>		



Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Gender Dysphoria	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p data-bbox="493 554 797 579"><b>Explanations and Limitations</b></p> <p data-bbox="493 583 808 609"><u>Treatment of Gender Dysphoria</u></p> <p data-bbox="108 653 1073 711"><u>Gender dysphoria is a condition characterized by a significant and persistent distress or discomfort with one's assigned sex or gender identity. It is defined as:</u></p> <ul data-bbox="142 732 1024 884" style="list-style-type: none"> <li><u>A marked difference between one's experienced gender and the sex assigned at birth.</u></li> <li><u>A strong desire to live and be recognized as the opposite gender.</u></li> <li><u>Significant distress or impairment in social, occupational, or other important areas of functioning due to the difference between experienced gender and assigned sex.</u></li> </ul> <p data-bbox="108 905 1117 999"><u>It is important to note that gender dysphoria is distinct from gender nonconformity, which refers to individuals whose gender expression or identity does not align with traditional expectations associated with their assigned sex but does not cause significant distress</u></p> <p data-bbox="108 1041 1089 1230">The Plan covers medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by health care practitioners acting within the scope of their license. Determinations of medical necessity shall include consideration of the most recent <i>Standards of Care</i> published by the World Professional Association for Transgender Health, or its successor organization.</p> <p data-bbox="108 1293 1089 1419">If coverage for treatment of a condition relating to gender dysphoria or gender incongruence is denied on the basis that the requested treatment is not medically necessary, consideration of any appeal from such denial will include consultation with a <u>provider of health care/health care provider</u> who has experience in prescribing or delivering gender-affirming treatment.</p> <p data-bbox="108 1440 1089 1566">The Plan does not cover cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary. "Cosmetic surgery" means a surgical procedure that does not meaningfully promote the proper function of the body, does not prevent or treat illness or disease, and is primarily directed at improving the appearance of a person.</p> <p data-bbox="108 1587 1089 1650">Procedures, services, and supplies related to surgery and sex hormones associated with gender affirmation/confirmation should be reviewed by the UM company for medical necessity.</p>		

Formatted: Font: 12 pt

Formatted: Line spacing: Multiple 1.15 li

Formatted: Space After: 0 pt, Line spacing: Multiple 1.15 li

Formatted: Line spacing: Multiple 1.15 li

Formatted: Space After: 0 pt, Line spacing: Multiple 1.15 li

Formatted: Font: 12 pt

Formatted: Normal, Left, Space After: 0 pt, Line spacing: Multiple 1.15 li

Formatted: Line spacing: Multiple 1.15 li

Formatted: Font: 12 pt

Formatted: Indent: Left: 0", Line spacing: Multiple 1.15 li

Formatted: Font: 12 pt

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Genetic Counseling/Testing	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

**Explanations and Limitations**  
Genetic Testing and Counseling

Genetics is the study of how genes and how traits are passed down from one generation to the next:

**Formatted:** Left

Covered services include medically necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests solely for research, or for the benefit of individuals not covered under the Plan.

Covered services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk, and review testing options, where available.

Genetic testing may only be done after consultation with a certified genetic counselor and/or, in our discretion, as approved by a physician that we may designate to review the utilization, medical necessity, clinical appropriateness (the right care for the right person at the right time by the right provider), and quality of such genetic testing. Medically necessary genetic counseling will be covered in connection with pregnancy management with respect to the following individuals:

Expenses for genetic tests, except where otherwise noted in this document, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities, or genetically transmitted characteristics including:

**Formatted:** Indent: Left: 0.5", Right: 0", No bullets or numbering

- Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents; and
- Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder, except that payment is made for fluid or tissue samples obtained through amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), fetoscopy and alpha fetoprotein (AFP) analysis in pregnant women.
- Participants should contact the Plan's Claims Administrator to determine if proposed genetic testing is covered or excluded and the UM company for prior authorization requirements. See also the exclusions related to prophylactic surgery or treatment later in this section.

**Formatted:** Indent: Left: 0.25", Hanging: 0.25", Space After: 0 pt, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.25", Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers

Genetic Counseling except as related to covered genetic testing as listed in the Genetic Testing and Counseling and the Preventive Covered services include genetic testing of heritable disorders as medically necessary when the following conditions are met:

**Formatted:** Font: 12 pt, Font color: Black

- The results will directly impact clinical decision-making and/or clinical outcome for the individual.
- The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and
- One of the following conditions is met:

## Schedule of Benefits

- The participant demonstrates signs/symptoms of a genetically linked heritable disease, or
- The participant or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

Additional genetic testing/counseling will be covered in accordance with federal or state mandates.

The Plan provides benefits for medically necessary biomarker testing for the diagnosis, treatment, case management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.

In the absence of specific information regarding advances in the knowledge of mutation characteristics for a disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the member.

Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology or mandated by federal or state law.

Certain Genetic Testing and Counseling require precertification. Contact the UM company for precertification requirements for covered genetic testing.

Benefits include amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), alpha-fetoprotein (AFP), BRCA1 and BRCA2, apo E.

- Amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in pregnant women only if the procedure is medically necessary as determined by the UM company.
- Genetic counseling when provided before and/or after amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis.
- BRCA1 and BRCA2 counseling for individuals already diagnosed with breast and/or ovarian cancer.
- Apo E genetic test to help physicians identify those individuals at highest risk for heart disease and determine the most appropriate dietary and fitness program for the covered PEBP participant.
- BRCA1 and BRCA2 genetic test when indicated
  - The U.S. Preventive Services Task Force recommends that women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutation be assessed by their primary care physician with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, appropriate genetic testing.

This list is not all-inclusive for what genetic tests may be covered.

Contact the UM company for coverage details and precertification/prior authorization requirements for covered genetic testing.

The Plan provides benefits for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.

Formatted: Space After: 0 pt

Formatted: Font: 12 pt

Formatted: Body Text, Space After: 12 pt, Don't add space between paragraphs of the same style

Formatted: Indent: Left: 0"

Formatted: Indent: Left: 0"

Formatted: Indent: Left: 0"

Schedule of Benefits

~~See the *Key Terms and Definitions* and the *Exclusions* sections relating to genetic testing and counseling, including non-payment for pre-parental genetic testing.~~

**Formatted:** Justified, Indent: Left: 0", Right: 0.1",  
Space After: 6 pt

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Hearing Aids	Plan pays 80% after Plan Year Deductible (maximum benefit \$1,500 per device, per each ear)	Plan pays 50% after Plan Year Deductible (maximum benefit \$1,500 per device, per each ear)
<b>Explanations and Limitations</b>		
Hearing Aids		
<p>When air conduction hearing aids are medically necessary, each air conduction hearing aid is subject to the deductible, then the Plan pays 80% up to a maximum benefit of \$1,500 per device <del>(one device per ear), per device, per each ear,</del> every three years.</p> <p>Participants may submit a copy of their hearing aid payment receipt from the hearing aid provider to the third-party claims administrator to request reimbursement for the hearing aid benefit, less applicable copayment(s), and to receive credit towards the Out-of-Pocket Maximum.</p> <p>Over the Counter hearing aids are excluded from plan benefits.</p>		

Benefit Description	In-Network	Out-of-Network
Hinge Health	\$0; not subject to Deductible or Coinsurance	Not Covered
<b>Explanations and Limitations</b>		
Hinge Health Digital Musculoskeletal (MSK) Care Program		
<p>Hinge Health’s Digital MSK Program is offered through the Pharmacy Benefit Manager <a href="#">(PBM)</a> and is designed to help members with musculoskeletal care using digital technology. The program offers qualifying participants virtual digital physical therapy focusing on prevention, acute injury, chronic and surgical care programs via digital physical therapy plus additional physical and behavioral support through a full clinical-care team. Members will also have access to other services, such as pelvic floor therapy, advanced wearable technology for electrical nerve stimulation and pain relief, expert medical opinion consultation, health education, etc.</p> <p>Members will complete a screening questionnaire to assess which Digital MSK Clinic program is right for them. The questionnaire screener leverages data analytics combined with a dedicated clinical care team review to match each member’s personal needs with the right program, tools and resources. This program is managed by <del>Express Scripts</del><a href="#">the PBM</a> and is provided at no cost to members.</p>		

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Home Health Care and Home Infusion Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; or for infusion drug services 110% of the Medi-Span AWP after Plan Year Deductible

**Explanations and Limitations**

Home Health Care and Home Infusion Services

Home infusion services involve the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Participants must be assessed and determined to be a candidate for this service. It must be prior authorized.

Such care will not be available if it is substantially or primarily for the participant's convenience or the convenience of a caregiver. Home care is covered in the home only on a part-time and temporary basis and to the extent that such care is performed by a licensed or registered nurse or other therapist or provider acting within the scope of their license.

Home health care is intermittent skilled nursing care services provided by a licensed home health care agency. Coverage includes skilled nursing care, therapies, and other health related services provided in the home environment for other than convenience for patient or patient's family, personal assistance, or maintenance of activities of daily living or housekeeping. Covered home health care services under this part include home health care provided by a professional as the nature of the illness dictates.

Formatted: Left

- ~~• Home Health Care and Home Infusion requires precertification by the UM company.~~
- ~~• Home health care and home infusion services are covered only when ordered by a physician or health care practitioner.~~
- ~~• Benefits include part time, intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion services, subject to maximum Plan benefits.~~
- The maximum Plan benefit for home health care (skilled nursing care services) and supplies to provide home health care and home infusion services is 60 visits per person per Plan Year. Additional visits are subject to preauthorization by the UM Company.
- A home health care visit will be considered a periodic visit by a nurse or therapist, or four (4) hours of home health services.
- Charges are covered for private duty nursing by a licensed nurse (RN or LVN/LPN) only when care is medically necessary and not custodial in nature. Outpatient private duty nursing care on a 24-hour shift basis is not covered.
- Outpatient private duty nursing care on a 24-hour shift basis and/or home services other than skilled nursing care are not covered.
- Home services other than skilled nursing care are not covered
- See Benefit Limitations and Exclusions section related to home health care and custodial care,

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Home Health Care and Home Infusion Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; or for infusion drug services 110% of the Medi-Span AWP after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b></p> <p style="text-align: center;">Home Health Care and Home Infusion Services</p> <p><u>Home infusion services involve the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Participants must be assessed and determined to be a candidate for this service. It must be prior authorized.</u></p> <p><u>Such care will not be available if it is substantially or primarily for the participant’s convenience or the convenience of a caregiver. Home care is covered in the home only on a part-time and temporary basis and to the extent that such care is performed by a licensed or registered nurse or other therapist or provider acting within the scope of their license.</u></p> <p><u>Home health care is intermittent skilled nursing care services provided by a licensed home health care agency. Coverage includes skilled nursing care, therapies, and other health related services provided in the home environment for other than convenience for patient or patient’s family, personal assistance, or maintenance of activities of daily living or housekeeping. Covered home health care services under this part include home health care provided by a professional as the nature of the illness dictates.</u></p> <p><u>including personal care and childcare.</u></p>		

Formatted: Left



Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Hospice	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

**Explanations and Limitations**  
Hospice

The following hospice care services are covered for members with a life expectancy of six months or less where the person lives.

- Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week. Hospice care of greater than 185 days requires preauthorization by the UM company.
- Outpatient bereavement counseling of the participant and his or her immediate family (limited to 6 visits for all family members combined if they are not otherwise eligible for mental health benefits under their specific plan). Counseling must be provided by:
  - A psychiatrist.
  - A psychologist; or
  - A licensed, master’s level clinician.
- Respite care provides nursing care for a maximum of 8 inpatient respite care days per Plan Year and 37 hours per Plan Year for outpatient respite care services.
- Inpatient respite care will be provided only when the UM company determines that home respite care is not suitable or practical.

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Indent: Left: 0.5", No bullets or

~~The hospice care program administers palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill patients with a life expectancy of six months or less. Such services consist of part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week. Hospice care of greater than 185 days requires preauthorization by the UM company. Hospice may be provided by a licensed hospice agency or a licensed home health care agency.~~

The Plan also covers outpatient bereavement counseling services provided by a licensed master’s level clinician or a licensed pastoral care counselor for the patient’s immediate family (covered spouse and or dependent children) provided as part of the hospice service. Bereavement counseling beyond that included as a part of the hospice program is payable under the Behavioral Health benefits of this Plan.

For more information, see Hospice Care in the Key Terms and Definitions section.

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Pre-planned Hospital Services (Inpatient)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b></p> <p style="text-align: center;"><u>Pre-Planned Hospital Services (Inpatient)</u></p> <p><del>Elective Pre-planned</del> hospitalization is subject to <del>precertification and</del> concurrent review <u>by the UM Company</u>. <del>See the Utilization Management section for more information.</del></p> <p><u>Must be prior authorized.</u></p> <p><u>Services include:</u></p> <ul style="list-style-type: none"> <li>• Room, <del>and board,</del> and facility fees in a <del>semiprivate</del><u>semi-private</u> room with general nursing services; Specialty Care Units (e.g., intensive care unit, cardiac care unit);</li> <li>• <u>Ancillary services such as</u> lab, x-ray, and diagnostic services; <del>related medically necessary ancillary services (e.g.,</del> prescriptions, <u>and</u> supplies).</li> <li>• <u>Newborn care and circumcision.</u></li> </ul> <p>Private room is payable at the semi-private rate unless it is determined that a private room is medically necessary, or the facility does not provide semi-private rooms.</p> <p>Outpatient services with an observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement under this Plan.</p> <p>Under the following circumstances, the Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the UM company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services:</p> <ul style="list-style-type: none"> <li>○ Dental general anesthesia for an individual when services are rendered in a hospital or outpatient surgical facility, when the individual is being referred because in the opinion of the dentist, the individual:             <ul style="list-style-type: none"> <li>○ Is under age 18 and has a physical, mental, or medically compromising condition; or</li> <li>○ Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, <del>an anatomic</del><u>anatomic</u> anomaly, or an allergy; or</li> <li>○ Patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient.</li> <li>○ Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.</li> <li>○ No payment is extended toward the dentist or the assistant dental provider under this Plan.</li> </ul> </li> </ul> <p><b>No coverage for non-emergency hospital admission:</b> The Plan does not cover care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.</p>		

Formatted: Not Highlight

Formatted: Indent: Left: 0.5", No bullets or

Formatted: Font: 11.5 pt

Formatted: Font: 11.5 pt

Formatted: Normal, No bullets or numbering


Formatted: Font: 11.5 pt

Formatted: Normal, No bullets or numbering

Schedule of Benefits


Benefit Description	In-Network	Out-of-Network
<a href="#">Pre-planned Hospital Services (Inpatient)</a>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p align="center"><b>Explanations and Limitations</b></p> <p align="center"><a href="#">Pre-Planned Hospital Services (Inpatient)</a></p> <p>Inpatient private duty nursing by a licensed nurse (RN, LVN or LPN) is covered only when care is medically necessary and not custodial, and the hospital's intensive care unit is filled, or the hospital has no intensive care unit.</p>		

Formatted: Not Highlight

Benefit Description	In-Network	Out-of-Network
<a href="#">Laboratory Outpatient Services</a>		
<p><b>Free-standing lab facility</b> Preferred non-hospital-based lab facilities: Lab Corp or Quest</p>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p><b>Outpatient hospital-based lab facility and hospital-based lab draw station</b> Lab services for pre-admission testing, urgent care, and emergency room only</p>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p align="center"><b>Explanations and Limitations</b></p> <p align="center"><a href="#">Laboratory Outpatient Services</a></p> <ul style="list-style-type: none"> <li><a href="#">Outpatient lab services are covered when medically necessary, when ordered by a physician or health care practitioner, and when services are performed in accordance with the Laboratory Outpatient Services benefit described in this section.</a></li> </ul> <p> <b>Free-standing, non-hospital -based laboratory facility:</b> <a href="#">The Plan covers outpatient routine and preventive lab services performed at free-standing, non-hospital-based lab facilities. Although there may be other in-network free-standing, non-hospital-based lab facilities in the network, the Plan's preferred facilities include Lab Corp and Quest. Routine and preventive lab services include:</a></p> <ul style="list-style-type: none"> <li><a href="#">Medically necessary routine labs when ordered by a physician or other licensed provider acting within the scope of his/her license as part of comprehensive medical care. To be covered at 100%, the lab must be used to proactively screen for protentional diseases for which a participant has no symptoms of. This includes, but not limited to, cholesterol to screen for heart disease.</a> <ul style="list-style-type: none"> <li><a href="#">Labs used to diagnose or rule out conditions are diagnostic and subject to cost sharing.</a></li> </ul> </li> <li><a href="#">Outpatient hospital-based lab facilities and hospital-based lab draw stations:</a> <a href="#">The Plan covers outpatient lab services for pre-admission testing when performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to sickness or injury for which</a></li> </ul>		

Formatted: Space Before: 0 pt, After: 0 pt

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		
<p><u>admission or surgery is planned.</u></p> <ul style="list-style-type: none"> <li><u>If a free-standing, non-hospital-based outpatient laboratory facility is not available within 50 miles of a participant's residence, participants may use a hospital-based laboratory facility or hospital-based draw station.</u></li> </ul> <p>The following screening is covered as preventive as a component of the Affordable Care Act (ACA):</p> <ul style="list-style-type: none"> <li><u>One-time screening for Abdominal Aortic Aneurysm with ultrasound in men aged 65 – 75.</u></li> <li><u>Screening for anxiety disorders in children aged 8 – 18, pregnant women, and adults aged 64 and older.</u></li> <li><u>Screening for asymptomatic bacteriuria in pregnant women.</u></li> <li><u>Chlamydia and Gonorrhea screening in sexually active women under 24 and women aged 25 years and older at increased risk.</u></li> <li><u>Screening for syphilis in pregnant women and those at increased risk.</u></li> <li><u>Depression and suicide risk in children aged 12 – 18 and adult aged 65 years and older.</u></li> <li><u>Screening for gestational diabetes in pregnant women 24 weeks and over.</u></li> <li><u>Screening for HEP B in pregnant women and those at increased risk.</u></li> <li><u>Screening for HEP C in adults aged 18 to 79.</u></li> <li><u>HIV Screening in pregnant women and adults aged 15 – 65.</u></li> </ul> <p><u>Tuberculosis screening in adults at increased risk.</u> — Explanations and Limitations</p>		
<p><u>Lung cancer screening in adults aged 50 – 80 who smoke more than 20 packs per year.</u></p> <p><u>Screening for diabetes for adults aged 35 – 70 who are overweight/obese.</u></p> <p><u>Rh(D) bleeding typing and antibody testing for pregnant women.</u></p>		
<p style="text-align: center;"><u>Laboratory Outpatient Services</u></p> <ul style="list-style-type: none"> <li><del>Outpatient lab services are covered when medically necessary, when ordered by a physician or health care practitioner, and when services are performed in accordance with the Laboratory Outpatient Services benefit described in this section.</del></li> </ul> <p> <del><b>Free-standing, non-hospital-based laboratory facility:</b> The Plan covers outpatient routine and preventive lab services performed at free-standing, non-hospital-based lab facilities. Although there may be other in-network free-standing, non-hospital-based lab facilities in the network, the Plan's preferred facilities include Lab Corp and Quest. Routine and preventive lab services include:</del></p> <ul style="list-style-type: none"> <li><del>Medically necessary routine labs when ordered by a physician or other licensed provider acting within the scope of his/her license as part of comprehensive medical care.</del></li> </ul>		

Formatted: No bullets or numbering

Formatted: Font:

Formatted: Space Before: 0 pt, After: 0 pt

Formatted: Space Before: 0 pt, After: 0 pt

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Left

Formatted: Indent: Left: 0.45"

Formatted: Indent: Left: 0.45", No bullets or numbering

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		
<p><del>○ Preventive laboratory services such as but not limited to basic metabolic panel, lipid panel, etc. Refer to the <i>Preventive Care/Wellness Services</i> for information regarding benefits for screening tests and preventive lab testing.</del></p> <p><del>● <b>Outpatient hospital-based lab facilities and hospital-based lab draw stations:</b> The Plan covers outpatient lab services for pre-admission testing when performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.</del></p> <p><del>● If a free-standing, non-hospital-based outpatient laboratory facility is not available within 50 miles of your residence, you may use a hospital-based laboratory facility or hospital-based draw station.</del></p> <p><del>● See the <i>Key Terms and Definitions</i> section for the definitions of <i>Free-standing Laboratory Facility</i> and <i>Outpatient Hospital-Based Laboratory</i> and <i>Outpatient Hospital-Based Laboratory Draw Station</i>.</del></p>		

Benefit Description	In-Network	Out-of-Network
Mastectomy and <del>Reconstructive Services and Breast Reconstruction after Mastectomy</del>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b></p> <p style="text-align: center;"><del>Reconstruction Services</del><u>Mastectomy</u> and Breast Reconstruction <del>after Mastectomy</del></p> <p>This Plan complies with the Women’s Health and Cancer Rights Act of 1998. <u>A mastectomy is the removal of a breast and breast reconstruction is to restore the shape of the breast. The following are covered:</u><del>Breast reconstructive surgery and 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:</del></p> <ul style="list-style-type: none"> <li><del>● <u>Implants and/or autologous tissue.</u></del></li> <li><del>● All stages of reconstruction of the breast on which the mastectomy has been <u>performed;</u>performed.</del></li> <li><del>● Surgery and reconstruction of the other breast to produce a symmetrical appearance; <u>-and</u></del></li> <li><del>● <u>External prostheses and treatment of physical complications of all states of mastectomy, including lymphedema, that are needed before or during reconstruction; and</u></del></li> </ul> <p><del>●</del></p> <p><u>If reconstructive surgery occurs within three years after a mastectomy, the amount of the benefits for that surgery will equal the amounts provided for in the Plan at the time of the mastectomy. If the surgery</u></p>		

Formatted: Font: 11.5 pt

Formatted: Normal, Indent: Left: 0.2", No bullets or numbering

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Mastectomy and <a href="#">Reconstructive Services and Breast Reconstruction after Mastectomy</a>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b></p> <p style="text-align: center;"><a href="#">Reconstruction Services Mastectomy</a> and Breast Reconstruction <a href="#">after Mastectomy</a> occurs more than three years after the mastectomy, the benefits provided are subject to the terms, conditions, and exclusions contained in the Plan at the time of reconstructive surgery.</p> <p><a href="#">The treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy.</a></p> <ul style="list-style-type: none"> <li>• <a href="#">The mastectomy and breast reconstruction may be performed together or separately and must be prior authorized. Treatment of physical complications of all stages of the mastectomy, including lymphedema. Treatment of a leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy. Prophylactic surgery is covered when prior authorized by the UM company.</a></li> </ul>		

- Formatted: Indent: Left: 0.45", No bullets or numbering
- Formatted: Normal, Indent: Left: 0.2", Space After: 0 pt, No bullets or numbering
- Formatted: Left, Indent: Left: 0.2", Right: 0", Space After: 4 pt

Benefit Description	In-Network	Out-of-Network
Maternity and Newborn Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b></p> <p style="text-align: center;">Maternity <a href="#">and Newborn</a> Services</p> <p>This Plan covers <a href="#">the following</a>:</p> <ul style="list-style-type: none"> <li>• <a href="#">Prenatal care and delivery for an employee or spouse/domestic partner only. Delivery is covered in either a hospital or a birthing center, which is a facility designed to provide a more homelike environment for low-risk deliveries with the assistance of midwives.</a></li> <li>• <a href="#">Prenatal care for covered dependent children. Delivery is not covered unless it is related to a complication of pregnancy. Complications of pregnancy include gestational hypertension, pre-eclampsia, gestational diabetes, miscarriage, placental abruption, infections, low amniotic fluid, anemia, preterm labor, premature rupture of membranes, severe and persistent nausea and vomiting, and stillbirth.</a></li> <li>• <a href="#">Elective termination of pregnancy in accordance with NRS 422.250.</a></li> </ul> <p><a href="#">Some prenatal care may be covered under preventive services such as obstetrical office visits, breastfeeding support, screening for gestational diabetes, blood type and Rh lab services.</a></p>		

- Formatted Table
- Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
- Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
- Formatted: Space Before: 0 pt, After: 0 pt

Schedule of Benefits

~~hospital and birth center charges and professional fees for medically necessary maternity services.~~

- ~~• Prenatal care and delivery is covered for an employee or spouse/domestic partner only. For covered dependent children, only prenatal coverage is provided for maternity, except for complications of pregnancy for the dependent child (see the definition of Complications of Pregnancy in the Key Terms and Definitions section of this document).~~
- ~~• Some preventive prenatal services including, but not limited to, obstetrical office visits, breastfeeding support, screening for gestational diabetes, blood type and Rh lab services for spouses and dependent children may be covered under the preventive care benefit. The preventive benefit does not include delivery of the newborn(s).~~
- Coverage for newly born and adopted children and children placed for adoption includes coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.
- 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 the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).
- ~~• 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. Termination of pregnancy— See the Genetic Testing section of this Schedule of Benefits.~~
- ~~• See Breastfeeding Support section for information and benefits related to this type of service. See the exclusions related to Maternity Services in the Exclusions section.~~

Coverage includes gestational carriers,

- ~~• See the Enrollment and Eligibility Master Plan Document for information regarding how to enroll a newborn dependent child(ren).~~

When the member has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days, consistent with [NRS 689B.033](#). Individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.

**Formatted:** No bullets or numbering

**Formatted:** Indent: Left: 0.44", Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

**Formatted:** List Paragraph, Indent: Left: 0.2", Space Before: 0 pt, After: 0 pt, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

**Formatted:** Font: 11.5 pt

**Formatted:** Font: 11.5 pt

**Formatted:** Normal, No bullets or numbering

**Formatted:** Indent: Left: 0.45", No bullets or numbering

Benefit Description	In-Network	Out-of-Network
---------------------	------------	----------------

Schedule of Benefits

Nondurable Supplies	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge or 110% of the Medi-Span AWP after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b> Nondurable Supplies</p> <p><u>Non-durable supplies or items that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap, or cleansing solutions.</u></p> <p>Coverage is provided for up to a 31-day supply per month of:</p> <ul style="list-style-type: none"> <li>• Sterile surgical supplies used immediately after surgery;</li> <li>• Supplies needed to operate, or use covered durable medical equipment or corrective appliances; and</li> <li>• Supplies needed for use by skilled home health or home infusion personnel, but only during their required services.</li> <li>• <u>Diabetic supplies may be covered under this area or under the prescription drug benefit.</u></li> </ul> <p><u>Please see the <i>Participant Contact Guide</i> for information regarding the preferred diabetic supplies mail order program.</u></p> <p><u>Diabetic supplies may also be covered under the prescription drug benefit, see the section on <i>Prescription Drug Benefits</i> in this document for more information.</u></p>		

Formatted: Justified, Indent: Left: 0"

Formatted: Font: Not Highlight

Formatted: Not Highlight

Formatted: Highlight

Benefit Description	In-Network	Out-of-Network	
Obesity Care Disease Management Program (Enhanced Benefits)			
Office Visits	Plan pays 100%; not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible	
Laboratory Test (must be performed using a free-standing, non-hospital-based laboratory)	Plan pays 100%; not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible	
Nutritional Counseling Services	Plan pays 100%; not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible	
Weight loss medications	Preferred Retail 30-Day Supply	Smart90 Retail or ESI Home Delivery 90-Day Supply	
Preferred Generic	*\$5 Copay	\$15 Copay	Not covered



Schedule of Benefits

Benefit Description	In-Network		Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)			
Preferred Brand	*\$25 Copay,	*\$75 Copay,	Not covered
Non-Preferred Brand	Not covered		Not covered
<b>Explanations and Limitations</b> Obesity Care Disease Management Program (Enhanced Benefits)			
<p><u>Obesity is defined as a body mass index of 30 kg/m2 or higher is used to identify individuals with obesity as defined by the National Library of Medicine.</u></p>			
<p>Preferred Retail Network Pharmacies: Copayments apply <del>if you fill your</del>for prescriptions at an Express Advantage Network (EAN) retail pharmacy. If <del>you fill your</del>prescriptions are filled at a non-EAN retail pharmacy, <del>you participants</del> will pay an additional \$10 per prescription. If <del>you participants</del> currently use a non-EAN pharmacy and <del>you</del> want to avoid the \$10 upcharge, <del>they may</del> call an EAN pharmacy to transfer <del>your the</del> prescription. Certain weight loss medications may not be available in 90-day supply. <del>Contact Express Scripts for information about your prescribed medication.</del></p>			
<p>The Obesity Care Management (OCM) Program is a disease management program that provides enhanced benefits to participants who have been diagnosed as obese by their physician, who meet the criteria in this section, and have enrolled in the OCM Program.</p>			
<p>The OCM Program is a voluntary opt-in program that requires enrollment with the <del>third-party claims administrator Pharmacy Benefit Manager (PBM)</del> to determine if <del>you participants</del> meet the criteria for participation in the program. If the <del>third-party claims administrator PBM</del> determines <del>you to be eligible participant to be eligible</del> for the program, the effective date of enrollment and enhanced benefits is determined by the <del>third-party claims administrator PBA</del>.</p>			
<p><b>How to enroll in the OCM Program:</b></p>			
<ul style="list-style-type: none"> <li>• Contact the <del>third-party claims administrator PBM</del> for a list of In-Network weight loss providers. The list of In-Network weight loss providers and the <i>OCM Enrollment and Evaluation Form</i> may be obtained by logging into the E-PEBP Portal at <a href="https://pebp.nv.gov/">https://pebp.nv.gov/</a> and selecting UMR.</li> <li>• Schedule an appointment with a provider from the list of participating In-Network weight loss providers.</li> <li>• Attend <del>your the</del> scheduled appointment and have <del>you the</del> provider complete, sign and submit the <i>Enrollment and Evaluation Form</i> to the third-party claims administrator’s address or fax number provided on the form.</li> <li>• The <del>third-party claims administrator PBM</del> will review the information submitted by <del>you the</del> provider and if the information indicates that <del>the you participant</del> meet the criteria for the weight loss program benefits, the third-party claims administrator will enroll <del>you them</del> in the program and notify the Pharmacy Benefit Manager of <del>you the</del> enrollment.</li> <li>• If <del>you participants</del> do not meet the criteria for the weight loss program and enhanced benefits, the <del>third-party claims administrator PBM</del> will notify of the denial of the OCM Program’s enhanced benefits.</li> </ul>			

Formatted: Font: +Body (Calibri)  
Formatted: Left

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)		
<p>OCM Program participation criteria for adults 18 years and older and services must be provided by:</p> <ul style="list-style-type: none"> <li>• An In-Network provider who specializes in weight loss services;</li> <li>• An In-Network provider who is certified by the American Board of Bariatric Medicine (ABBM);</li> <li>• An In-Network provider who is in training to become certified by the American Board of Bariatric Medicine (ABBM); or</li> <li>• If no provider as described above is available within 50 miles of a participant’s residence, then any In-Network provider.</li> </ul> <p>The patient’s BMI must be greater than 30 kg/m2, with or without any co-morbid conditions present, or greater than 25 kg/m2 (or waist circumference greater than 35 inches in women, 40 inches in men) if one or more of the following co-morbid conditions are present:</p> <ul style="list-style-type: none"> <li>• Coronary artery disease.</li> <li>• Diabetes mellitus type 2.</li> <li>• Hypertension (Systolic Blood Pressure greater than or equal to 140 mm Hg or Diastolic Blood Pressure greater than or equal to 90 mm Hg on more than one occasion).</li> <li>• Obesity-hypoventilation syndrome.</li> <li>• Obstructive sleep apnea.</li> <li>• Cholesterol and fat levels measured (Dyslipidemia): <ul style="list-style-type: none"> <li>• HDL cholesterol less than 35 mg/dL.</li> <li>• LDL cholesterol greater than or equal to 160 mg/dL; or</li> <li>• Serum triglyceride levels greater than or equal to 400 mg/dL.</li> </ul> </li> </ul> <p><u>For children ages two to 18 years:</u></p> <ul style="list-style-type: none"> <li>• All the above criteria.</li> <li>• Services must be provided by an In-Network provider who specializes in childhood obesity; and</li> <li>• Child must present a BMI ≥ 85th percentile for age and gender.</li> </ul> <p><u>Engagement in the OCM Program:</u></p> <p>In addition to meeting the criteria above, <del>you</del> <u>participants</u> must remain actively engaged by complying with the treatment plan established by <del>you and the</del> <u>weight loss</u> provider.</p> <p><u>Monitoring Engagement in the OCM Program:</u></p> <p><del>Your</del> <u>The</u> OCM provider must submit monthly reports to include <del>your</del> <u>the actual</u> weight loss (weight, BMI, and waist circumference) and <del>your</del> <u>compliance</u> with the treatment plan. Submission of these reports will be a requirement for payment under the OCM Program’s enhanced benefits. If <del>your</del> <u>the</u> monthly weight loss reports are not received by the third-party claim’s administrator, <del>your</del> <u>the</u> benefits under this program will end, and <del>your</del> <u>the</u> coverage will return to the standard CDHP benefits where other Plan limitations will apply. The effective date of the return to the standard CDHP benefits will be the first day of the month following the non-compliance notification received from the third-party claim’s administrator.</p> <p><del>You</del> <u>Participants</u> and <del>your</del> <u>their</u> weight loss provider will determine <del>your</del> <u>the</u> final weight loss goal when <del>you</del> <u>participants</u> initially start participating in the OCM Program. Once <del>you have met</del> <u>you</u> <del>the</del> <u>participant</u></p>		

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)		
<p><a href="#">has met their</a> final weight loss goal, the OCM Program’s enhanced benefits will return to the standard CDHP benefits on the first day of the following month. The OCM Program does not provide enhanced benefits for ongoing maintenance care. <del>Ongoing maintenance care will be subject to the standard CDHP benefits, which are services provided to maintain, support, and/or preserve a level of physical or mental function.</del></p> <p><b>Laboratory Services:</b> Routine wellness laboratory testing must be performed at an In-Network free-standing laboratory facility, for example Lab Corp or Quest. A hospital-based outpatient laboratory/draw station is not a free-standing laboratory.</p> <p><b>Nutritional Counseling Services:</b> The frequency of nutritional counseling services will be determined by the claims administrator and based on <del>your</del> <a href="#">the</a> weight loss provider’s recommendation and medical necessity.</p> <p><b>Weight Loss Medications:</b></p> <ul style="list-style-type: none"> <li>• The Plan covers certain only short-term use obesity/weight loss generic medications as identified by the Plan’s pharmacy benefits manager. <del>Contact the pharmacy benefit manager or refer to the Plan’s prescription drug formulary to determine what weight loss medications are covered by the enhanced benefit.</del></li> <li>• Copayment for a 31-90-day supply is subject to three times the listed 30-day retail copayment.</li> <li>• This Plan does not coordinate prescription drug plan benefits.</li> <li>• Medications purchased at non-participating pharmacies are not covered under this Plan.</li> </ul> <p><b>Other limitations:</b></p> <ul style="list-style-type: none"> <li>• Weight loss medications: Preferred Retail Network Pharmacies, Smart90 Retail, and <a href="#">Express Scripts</a> <del>The PBM</del> Home Delivery Program requirements apply. Refer to the <i>Schedule of Prescription Drug Benefits</i> for coverage limitations, cost implications and details regarding these programs.</li> </ul>		
<p><b>The Obesity Care Management Program is administrated by the Claims Administrator.</b></p>		
<p><b>Actively engaged means:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Participation in regular office visits with a provider. The frequency of the office visits will be determined by the provider who will in turn report this information to the third-party administrator for monitoring.</a></li> <li>• <a href="#">Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by a weight loss provider including but not limited to routine exercise, proper nutrition and diet, and pharmacotherapy if prescribed. Commitment to weight loss treatment will be measured by the third-party administrator who will review monthly progress reports submitted by the provider; and</a></li> </ul>		

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)		
<ul style="list-style-type: none"> <li><a href="#">Losing weight at a rate determined by the weight loss provider.</a></li> </ul>		

Benefit Description	In-Network	Out-of-Network
Oral Surgery, Dental Services, and Temporomandibular Joint Disorder	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
<del>Injury to teeth; Oral and or craniofacial surgery.</del>	*TMJ related services: Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible

**Explanations and Limitations**

Oral Surgery, Dental Services, and Temporomandibular Joint Disorder

- ~~Oral and Craniofacial Services~~ Expenses for dental services may be covered under the medical plan if the expenses are incurred for the repair or replacement of injury to teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the medical Plan, an accident does not include any injury caused by biting or chewing.
  - Treatment of injury to teeth must be provided by a dentist or physician and is limited to restoration of teeth or jaw to a functional level, as determined by the Plan Administrator or its designee.
- Coverage for dental services as the result of an injury to teeth will be extended under the medical plan to a maximum of two years following the date of injury, regardless of date enrolled in the plan. Restorations past the two-year time frame may be considered under the dental benefits described in the PEBP Self-funded Dental PPO Plan Master Plan Document available at <https://pebp.nv.gov/>.
- Oral or craniofacial surgery is limited to surgical procedures to remove tumors, cysts, abscess including dental abscesses and cellulitis, or for acute injury. Must be prior authorized.
- Frenectomy is based on medical necessity as determined by the UM company and must be prior authorized.
- \*Temporomandibular Joint (TMJ) services are payable under the medical Plan when medically necessary but not if treatment is recognized as a dental procedure, involves extraction of teeth or application of orthodontic devices (e.g., braces) or splints. Must be prior authorized.

For additional information, see the Exclusions section related to dental services.

- ~~Expenses for dental services may be covered under the medical plan if the expenses are incurred for the repair or replacement of injury to teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the medical Plan, an accident does not include any injury caused by biting or chewing.
 
  - Treatment of injury to teeth must be provided by a dentist or physician and is limited to restoration of teeth to a functional level, as determined by the Plan Administrator or its~~

Formatted: Font: 12 pt  
Formatted: Centered

Formatted: Justified, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Oral Surgery, Dental Services, and Temporomandibular Joint Disorder	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
<del>Injury to teeth; Oral and or craniofacial surgery, \</del>	<del>*TMJ related services: Plan pays 80% after Plan Year Deductible</del>	<del>Plan pays 50% of the Maximum Allowable Charge after Deductible</del>
<del>designee.</del> <ul style="list-style-type: none"> <li><del>Coverage for dental services as the result of an injury to teeth will be extended under the medical plan to a maximum of two years following the date of injury, regardless of date enrolled in the plan. Restorations past the two year time frame may be considered under the dental benefits described in the PEBP Self-funded Dental PPO Plan Master Plan Document available at <a href="https://pebp.nv.gov/">https://pebp.nv.gov/</a>.</del></li> <li><del>Certain oral or craniofacial surgery is required to be prior authorized by the utilization management company. See the UM section of this document or refer to Participant Contact Guide.</del></li> <li><del>Oral or craniofacial surgery is limited to surgical procedures to remove tumors, cysts, abscess including dental abscess and cellulitis, or for acute injury.</del></li> <li><del>Frenectomy based on medical necessity as determined by the UM company.</del></li> <li><del>*Temporomandibular Joint (TMJ) services are payable under the medical Plan when medically necessary but not if treatment is recognized as a dental procedure, involves extraction of teeth or application of orthodontic devices (e.g., braces) or splints.</del></li> </ul> <del>For additional information, see the Exclusions section related to dental services.</del>		

Benefit Description	In-Network	Out-of-Network
<del>Outpatient Ambulatory Surgery Surgical Facility/Center</del>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
<p align="center"><b>Explanations and Limitations</b></p> <p align="center"><del>Ambulatory Surgical Facility/Center</del> <b>Outpatient Surgery Facility</b></p> <p><del>An ambulatory surgical center (ASC) is a healthcare facility that performs surgical procedures on patients who don't need to stay overnight in the hospital.</del></p> <p><del>An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.</del></p> <ul style="list-style-type: none"> <li><del>See the UM section for precertification requirements.</del></li> <li><del>Outpatient ambulatory surgical facility/surgical center.</del></li> <li><del>Physician fees payable under the physician services section of this Schedule of Benefits. Procedures must be outpatient. If outpatient procedure has an observation period that lasts more than 23 hours, it will no longer be considered outpatient, it will be considered inpatient.</del></li> <li><del>Must be prior authorized.</del></li> </ul>		

Formatted: Font: Not Bold

Formatted: Centered

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<a href="#">Outpatient Ambulatory Surgery Surgical Facility/Center</a>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
<ul style="list-style-type: none"> <li>• <a href="#">Facility fees are separate from physician fees. Anesthesia may be included in the facility fee, or it may be a separate fee.</a></li> <li>• <del>Outpatient surgery with an observation period that lasts more than 23 hours will be considered and paid as an Inpatient confinement under this medical Plan.</del></li> <li>• <del>Dental procedures are covered under the dental component of this plan. Outpatient facility fees and anesthesia associated with medical necessary dental services for an individual when the individual is being referred by the dentist, and the following criteria are met:</del> <ul style="list-style-type: none"> <li>• <del>Is under age 18 and has a physical, mental, or medically compromising condition; or</del></li> <li>• <del>Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy; or patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient; or is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.</del></li> </ul> </li> <li>• <del>No payment is extended toward the dentist or the assistant dental provider fees under this medical Plan. Refer to the dental benefits described in the PEBP Self-funded PPO Dental Plan Master Plan Document available at <a href="https://pebp.nv.gov/">https://pebp.nv.gov/</a>. A surgical facility/center may be used for dental outpatient procedures but must be prior authorized by a dental professional.</del></li> </ul>		

Formatted: Indent: Left: 0.25", Bulleted + Level: 1 + Aligned at: 1" + Indent at: 1.25"

Benefit Description	In-Network	Out-of-Network
<a href="#">Physician and Other Health Care Practitioner Services Provider of Health Care</a>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p align="center"><b>Explanations and Limitations</b></p> <p align="center"><del>Physician and Other Health Care Practitioner Services Provider of Health Care</del></p> <p>This benefit includes <del>physician and health care practitioner's</del> <a href="#">licensed medical professional</a> fees for services provided in a hospital, emergency room, urgent care center, <del>a laboratory, or surgical center, health care practitioner's office or at home. Physician and health care practitioners include licensed providers acting within the scope of their license, such as but are not limited to the following: A provider of health care is defined in NRS 629.031.</del></p> <ul style="list-style-type: none"> <li>• <del>Surgeon</del></li> <li>• <del>Assistant surgeon (if medically necessary)</del></li> <li>• <del>Anesthesia by physicians and Certified Registered Nurse Anesthetists (CRNA)</del></li> <li>• <del>Pathologist; Radiologist</del></li> <li>• <del>Physician Assistant; Nurse Practitioner; Nurse Midwife</del></li> <li>• <del>Homeopathic Physicians, Christian Science Practitioners, Oriental Medicine Doctor (OMD) only for Acupuncture</del></li> <li>• <del>Podiatrist</del></li> <li>• <del>Psychologist, Psychiatrist, Licensed Clinical Social Worker</del></li> </ul>		

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Physician and Other Health Care Practitioner Services Provider of Health Care	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p align="center"><b>Explanations and Limitations</b></p> <p align="center"><u>Physician and Other Health Care Practitioner Services Provider of Health Care</u></p> <p>The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery/Surgeries" in the <i>Key Terms and Definitions</i> section.</p> <p>Assistant surgeon <u>and certified surgical assistant</u> fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. <u>A Certified Surgical Assistant (see Key Terms and Definitions section) is payable as an assistant surgeon.</u></p> <p><u>Podiatry benefits include routine foot care for the treatment of foot problems such as bunions, corns, calluses, and toenails are covered only for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral vascular insufficiency affecting the feet.</u></p> <p><u>No coverage is provided for pProphylactic surgery or treatment is not covered. as defined in the Key Terms and Definitions section and as explained in the Exclusions section, unless otherwise specified in this document.</u></p> <p><u>No coverage for homeopathic Homeopathic treatments, supplies, remedies, or substances are not covered.</u></p>		

- Formatted: Not Highlight
- Formatted: Not Highlight
- Formatted: Not Highlight
- Formatted: Not Highlight

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
<b>Colorectal Cancer Screening</b> (Colonoscopy/bowel prep or Cologuard)	Plan pays 100%, not subject to Deductible	Not Covered
<b>Women's Preventive Services</b> <i>Well woman visits; screening for gestational diabetes; human papillomavirus testing; counseling/screening: human immune deficiency virus, mammograms; interpersonal and domestic violence</i>	Plan pays 100%, not subject to Deductible	Not Covered
<b>BRCA Risk Assessment and Genetic Counseling/Testing</b>	Plan pays 100%; not subject to Deductible	Not Covered
<ul style="list-style-type: none"> <li>• BRCA risk assessment for women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations.</li> </ul>		

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network	
<p><b>Preventive Care/Wellness Benefits</b></p> <ul style="list-style-type: none"> <li>Genetic Counseling following a positive result on risk assessment and, if indicated after counseling, genetic testing.</li> <li>BRCA testing requires <a href="#">precertification/prior authorization</a>.</li> </ul>	Plan pays 100%, not subject to Deductible	Not Covered	
<p><b>Breastfeeding Support/Equipment</b></p> <p>Coverage for comprehensive lactation support and counseling from trained providers for women during the prenatal and postpartum period and up to one year following delivery. Coverage for breastfeeding equipment and supplies in conjunction with each live birth. The Plan covers one manual or standard electric breast pump per live birth.</p> <p>Contact the third-party claims administrator regarding the purchase of covered breast pumps. Rental for heavy duty electrical (hospital grade) breast pump covered only when the UM company determines it is medically necessary and only during the newborn's inpatient hospital stay.</p>	Plan pays 100%, Not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible	
<p><b>Contraceptives / Family Planning</b></p> <ul style="list-style-type: none"> <li>Up to 12-month supply, per prescription, of a drug for contraception or its therapeutic equivalent;</li> <li>Devices for contraception, and insertion and removal of such devices;</li> <li>Self-administered hormonal contraceptives;</li> <li>Education and counseling relating to the initiation of the use of contraception and any necessary follow-up;</li> <li>Management of side effects of contraception; and</li> <li>Voluntary sterilization for women.</li> </ul> <p>Includes contraceptive injection or the insertion of contraceptive device at a hospital immediately after an insured gives birth.</p> <p>Methods of covered contraception:</p>	Plan pays 100%, not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible; pharmacy not covered	
<ul style="list-style-type: none"> <li>Elective sterilization for women</li> <li>Surgical sterilization implants for women</li> <li>Implantable rods</li> <li>Copper-based intrauterine devices</li> <li>Progesterone-based intrauterine devices</li> <li>Injections</li> </ul>	<ul style="list-style-type: none"> <li>Combined estrogen- and progestin-based drugs</li> <li>Progestin-based drugs</li> <li>Extended- or continuous-regimen drugs</li> <li>Estrogen- and progestin-based patches</li> </ul>	<ul style="list-style-type: none"> <li>Vaginal contraceptive rings</li> <li>Diaphragms w/spermicide</li> <li>Sponges w/spermicide</li> <li>Cervical caps w/spermicide</li> <li>Female condoms</li> <li>Male condoms</li> <li>Spermicide</li> </ul>	<ul style="list-style-type: none"> <li>Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception</li> <li>Ulipristal acetate for emergency contraception</li> </ul>



Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
<b>Explanations and Limitations</b>		
<p style="text-align: center;">Preventive Care/Wellness Benefits</p> <p>This Plan complies with the Patient Protection and Affordable Care Act; IRS rules and regulations for HSAs, and in particular, <a href="#">Section 223</a> of the Internal Revenue Code; and applicable Nevada law regarding covered preventive care.</p> <p>Recommended preventive care services are covered with no cost sharing when provided by in-network providers. Preventive care services are not subject to and will not apply to the Plan Year Deductible or Out-of-Pocket Maximum. Some preventive care services have service quantity limitations.</p> <p>Preventive care focuses on detecting and preventing medical problems before they become more serious. Preventive care services include:</p> <ul style="list-style-type: none"> <li>• Recommendations of the U.S. Preventive Services Task Force with a current rating of “A” or “B,” including: <ul style="list-style-type: none"> <li>○ Screening for various conditions, including depression, diabetes, obesity, hypertension, sexually transmitted infections, prenatal conditions, and various cancers;</li> <li>○ Medications intended to prevent conditions, including those intended to prevent HIV, breast cancer, and heart disease; and</li> <li>○ Counseling for various medical concerns, including addressing drug use, tobacco use, healthy diet, and physical activity.</li> <li>○ Immunizations recommended by the federal Advisory Committee on Immunization Practices (ACIP), including influenza, COVID-19, hepatitis A, hepatitis B, HPV, measles/mumps/rubella, meningitis, RSV, shingles, and Tdap.</li> </ul> </li> <li>• Recommendations by the Women’s Preventive Services Initiative, including well-woman visits, pelvic examinations, Pap smears, breast exams, and prenatal visits.</li> </ul> <p>Recommendations by the Health Resources and Services Administration’s with respect to the health of infants, children, and adolescents, including well-child visits, behavioral and developmental assessments, and screening for autism, certain genetic diseases, lipid disorders, tuberculosis, and vision impairment.</p> <p>Annual check-ups, including related screening lab and x-rays.</p> <ul style="list-style-type: none"> <li>○ <a href="#">Note: routine lab services from independent labs may not be recognized as preventive care unless there is a corresponding wellness office visit within a reasonable number of days prior to or after lab date</a></li> </ul> <p><a href="#">A physician may recommend a preventive service that is not listed in this document. For additional information regarding preventive benefit information, contact the third-party claims administrator listed in the <i>Participant Contact Guide</i>.</a></p>		

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered

Note: Once an individual becomes symptomatic, or has been diagnosed with a serious health condition, all diagnostic testing and blood testing no longer fall under preventive care/wellness. An example of this would be the removal of a polyp during a colorectal cancer screening.

Please note: routine lab services from independent labs may not be recognized as preventive care unless there is a corresponding wellness office visit within a reasonable number of days prior to or after lab date

Your physician may recommend a preventive service that is not listed in this document. For additional information regarding preventive benefit information, contact the third-party claims administrator listed in the *Participant Contact Guide*.

Formatted: Normal, No bullets or numbering

Formatted: Normal, Indent: Left: 0"

Guidelines for common preventive services:

**Mammogram:** The first preventive mammogram of the Plan Year is covered at 100% for women aged 40 years and older or beginning at age 35 for members with a high-risk of breast cancer, when performed in-network.

**Colorectal cancer screening:** ~~Once:~~ Once every 10 years for adults aged 45 years and older who are at average risk of colorectal cancer, or beginning at age 40 for members with a high-risk of colorectal cancer.

**Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors:** Behavioral Counseling Interventions for adults aged 18 years and older are covered under the Wellness/Preventive Benefit when referred by a primary care practitioner for those who have a basal metabolic index (BMI) of 30 or greater and have additional cardiovascular disease (CVD) risk factors. This wellness/preventive benefit is limited to twelve (12) Healthy Diet/Physical Activity Counseling or Obesity Screening/Counseling visits per Plan Year. Additional visits are subject to a specialist visit copay, deductible, or coinsurance where applicable.

**Smoking/Tobacco Cessation:**

- Prescription and over-the-counter smoking/tobacco cessation products are covered under the prescription drug program. Over-the-counter smoking cessation products must be accompanied by a prescription written by a physician.
- Some examples of cessation products eligible to be paid at 100% include Chantix (by prescription only), nicotine gum, nicotine patches, and nicotine lozenges. Some limitations on quantity may apply and are at the discretion of the Pharmacy Benefit Manager and your physician.
- Benefits for over-the-counter products are limited to those that are FDA-approved and recommended by the Surgeon General.
- Over-the-counter smoking/tobacco cessation products may be obtained by presenting your physician's written prescription to an in-network pharmacy, or you can submit your

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
<p>purchase receipt for the product with <del>your</del> <u>the</u> physician's written prescription attached to the Prescription Drug Reimbursement Claim Form (this form is located at <a href="https://pebp.nv.gov/">https://pebp.nv.gov/</a>).</p> <ul style="list-style-type: none"> <li>• Second-line therapies such as clonidine hydrochloride and nortriptyline hydrochloride are sometimes used in the management of smoking/tobacco-cessation <u>are not FDA approved and are not covered</u>; <del>however, due to the lack of an FDA-approved indication for smoking cessation, as well as undesirable side effect profiles, currently prohibit these agents from achieving first-line classification and therefore, not covered under the Preventive Care/Wellness Services Benefit.</del></li> <li>• <u>The Plan does not cover electronic cigarettes.</u></li> </ul> <p><u>Additional services covered as preventive as a component of the Affordable Care Act (ACA).</u></p> <ul style="list-style-type: none"> <li>• <u>One-time screening for abdominal aortic aneurysm with ultrasonography in men aged 65 – 75 who have smoked.</u></li> <li>• <u>Anxiety screening for adults 64 years of age and younger (including pregnant and postpartum)</u></li> <li>• <u>Anxiety screening for children aged 8 – 18.</u></li> <li>• <u></u></li> </ul> <p>For more information, please visit or contact the third-party claims administrator.</p> <p><b>Helpful Resources</b></p> <p><del>For more information on recommendations issued by medical and scientific bodies that affect what is considered preventive care, please see their websites:</del></p> <p><del>U.S. Preventive Services Task Force: <a href="https://www.uspreventiveservicestaskforce.org/uspstf/">https://www.uspreventiveservicestaskforce.org/uspstf/</a></del></p> <p><del>Advisory Committee on Immunization Practices: <a href="https://www.cdc.gov/vaccines/acip/index.html">https://www.cdc.gov/vaccines/acip/index.html</a></del></p> <p><del>Women's Preventive Services Initiative: <a href="https://www.womenspreventivehealth.org/recommendations/">https://www.womenspreventivehealth.org/recommendations/</a></del></p> <p><del>Health Resources &amp; Services Administration, Bright Futures: <a href="https://mchb.hrsa.gov/programs-impact/bright-futures">https://mchb.hrsa.gov/programs-impact/bright-futures</a></del></p>		

Formatted: Font: 11.5 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 11.5 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Normal, No bullets or numbering

Benefit Description	In-Network	Out-of-Network
---------------------	------------	----------------

Schedule of Benefits

Radiology & Radiation Therapy	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p align="center"><b>Explanations and Limitations</b></p> <p align="center"><del>Radiation Therapy, including Radiology (X-Ray), Nuclear Medicine &amp; Radiation Therapy Services (Outpatient)</del></p> <p><u>Radiology</u></p> <p>The Plan covers medically necessary <u>specialty-outpatient</u> radiology when ordered by a physician or health care practitioner acting with the scope of their license, <del>including MRI, MRA, MRS-MRT, PET, SPEC, and CT scan.</del></p> <ul style="list-style-type: none"> <li><del>Precertification</del><u>Prior authorization</u> required for <u>outpatient CT, MRI, SPECT and PET radiology.<del>For other precertification requirements, see the Utilization Management (Prior Authorization) section.</del></u></li> <li>The Plan covers technical and professional fees associated with outpatient radiology <u>tests that is</u> performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to <u>the a</u> sickness or injury for which admission or surgery is planned.</li> </ul> <p><del>Refer to the Preventive Care/Wellness Services section of this document for information regarding benefits for screening radiology services and other preventive radiology testing.</del></p> <p><u>Radiation Therapy</u></p> <ul style="list-style-type: none"> <li><u>Medically necessary professional services related to radiation therapy are covered.</u></li> </ul>		

Formatted: Space After: 0 pt

Formatted: Space After: 0 pt

Formatted: Font: 12 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Space After: 0 pt, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Space After: 0 pt

Formatted: Font: 12 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Benefit Description	In-Network	Out-of-Network
Real Appeal	No cost to Participants	Not Covered
<p align="center"><b>Explanations and Limitations</b></p> <p align="center"><u>Real Appeal</u></p> <p>Real Appeal provides eligible members who are at least 18 years old a benefit for virtual weight loss and weight management coaching sessions, with no cost to the member.</p> <p>This support includes one-on-one coaching and online group sessions with supporting video content delivered by a virtual coach.</p> <p>A qualified enrolled member will receive:</p> <ul style="list-style-type: none"> <li>Access to a coach who will guide <u>you-participants</u> through the program and develop a custom plan that fits <u>your-their</u> needs, preferences, and goals;</li> <li>24/7 access to digital tools and dashboards;</li> </ul>		

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Indent: Left: 0"

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Real Appeal	No cost to Participants	Not Covered
<p align="center"><b>Explanations and Limitations</b></p> <p align="center"><a href="#">Real Appeal</a></p> <p>Real Appeal provides eligible members who are at least 18 years old a benefit for virtual weight loss and weight management coaching sessions, with no cost to the member.</p> <ul style="list-style-type: none"> <li>• A Real Appeal kit containing health weight management tools that may include fitness guides, recipes, digital food and weight scales; and</li> <li>• Support from online group classes with a coach and other members who share what has helped them achieve success.</li> </ul> <p>For more information, contact the Plan’s third-party claims administrator listed in the Participant Contact Guide.</p>		

- Formatted: Font: Not Bold
- Formatted: Font: Not Bold
- Formatted: Indent: Left: 0"

Benefit Description	In-Network	Out-of-Network
Rehabilitation Services ( <del>Cardiac</del> , Physical, Occupational, and Speech Therapy)	Inpatient or Outpatient: Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p align="center"><b>Explanations and Limitations</b></p> <p align="center">Rehabilitation Services (Physical, Occupational, and Speech Therapy)</p> <p><a href="#">Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness, surgery, or medically necessary treatment of a behavioral health condition and that is performed by a licensed therapist acting within the scope of his or her license. Also, cardiac therapy.</a></p> <ul style="list-style-type: none"> <li>• Rehabilitation services are covered only when ordered by a physician or other provider acting within the scope of their license.</li> <li>• Inpatient rehabilitation admission requires prior authorization.</li> <li>• <del>Prior authorization for outpatient rehabilitative and habitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year. Visit limits will do not apply to Medically Necessary treatment of mental health or substance use disorder. Visit limits do not apply to speech therapy for children under the age of 18.</del></li> <li>• <del>There is no limit for Cardiac Rehabilitation services is included under this header. Cardiac rehabilitation is a program that helps people with heart disease improve their cardiovascular</del></li> </ul>		

- Formatted: Left
- Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
- Formatted: Font: 12 pt
- Formatted: Font: 11.5 pt

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
Rehabilitation Services ( <del>Cardiac</del> , Physical, Occupational, and Speech Therapy)	Inpatient or Outpatient: Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b></p> <p style="text-align: center;">Rehabilitation Services (Physical, Occupational, and Speech Therapy)</p> <p><u>Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness, surgery, or medically necessary treatment of a behavioral health condition and that is performed by a licensed therapist acting within the scope of his or her license. Also, cardiac therapy.</u></p> <p><u>health. It can include exercise, education, and support. There is no limit to cardiac rehabilitation.</u></p> <ul style="list-style-type: none"> <li>• Benefits for rehabilitation therapy are limited to services given for acute or recently acquired conditions that, in the judgement of the member's physician, are subject to significant improvement through short-term therapy.</li> <li>• Short term active, progressive rehabilitation services for occupational, physical, or speech therapy must be performed by a licensed or duly qualified therapist/provider acting within the scope of their license.</li> <li>• Inpatient rehabilitation services in an acute hospital, rehabilitation unit or facility or skilled nursing facility for short term, active, progressive rehabilitation services that cannot be provided in an outpatient or home setting.</li> <li>• Maintenance Rehabilitation and coma stimulation services are not covered. <u>Once an individual meets their function goal, no additional therapy sessions will be covered. (see specific exclusions relating to rehabilitation therapies in the Exclusions section).</u></li> <li>• <del>Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagia, swallowing defects, to correct speech disorders due to childhood developmental delays and disorders due to illness, injury, or a surgical procedure. Speech therapy is payable following surgery to correct a congenital</del> <u>the congenital</u> condition of the oral cavity, throat, or nasal complex (other than a frenectomy), an injury, or sickness that is other than a learning disorder. <u>Maintenance Rehabilitation and coma stimulation are not covered.</u></li> </ul> <p><del>See the see the Utilization Management section for prior authorization requirements.</del></p>		

Formatted: Left

Formatted: Font: 11.5 pt

Formatted: Font: 11.5 pt

Formatted: Right: 2.6", Space After: 6 pt

Formatted: Justified, Right: 2.6", Space After: 6 pt

Schedule of Benefits

Benefit Description	In-Network	Out-of-Network
<a href="#">Second Physician Opinion Services</a> <a href="#">Includes only one office visit per opinion</a>	Plan pays <del>80</del> 100% after Plan Year Deductible	<del>Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible</del> Not Covered
<b>Explanations and Limitations</b> Second Physician Opinion		
<p>For <del>your</del>a second opinion, <del>you</del>participants may choose any In-Network, <del>Board-certified</del>licensed specialist who is not an associate of the <del>attending</del>diagnosing physician.</p> <p><a href="#">Limit to one officer visit per opinion.</a></p> <p>2nd.MD is PEBP's preferred second opinion service. See benefits in the Schedule of Benefits, below, for additional information.</p>		

- Formatted: Indent: Left: 0"
- Formatted: Font: 11.5 pt
- Formatted: Normal, Indent: Left: 0", Right: 0.2", Space After: 12 pt
- Formatted: Indent: Left: 0"

Benefit Description	In-Network	Out-of-Network
<del>2nd.MD (Second Opinion Service)</del>	<del>Plan Pays 100%, not subject to Deductible</del>	<del>Not Covered</del>
<a href="#">Telemedicine &amp; Telehealth Doctor on Demand (DoD) only</a>	Listed prices are before deductible has been met. The plan pays 80% after Plan Year Deductible is met.	Not Covered
Medical Visit	\$49	Not Covered
Psychology Visit (25-minute visit)	\$79	Not Covered
Psychology Visit (50-minute visit)	\$129	Not Covered
Psychiatry Visit (initial 45-minute visit)	\$229	Not Covered
Psychiatry Visit (15-minute follow-up visit)	\$99	Not Covered
<a href="#">Telehealth (other telemedicine providers)</a>	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<b>Explanations and Limitations</b> Telemedicine and Telehealth		

- Formatted: Highlight
- Formatted: Highlight
- Formatted: Highlight
- Formatted: Highlight
- Formatted: Highlight

Schedule of Benefits

Telehealth means the delivery of services from a provider of health care to a patient at a different location using information and audio-visual communication technology, not including facsimile, or electronic mail.

Telemedicine (vendor/virtual visit) is the practice of medicine using technology to deliver care at a distance via electronic communications through a vendor.

- ~~Doctor on Demand telemedicine services is PEBP's contracted telehealth provider and are considered In-Network. To learn more, visit <http://www.doctorondemand.com/pebp>.~~
- ~~2nd.MD provides eligible members with direct access to elite specialists across the county for expert second opinions. Specialists answer questions about disease, cancer, chronic conditions, surgery or procedure, medications, and treatment plans. Specialists are board certified, leaders in research, and pioneers in medicine. To learn more visit [www.2nd.MD/PEBP](http://www.2nd.MD/PEBP) or call 1-866-841-2575.~~

~~Alternatively, telemedicine/telehealth/telemedicine may be is available from in-network providers and is covered on the same basis as in-person services. It is ~~you~~participants responsibility to ensure the providers ~~you use~~ are in-network providers. Failure to use in-network providers will result in a denial of benefits and higher cost to ~~you~~participants.~~

- ~~Doctor on Demand telemedicine services is PEBP's contracted telehealth provider and are considered In-Network. To learn more, visit <http://www.doctorondemand.com/pebp>.~~

Formatted: Font: 11.5 pt

Formatted: Normal, No bullets or numbering

Formatted: Normal, Left, Right: 0", Space After: 0 pt, No bullets or numbering

Formatted: Font: 12 pt

Formatted: Font: 11.5 pt

Formatted: Normal, Space After: 0 pt, No bullets or numbering

Formatted: Font: 11.5 pt

Formatted: Font: 12 pt, Bold

Benefit Description	In-Network	Out-of-Network
Skilled Nursing Facility (SNF) and Subacute Care Facility	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

**Explanations and Limitations**

Skilled Nursing Facility (SNF) and Subacute Care Facility

- Admission to a skilled nursing facility or subacute care facility must be ordered by a physician and requires prior authorization (see the *Utilization Management* section of this document).
- ~~Medically necessary care at a skilled nursing facility (limited to 60 days per Plan Year) is covered. A skilled nursing facility is a facility that is duly licensed by the state and/or federal government and that provides inpatient skilled nursing care, rehabilitation services, or other related health services that are not custodial or convenient in nature. Skilled nursing care includes medically necessary services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse. This Plan does not cover skilled nursing care that is not covered by CMS. Prior care in a hospital is not required before being eligible for coverage for care in a skilled nursing facility.~~

Formatted: Normal, Right: 0.01", Space After: 12 pt, No bullets or numbering

Formatted: Font: 12 pt

- ~~Skilled nursing facility (SNF) confinement or subacute care facility confinement payable up to 60 days per Plan Year for confinements related to the same cause. Additional visits are subject to preauthorization by the UM Company.~~

Formatted: Indent: Left: 0.35", No bullets or numbering



Schedule of Benefits

Benefit Description	Center of Excellence	Non-Center of Excellence
Transplant <del>Services</del> (Organ and Tissue)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b> Transplants (Organ and Tissue)</p> <p><u>A transplant is the transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.</u></p> <ul style="list-style-type: none"> <li>• Coverage is provided only for eligible services related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.</li> <li>• Coverage is provided for the donor when the receiver is a participant under this Plan.</li> <li>• Coverage is provided for organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs related to a living or nonliving donor (transport within the U.S. or Canada only).</li> <li>• When the donor has medical coverage, his or her plan will pay first and the benefit under this Plan will be reduced by the amount payable by the donor’s plan.</li> <li>• <del>Expenses incurred by a participant of this Plan who donates an organ or tissue are not covered unless the person who receives the donated organ/tissue is also a participant covered by this Plan.</del></li> <li>• Transplantation-related services require <u>precertification/prior authorization</u>. (see the <i>Utilization Management</i> section of this document for details). Coverage is provided only for eligible services related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.</li> <li>• See the <i>Exclusions</i> section related to experimental and investigational services and transplants.</li> <li>• To receive maximum Plan benefits, members must use a Center of Excellence for single organ or combined organs and tissue transplants. Transplant Center of Excellence facilities will be identified by the claim’s administrator. For information regarding transplant benefits and Centers of Excellence facilities, contact the third-party claims administrator at 888-763-8232.</li> <li>• This Plan provides for reimbursement of certain costs associated with travel and lodging <del>accommodations</del><u>accommodation</u> for the patient and one additional person (spouse/domestic partner, family member or friend) when associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. For travel expense benefits, refer to the <i>Travel Expenses</i> section.</li> <li>• Expenses incurred for travel and lodging accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.</li> <li>• PEBP does not provide advance payment for travel expenses related to organ or tissue transplants.</li> </ul>		

Formatted: Justified

Schedule of Benefits

Benefit Description	
Travel Expenses	Not Subject to Deductible and Out-of-Pocket Maximum
<p style="text-align: center;"><b>Explanations and Limitations</b> Travel Expenses</p> <p>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).</p> <p>Travel expenses are covered when incurred in conjunction with the member's:</p> <ul style="list-style-type: none"> <li>• Transplant or bariatric surgery. <ul style="list-style-type: none"> <li>○ This includes pre-surgery appointments such as evaluations, testing, counseling, etc.</li> </ul> </li> <li>• 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 <ul style="list-style-type: none"> <li>○ This includes pre-surgery evaluations, and</li> <li>○ For one year after surgery for follow-up visits as required by the patient's surgeon; and</li> </ul> </li> <li>• 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. <ul style="list-style-type: none"> <li>○ 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.</li> </ul> </li> <li>• Travel for a participant located in a State with more restrictive access to abortion than Nevada, see <a href="#">NRS 422.250</a>, to the nearest care center for abortion services covered under this Plan.</li> </ul> <p>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.</p> <p>If the travel companion has their own separate PEBP plan, travel expense reimbursement will not apply to the companion.</p> <p>PEBP does not provide advance payment for travel expenses.</p> <p>The Plan will reimburse up to the GSA rate for lodging, travel, meals, or actual expenses, whichever is less.</p> <p><b>Pre-approval for travel expenses:</b></p> <ul style="list-style-type: none"> <li>• Travel expenses must be pre-approved by PEBP <del>or its designee</del>. <a href="#">Pre-approval requests shall be sent to PEPBs Quality Control Unit.</a></li> </ul>	

Schedule of Benefits

Benefit Description	
Travel Expenses	Not Subject to Deductible and Out-of-Pocket Maximum
<p style="text-align: center;"><b>Explanations and Limitations</b> Travel Expenses</p> <ul style="list-style-type: none"> <li>○ 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 <del>or its designees</del> <a href="#">Quality Control Unit</a> after the transplant surgery.</li> </ul> <p>Pre-approval will provide an estimation of <del>your</del> travel reimbursement based on GSA rates. A Travel Pre-Authorization form is available at <a href="http://pebp.nv.gov">pebp.nv.gov</a>.</p> <p><b>Submitting Travel Reimbursement form and receipts:</b></p> <ul style="list-style-type: none"> <li>• Requests for travel expense reimbursement must be submitted to PEBP's <a href="#">Quality Control Unit</a> using the Travel Reimbursement form available at <a href="http://pebp.nv.gov">pebp.nv.gov</a>.</li> <li>• Travel Reimbursement forms and receipts (<a href="#">hotel, toll roads, parking</a>) must be submitted within 12 months of the date of the service.             <ul style="list-style-type: none"> <li>○ The form must be completed, including the start and end times, destination, and purpose of trip</li> <li>○ 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 <u>must be</u> attached for meal justification.</li> </ul> </li> </ul> <p>Reimbursement of eligible travel expenses, including any relating to a travel companion, will be payable to the primary participant.</p> <p>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 lesser of GSA rates or actual expenses will be used.</p> <p>Meals will be reimbursed in accordance with the meals and incidental expense (M&amp;IE) allowance. Receipts are not required for the M&amp;IE allowance. Participants should refer to the GSA's website <a href="http://gsa.gov">http://gsa.gov</a> and the link "Per Diem Rates" for the most current rates.</p> <p><a href="#">Mileage, if driving, will be reimbursed in accordance with Nevada current mileage non-medical reimbursement rate.</a></p> <p><b>Eligible Travel Expenses include:</b></p> <p>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.</p> <ul style="list-style-type: none"> <li>• Method of transportation including personal car, airline, rental car, bus, taxi, etc. The least expensive method of transportation must be used.</li> </ul>	

Formatted: Justified

Schedule of Benefits

Benefit Description	
Travel Expenses	Not Subject to Deductible and Out-of-Pocket Maximum
<p style="text-align: center;"><b>Explanations and Limitations</b> Travel Expenses</p> <ul style="list-style-type: none"> <li>○ Flight expenses for commercial air (regular coach rate).</li> <li>○ Mileage reimbursement for personal vehicle (GSA non-medical mileage rate).</li> <li>● Travel meals (for patient and travel companion only).               <ul style="list-style-type: none"> <li>○ Reimbursement for meals while traveling will apply the GSA rate for the travel day for the first and last day of travel.</li> </ul> </li> <li>● Lodging accommodations (GSA rate)               <ul style="list-style-type: none"> <li>○ For transplants, some Centers of Excellence facilities may have on-site or affiliated lodging services.                   <ul style="list-style-type: none"> <li>▪ For required lodging, the plan will pay the lesser of the affiliated lodging or GSA rates, subject to verification of availability.</li> </ul> </li> </ul> </li> </ul> <p>Travel expenses are not subject to cost-share (Deductible, copay, and/or Out-of-Pocket Maximum). Therefore, PEBP will issue <u>appropriate-applicable</u> reporting forms (form 1099, W2, etc.) for federal tax reporting purposes. <u>You/Participants</u> may be liable for taxes and must consult <u>your</u> tax professional for further assistance.</p> <p><b>Excluded travel expenses:</b></p> <p>The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved):</p> <ul style="list-style-type: none"> <li>● Alcoholic beverages.</li> <li>● Car maintenance.</li> <li>● Vehicle insurance.</li> <li>● <u>Flight insurance.</u></li> <li>● <u>Travel insurance.</u></li> <li>● <u>Room service fees.</u></li> <li>● Cards, stationery, stamps.</li> <li>● Clothing.</li> <li>● Dry cleaning.</li> <li>● Entertainment (cable televisions, books, magazines, movie rentals).</li> <li>● Flowers.</li> <li>● Household products.</li> <li>● Household utilities, including cell phone charges, house cleaner, baby-sitter, or day care services.</li> <li>● Kennel fees.</li> <li>● Laundry services.</li> <li>● Security deposits.</li> </ul>	

Schedule of Benefits

Benefit Description	
Travel Expenses	Not Subject to Deductible and Out-of-Pocket Maximum
<p style="text-align: center;"><b>Explanations and Limitations</b> Travel Expenses</p> <ul style="list-style-type: none"> <li>• Toiletries.</li> <li>• 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</li> <li>• Travel expenses incurred on or after one year following services are not eligible for reimbursement.</li> </ul>	

Benefit Description	In-Network	Out-of-Network
Vision Screening Exam (Preventive)	Plan pays 80% after Plan Year Deductible	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible
<p style="text-align: center;"><b>Explanations and Limitations</b> Vision Screening Exam*</p> <ul style="list-style-type: none"> <li>• One annual preventive vision screening exam including refractive error testing per Plan Year.</li> <li>• Hardware such as but not limited to contact lenses, lenses and frames are not covered.</li> <li>• <u>*When refraction is conducted in conjunction with an examination with a medical diagnosis, such as cataracts, it will be paid under the medical benefit, subject to Deductible and Coinsurance.</u></li> <li>• <u>Hardware such as but not limited to contact lenses, lenses and frames are covered up to \$150 per plan year, subject to deductible and coinsurance for individuals aged 19 and above. There is no limit for children up through age 18.</u></li> <li>• PEBP does not maintain a network specific to vision care; however, the PPO network does have a list of some vision providers.</li> </ul>		

Formatted: Font: 11.5 pt

Formatted: Font: 11.5 pt

Formatted: Normal, Indent: Left: 0.25", No bullets or numbering

## Schedule of Prescription Drug Benefits

Benefits for prescription drugs are provided through the prescription drug plan administered by the Pharmacy Benefit Manager, ~~Express Scripts~~[The PBM](#) (ESI). Coverage is provided only for those pharmaceuticals (drugs and medicines) obtained from In-Network providers and approved by the U.S. Food and Drug Administration (FDA) as requiring a prescription and FDA approval for the condition, dose, route, duration, and frequency, if prescribed by a physician or other practitioner.

The following schedule includes explanations and limitations that apply to each benefit; however, the explanations and limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any ~~precertification~~[prior authorization](#) requirements), *Benefit Limitations and Exclusions*, ~~Key Terms and Definitions~~ and other sections that may apply to a specific benefit.

For helpful tools such as “Price a Medication” see the *Participant Contact Guide* section or go to the PEBP website at <https://pebp.nv.gov/>.

[A Formulary, which is a list of generic and brand name drug products available for use by participants, is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.](#)

[A generic drug is a prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. The Plan considers as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the pharmacist as being generic](#)

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
<b>Preferred/Formulary Generic Drugs</b>	Plan pays 80% after Plan Year Deductible	Not Covered
<b>Preferred/Formulary Brand Drugs</b>	Plan pays 80% after Plan Year Deductible	Not Covered
<b>Non-Preferred/Non-Formulary Brand Drugs</b>	<del>You</del> <a href="#">Participants</a> pay 100% of the cost of the medication; Deductible and Out-of-Pocket Maximum credit is not applied	Not Covered
<b>Specialty Pharmaceutical Drug (Accredo Specialty Pharmacy)</b>	Plan pays 80% after Plan Year Deductible; for drugs not on the	Not Covered

Schedule of Prescription Drug Benefits

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
	SaveOnSP program, there is \$100 min/\$250 max copay	
<p><b>Preventive Medications</b> (Limited only to those preventive drugs identified by the pharmacy benefit manager)</p>	<p>ACA Mandated Preventive Drugs: Plan Pays 100%, not subject to Plan year Deductible Other Preventive Drugs: Plan pays 80%, not subject to Plan Year Deductible</p>	<p>Not Covered</p>
<p style="text-align: center;"><b>Explanations and Limitations</b> Prescription Drug Benefit</p> <p>This Plan does not coordinate prescription drug plan benefits.</p> <p>Some over the counter (OTC) drugs and prescription drugs are eligible to be covered under the Plan’s <i>Preventive Care/Wellness Services</i> benefit in accordance with the Affordable Care Act; whereby, the Plan will waive the Copays and Deductibles and products are paid at 100%. Please contact <a href="#">Express-ScriptsThe PBM</a> for more information.</p> <p><a href="#">This plan allows for step therapy, which is a cost -savings measure that requires participants to try a less expensive medication before trying a more expensive one. Some classes of medications are excluded from step therapy.</a></p> <p><a href="#">This plan allows for three emergency refills per plan year.</a></p> <p>Certain OTC <del>female</del>-contraception products are covered when presented with a prescription from <del>your-a</del> physician to <del>your-a</del> pharmacy. These types of products include <del>the female</del> condoms, sponges, and spermicides. Refer to the “Contraceptives/Family Planning” portion of the <i>Preventive Care/Wellness Benefits</i> section or contact <del>Express-ScriptsThe PBM</del> for more information. The plan adheres to <a href="#">NRS 695G.1715</a> regarding drugs for contraception or its therapeutic equivalent.</p> <p>Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. Contact <del>Express-Scripts or visit www.express-scripts.com to check</del> <a href="#">the Pharmacy Benefit Manager (PBM) to verify</a> vaccine coverage and locate <del>your-the</del> nearest In-Network pharmacy. Contact the pharmacy to verify their current vaccination schedule and vaccine availability. <a href="#">Note: Some vaccines have age limitations; contact the PBM for more information.</a></p>		

Schedule of Prescription Drug Benefits

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
<p data-bbox="152 537 1133 621"><u>The following are considered routine vaccinations: Covid-19, dengue, diphtheria, tetanus and pertussis, Flu, Hepatitis A &amp; B, Shingles &amp; Herpes Zoster, HPV, Measles, Mumps, and Rubella (MMR), Meningococcal, Monkeypox, Pneumonia, TDAP (whooping cough), Polio, RSV, Rotavirus, and Varicella.</u></p> <p data-bbox="152 646 607 674">Coverage is also provided for, but not limited to:</p> <ul style="list-style-type: none"> <li data-bbox="201 684 1029 737">• <del>Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (whooping cough)</del></li> <li data-bbox="201 743 630 770">• Prenatal &amp; pediatric prescription vitamins</li> <li data-bbox="201 774 607 802">• Prescription female oral contraceptives</li> <li data-bbox="201 806 1068 911">• <u>Hormone therapy drugs: The following male to female drugs are covered: Estrace, Estradiol, Delestrogen, and Spironolactone. The following female to male drugs are covered: Testosterone Cypionate, AndroGel Gel Pump, and Depo Testosterone. May require prior authorization.</u></li> <li data-bbox="201 917 1040 970">• Insulin, diabetic supplies (such as lancets, syringes, test strips), insulin pumps, and insulin pump supplies.</li> <li data-bbox="201 976 1053 1029">• Insulin pumps and supplies are covered under the pharmacy benefit's base day and quantity limits, subject to copayments, deductibles, or coinsurance.</li> <li data-bbox="201 1035 1058 1087">• <u>Quantity limits include, but are not limited to, one Omni pod Kit within a rolling 720 days, and a maximum of 15 pods within a 21-day period.</u></li> <li data-bbox="201 1094 1058 1199">• Orally Administered Chemotherapy: The Copayment, after deductible, or Coinsurance amount for orally administered chemotherapy drugs will be consistent with the drug's formulary tier for retail, home delivery and Specialty pharmacy; and in accordance with <a href="#">NRS 695G.167</a>, the cost will not exceed \$100 per prescription for a 30-day supply.</li> <li data-bbox="201 1205 1013 1260">• Prescription drugs irregularly dispensed for purposes of synchronization of chronic medication pursuant to the provisions of <a href="#">NRS 695G.1665</a></li> <li data-bbox="201 1266 984 1318">• Refills for topical ophthalmic products consistent with the provisions of <a href="#">NRS 695G.172</a>:</li> <li data-bbox="201 1325 1078 1430">• (a) After 21 days or more but before 30 days after receiving any 30-day supply of the product; (b) After 42 days or more but before 60 days after receiving any 60-day supply of the product; or (c) After 63 days or more but before 90 days after receiving any 90-day supply of the product.</li> <li data-bbox="201 1436 997 1463">• Medically necessary prescription drugs to treat sickle cell disease and its variants</li> <li data-bbox="201 1470 678 1497">• Human papillomavirus testing <del>and vaccination.</del></li> <li data-bbox="201 1524 1078 1629">• <u>Drugs approved by the U.S. Food and Drug Administration for medication-assisted treatment of opioid use disorder, including, without limitation, buprenorphine, methadone, <del>and</del> naltrexone <del>and</del> Lofexidine. Step therapy is not required for such drugs. Prior authorization is required.</u></li> <li data-bbox="201 1635 1078 1663">• <u>Under this benefit, some opioids are excluded under the National Preferred Formulary.</u></li> </ul>		

**Formatted:** Right: 0.5", Space After: 12 pt, No widow/orphan control, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers, Tab stops: 0.68", Left + 0.68", Left

**Formatted:** Font: 12 pt

**Formatted:** Font: 11.5 pt

**Formatted:** Font: 11.5 pt



Schedule of Prescription Drug Benefits

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
<ul style="list-style-type: none"> <li>• <a href="#">Preventive medication to prevent breast cancer such as tamoxifen, raloxifene, or aromatase inhibitors for those at risk of breast cancer.</a></li> <li>• A drug prescribed to treat a psychiatric condition when the drug is approved by the U.S. Food and Drug Administration or otherwise supported by medical or scientific evidence to treat the condition and is prescribed by a health care practitioner acting within the scope of his or her license. Step therapy is not required for such drugs.</li> <li>• <a href="#">Drugs approved by the U.S. FDA for the treatment of cancer and cancer symptoms. Step therapy is not required for such drugs.</a></li> <li>• <a href="#">Drugs approved by the U.S. FDA for the prevention of HIV.</a></li> <li>• <a href="#">Anti-obesity branded products are excluded from this benefit. Only generic products are covered. Refer to the Obesity Care Management Program.</a></li> </ul>		
<i>Preventive Drug Benefit Program</i>		
<p>The Preventive Drug Benefit Program provides participants access to certain preventive drugs subject only to Coinsurance, without having to meet the Deductible. Coinsurance paid under the benefit will not apply to the Deductible but will apply to Out-of-Pocket Maximum costs. The medications covered under this benefit include categories of prescription drugs that are used for preventive purposes for conditions such as hypertension, asthma, and high cholesterol. A list of eligible preventive drugs covered under this benefit can be found by logging on to <a href="https://pebp.nv.gov/">https://pebp.nv.gov/</a> or by contacting <a href="#">the PBMExpress Scripts</a>.</p>		
<i>Specialty Prescription Drugs</i>		
<p>Specialty drugs are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, etc. Specialty drugs and prescriptions are generally limited to a 30-day supply. Specialty drugs are available only through Accredo, the Plan's Specialty Pharmacy. Plan participants are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. Contact <a href="#">Express Scripts</a> <del>the PBM</del> to determine if <del>you</del> <a href="#">your</a> prescription is considered specialty.</p>		
<p>Special pharmaceuticals, which include injectables, oral medications, and medications given by other routes of delivery, may be delivered in any setting. Special pharmaceuticals are pharmaceuticals that typically have:</p>		
<ul style="list-style-type: none"> <li>• Limited access.</li> <li>• Treat complex medical conditions;</li> <li>• Complicated treatment regimens;</li> <li>• Compliance issues;</li> <li>• Special storage requirements; or</li> <li>• Manufacturer reporting requirements.</li> </ul>		

Formatted: Font: 11.5 pt



Formatted: Right: 0.5", No widow/orphan control, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers, Tab stops: 0.68", Left

Formatted: Font: 11.5 pt

Schedule of Prescription Drug Benefits

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
<p data-bbox="151 564 1131 621"><del>Express Scripts</del>The PBM maintains a list of special drugs classified as special pharmaceuticals. For information regarding special pharmaceuticals, contact <del>Express Scripts</del>the PBM.</p> <p data-bbox="151 648 1131 732">For Specialty Drugs covered under the SaveOnSP program, the coinsurance applies. For Specialty Drugs not part of the SaveOnSP program, the applicable coinsurance applies with a copay limitation of \$100 minimum and a maximum of \$250.</p> <p data-bbox="134 760 464 787"><i>Preferred Retail Pharmacy Network</i></p> <p data-bbox="151 795 1131 879">For short-term prescriptions, such as antibiotics, use a Preferred Retail Pharmacy (for lower copays) or a Non-Preferred Retail Pharmacy (where <del>you</del>participants will pay \$10 extra for each short-term prescription).</p> <p data-bbox="151 907 1131 1020">The Preferred Retail Pharmacy Network has more than 34,000 pharmacies consisting of approximately 50% independent pharmacies in addition to grocers and other stores. To find a preferred pharmacy near <del>you</del>participants, <del>register or log in to express-scripts.com/findapharmacy or call Express Scripts' Member Services at 855-889-7708</del>contact the PBM.</p> <p data-bbox="134 1050 557 1077"><i>Smart90 Retail and Home Delivery Program</i></p> <p data-bbox="151 1085 1131 1220">The Smart90 program is a feature of <del>your</del>the prescription plan, managed by <del>Express Scripts</del>the PBM. With this program, <del>participants</del>you have two ways to get up to a 90-day supply of <del>your</del>long-term medications (those <del>participants</del>you take regularly for ongoing conditions). <del>You</del>Participants can fill <del>your</del>long-term prescriptions through home delivery from the <del>Express Scripts</del>PBM Home Delivery Pharmacy or at a retail pharmacy in the Smart90 network.</p> <p data-bbox="151 1247 1131 1415"> <b>Please arrange for <del>your</del> long-term medications to be filled with a 90-day supply through either a participating retail pharmacy or <del>Express Scripts</del>the PBM Home Delivery Pharmacy. If, after a second 30-day supply courtesy fill of <del>your</del>long-term medication, <del>you</del>participants do not make such arrangements, <del>you</del> will pay a higher cost for <del>your</del> prescription medication and will not receive credit toward <del>your</del> Deductible or Out-of-Pocket Maximum.</b></p> <p data-bbox="134 1444 350 1472"><i>Smart90 Retail Pharmacy</i></p> <p data-bbox="151 1472 1131 1575">To locate a participating Smart90 Retail Pharmacy or a Preferred Retail Network Pharmacy, log in to the E-PEBP Portal located at <a href="https://pebp.nv.gov/">https://pebp.nv.gov/</a> and select <del>Express Scripts</del>the listed PBM. <del>You</del>Participants can also get pharmacy information by <del>calling Express Scripts' Member Services at 855-889-7708</del>contacting the current PBM. <del>You</del>Participants can transfer <del>your</del> medications easily in-store, by phone or online.</p> <p data-bbox="134 1585 464 1612"><i>Express Scripts</i>The PBM Home Delivery</p> <p data-bbox="151 1612 1131 1671"><del>You</del>Participants may use home delivery through the <del>Express Scripts</del> PBM Home Delivery Pharmacy to receive a 90-day supply of <del>your</del> maintenance medications and have them mailed to <del>you</del>participants with</p>		

Schedule of Prescription Drug Benefits

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
<p>free standard shipping. Not all drugs are available via mail order. Check with <a href="#">Express Scripts the PBM</a> for further information on the availability of <a href="#">your</a> prescription medication. Enrolling in home delivery is easy! First, log in to <a href="#">express-scripts.com</a>.</p> <p>If <a href="#">you</a> <a href="#">participants</a> are enrolling a new prescription in home delivery:</p> <ul style="list-style-type: none"> <li>• <b>Contact <a href="#">you</a> <a href="#">their</a> doctor</b> and ask them to e-prescribe a 90-day prescription directly to <a href="#">Express Scripts the PBM</a></li> <li>• <b>Print and complete the Home Delivery Order Form OR send a request</b> through <a href="#">Express Scripts the PBM</a>' website by selecting "Forms" or "Forms &amp; Cards" from the "Benefits" menu, <del>print and mail order form</del> and follow the mailing instructions</li> <li>• <del>OR call</del> <b>Contact <a href="#">Express Scripts the PBM</a> Member Services at 855-889-77058</b> and they will contact <del>you</del> <a href="#">the</a> doctor <del>for you</del>.</li> </ul> <p>Transfer retail prescriptions to home delivery by clicking "Add to Cart" for eligible prescriptions and check out. <del>You</del> <a href="#">Participants</a> can also refill and renew prescriptions. <a href="#">Express Scripts The PBM</a> will contact <del>you</del> <a href="#">the</a> doctor and take care of the rest.</p> <p><del>You</del> <a href="#">Participants</a> may check the status and shipping of <del>you</del> <a href="#">their</a> prescriptions online or with <a href="#">Express Scripts the PBM</a>' mobile app. Please allow 5 to 7 days from the time <a href="#">Express Scripts the PBM</a> receives <del>you</del> <a href="#">the</a> prescription until it arrives at <del>you</del> <a href="#">the</a> door. Please keep in mind, longer delivery times may be due to additional correspondence needed with prescribers, medication availability and/or delivery times from the shipping vendor.</p> <p> <b>Generics Preferred Program</b></p> <p>When <del>you</del> <a href="#">a</a> doctor prescribes a brand-name drug and a generic substitute is available, <del>you</del> <a href="#">participants</a> will automatically receive the generic drug unless:</p> <ul style="list-style-type: none"> <li>• <del>You</del> <a href="#">The</a> doctor writes "dispense as written" (DAW) on the prescription; or</li> <li>• <del>You</del> <a href="#">R</a> request the brand-name drug at the time <del>you</del> <a href="#">the</a> fill <del>your</del> prescription <u>is filled</u>.</li> </ul> <p>If <del>you</del> <a href="#">participants</a> choose generic medicines, <del>you</del> <a href="#">participants</a> get safe medicines at lower cost. <del>You</del> <a href="#">The</a> cost for the generic drug will be less than the cost for the brand-name drug.</p> <p>If a generic is available, but <del>you</del> <a href="#">participants</a>, or <del>you</del> <a href="#">their</a> doctor, request the brand-name drug, <del>you</del> <a href="#">participants</a> will pay the applicable brand cost.</p> <p> <b>Payment assistance (manufacturer-funded patient assistance) for specialty drugs will not apply toward <del>your</del> Deductible and Out-of-Pocket Maximum.</b></p>		

## Schedule of Prescription Drug Benefits

### *SaveOnSP Program*

As part of ~~your~~ prescription drug plan, PEBP has partnered with an ~~Express Scripts~~The PBM cost assistance program, SaveOnSP, to help save money on certain specialty medications. When enrolled in the SaveOnSP Program, the select specialty drugs are reimbursed by the manufacturer at no cost to the participant. The cost of these drugs will not be applied towards satisfying ~~your~~ deductible or out-of-pocket maximum.

Members currently taking a medication or those who will be taking a medication that is on the *SaveOnSP Drug List*, are eligible to participate in the program.

- Select medications on the *SaveOnSP Drug List* ~~have a 30% coinsurance. Participants who qualify for and enroll in the program will have their medication covered at 100% (no cost to the enrolled participant). will be free of charge (\$0) to members who participate.~~
- Prescriptions must be filled through Accredo Specialty Pharmacy.
- The medications and associated cost included in this program are subject to the Pharmacy Benefit Manager's clinical rules.
- If the medication ~~you~~participants are taking is on the *SaveOnSP Drug List* and ~~you~~participants wish to participate, call SaveOnSP at 1-800-683-1074. ~~Program drug list can be found at~~ [www.saveonsp.com/pebp](http://www.saveonsp.com/pebp)



**Participation in the SaveOnSP Program is voluntary; however, if ~~you~~participants are taking or will be taking a medication that is on the SaveOnSP Drug List, and ~~you~~participants choose not to participate in the SaveOnSP Program, ~~you~~participants will be responsible for the cost of the medication and the cost will not apply toward ~~your~~ Deductible or Out-of-Pocket Maximum.**

### *Diabetes Care Value*

~~Express Scripts~~The PBM offers a program that supports members with diabetes (type 1 and 2), pre-diabetes, and even common comorbidities like obesity. ESI's digital diabetes prevention and obesity solution offers a personalized coaching and weight loss program to help patients avoid type 2 diabetes. The Diabetes Care Value is administered by ~~Express Scripts~~The PBM and qualifying participants will receive a personal invitation, with instructions, to join the program.

### *Diabetic Medications and Supplies*

Participants who enroll and participate in PEBP's Diabetes Care Management Program may receive up to a 90-day supply of preferred diabetic supplies and the cost of those supplies will not be subject to annual Deductible or Coinsurance requirements. Diabetic supplies under this program must be filled through ~~Express Scripts~~The PBM Home Delivery pharmacy and include blood glucose monitors, test strips, insulin, syringes, alcohol pads, and lancets. For more information contact ~~Express Scripts~~The PBM' Member Services at 855-889-7708.

### *Extended Absence Benefit*

If ~~you~~participants are going to be away from ~~your~~ home for an extended period, either in the country or outside of the country, ~~you~~participants may obtain an additional fill (30 or 90-day supply) of ~~your~~ prescription drugs from ~~your~~ local retail or mail order pharmacy. This limited benefit must be requested from ~~Express Scripts~~The PBM by the participant in advance. A maximum of two (2) early refills

Schedule of Prescription Drug Benefits

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
<p>are allowed every 180 days. <a href="#">YouParticipants</a> may be required to obtain a new written prescription from <a href="#">your</a> physician and any necessary prior authorizations.</p>		
<p><i>Out-of-Country Emergency Medication Purchases</i></p>		
<ul style="list-style-type: none"> <li>• This Plan may cover emergency prescription drugs purchased if <a href="#">youparticipants</a> reside in the United States and travel to a foreign country. <a href="#">YouParticipants</a> will need to pay for the drug at the time of purchase and later submit for reimbursement from <a href="#">Express-ScriptsThe PBM</a>. Prescription drug purchases made outside of the United States are subject to Plan provisions, Benefit Limitations and Exclusions, clinical review, and determination of medical necessity. The review may include application of pertinent Food and Drug Administration (FDA) regulations. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the United States.</li> <li>• <i>If <a href="#">youther</a> purchase is eligible for reimbursement, <a href="#">youparticipants</a> must use the Direct Claim Form available from <a href="#">Express-ScriptsThe PBM</a>. Direct Claim Forms may be requested from the prescription drug plan or obtained by logging in to <a href="#">www.express-scripts.com</a>. In addition to the Direct Claim Form, <a href="#">youparticipants</a> are required to provide:</i></li> <li>• A legitimate, legible copy of the written prescription completed by <a href="#">youa r</a>-physician.</li> <li>• Proof of payment from <a href="#">youparticipants</a> to the provider of service (typically <a href="#">youaf</a> credit card invoice).</li> <li>• Prescription and receipt must be translated to English and include the American equivalent National Drug Code for the prescription purchased.</li> <li>• Reimbursement request must be converted to United States dollars.</li> </ul>		
<p>Any foreign purchases of prescription medications will be subject to Plan limitations such as:</p>		
<ul style="list-style-type: none"> <li>• Benefits and coverage</li> <li>• Deductibles</li> <li>• Coinsurance</li> <li>• Dispensing maximums</li> <li>• Annual benefit maximums</li> <li>• Medical Necessity</li> <li>• Usual and Customary (U&amp;C) or prescription drug pharmacy benefit manager contracted allowable</li> <li>• FDA approval</li> <li>• Plan prior authorization requirements</li> </ul>		
<p>Contact <a href="#">Express-ScriptsThe PBM</a> before traveling or moving to another country to discuss any criteria that may apply to a prescription drug reimbursement request.</p>		

Schedule of Prescription Drug Benefits

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
<p data-bbox="136 537 391 564"><i>Out-of-Network Pharmacy</i></p> <p data-bbox="136 575 1130 659">Prescriptions filled at a domestic (inside the United States) out-of-network pharmacy location are not authorized for reimbursement under the prescription drug Plan. Prescription drugs must be filled at a participating in-network pharmacy location.</p> <p data-bbox="136 699 310 726"><i>Other Limitations:</i></p> <ul data-bbox="201 737 1130 873" style="list-style-type: none"> <li data-bbox="201 737 1130 821">• This Plan does not coordinate prescription drug plan benefits with other prescription drug plans. It is the participant’s responsibility to use the <del>appropriate</del> primary and secondary (if applicable) prescription plan.</li> <li data-bbox="201 825 1130 873">• See exclusions related to medications in the <i>Benefit Limitations and Exclusions</i> section of this document.</li> </ul> <p data-bbox="136 909 1130 957">The formulary is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.</p>		

## Benefit Limitations and Exclusions

This Plan ~~places limitations on some benefits. In this policy, a benefit limitation refers to the maximum amount of money that the Plan will pay for a service, those expenses that do not count towards participants out of the pocket maximum, and service non-covered services. does not cover certain services. This chapter lists the general medical and pharmacy benefit exclusions of this Plan. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum. Additional exclusions that apply to only a service or benefit are listed in the description of that service or benefit in the *Schedule of Benefits* sections. This list is not all-inclusive; if you have questions about a service or supply, contact the Claims Administrator listed in the *Participant Contact Guide*.~~

~~This Plan imposes a lifetime maximum on some health care services and procedures.~~

### ~~Expenses That Do Not Accumulate Toward Your Out-of-Pocket Maximum~~

~~The following services do not accumulate toward the out-of-pocket maximum, and you will be responsible for paying these expenses out of your own pocket.~~

- ~~• All expenses for medical and pharmacy services and supplies that are not covered by the Plan, to include but not limited to, expenses that exceed the CDHP network contract rate, services listed in the *Benefit Limitations and Exclusions* section.~~
- ~~• All charges in excess of the usual and customary charge determined by the Plan Administrator.~~
- ~~• Any additional amounts you must pay because you failed to comply with the utilization management requirements described in the *Utilization Management* section.~~
- ~~• Benefits exceeding those services or supplies subject to maximum individual or lifetime limit(s) for certain eligible medical expenses as listed in the *Schedule of Benefits*; and~~
- ~~• Certain wellness or preventive services that are paid by this Plan at 100% do not accumulate towards the out-of-pocket maximum.~~
- ~~• The value of manufacturer rebates for drugs on the SaveOnSP non-essential drug list.~~

~~This list is not all-inclusive and may not include certain services and supplies that are not listed above.~~

### ~~Benefit Limitations~~

~~In addition to the exclusions listed below, refer to the *Schedule of Benefits* sections for the maximum individual or lifetime limit(s) and any Plan Year limit applicable to certain covered expenses. Plan Year limits are met by days, hours, visits, or dollar limits paid under all components of the Plan.~~

## Benefit Limitations and Exclusions

### Lifetime Maximum

This Plan imposes a lifetime maximum on some health care services and procedures. For information on the lifetime maximums, refer to the *Schedule of Benefits* sections.

### Exclusions Under the Plan

The following is a list of services, ~~and~~ supplies, or expenses that are limited or not covered (excluded) by this Plan. Participants may pay out of pocket for these, but anyThe Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and terms of the Plan and determines eligibility and entitlement to Plan benefits. Any amount ~~you~~participants pay toward services that are not covered or otherwise excluded will not count toward ~~you~~the ~~r~~-out-of-pocket maximum.

**Abortion:** ~~Elective termination of pregnancy (abortion) is excluded from the plan, other than medically indicated abortions that are medically necessary to save the life of the mother and complications of such abortions.~~Abortions are covered in accordance with NRS 442.250.

This plan provides abortion benefits in accordance with NRS 422.250.

### Alternative/Complimentary Health Care Exclusions:

- ~~C~~Expenses for chelation therapy (except as may be medically necessary for treatment of mental health, acute arsenic, gold, mercury, or lead poisoning) and for diseases due to ~~clearly demonstrated~~ excess of copper or iron.
- ~~P~~Expenses for prayer, religious healing, or spiritual healing, ~~except services provided by a Christian Science Practitioner.~~
- ~~E~~Expenses for naturopathic, Naprapathy services or treatment/supplies.
- ~~H~~Expenses for homeopathic treatments/supplies that are not FDA approved.

**Autopsy:** ~~Expenses for an autopsy~~Autopsies are not covered.

~~and any related expenses, except as required by the Plan Administrator or its designee.~~

**Bariatric and Overweight Surgery:** ~~The Plan's individual limit is one (1) bariatric surgery while covered under any current or previous PEPP self-funded health plan. Must be performed at a Center of Excellence. Surgeries provided out of network are excluded. PEPP or its designee will determine the In-Network Center of Excellence facility.~~

~~The Plan's individual lifetime maximum is one (1) bariatric surgery while covered under any current or previous PEPP self-funded health plan.~~

~~**Bariatric and Overweight Surgery Not Performed at a Center of Excellence Provider:** Benefits are excluded for bariatric/weight loss surgery performed at an Out-of-Network facility, Out-of-Network surgeon, or when Out-of-Network ancillary providers are used, notwithstanding services covered under the No Surprises Act. PEPP or its designee will determine the In-Network Center of Excellence facility.~~

Formatted: Font: 12 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt, Font color: Black



## Benefit Limitations and Exclusions

### **Behavioral Health Care Exclusions:** The following behavioral health services are not covered.

- ~~Expenses for behavioral health care services related to:~~
  - adoption counseling;
  - ~~non-medically necessary~~ court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws);
  - custody counseling;
  - dance ~~therapy,~~
  - poetry, ~~or~~
  - art therapy;
  - developmental disabilities;
  - dyslexia;
  - learning disorders;
    - attention deficit disorders (with or without hyperactivity, except when the services are for diagnosis, the prescription of medication as prescribed by a physician or other health care practitioner, or when accompanied by a treatment plan as submitted to the Plan or its designee) or the treatment is related to the management of ADD/ ADHD without prescription drugs and is approved by the Plan or its designee;
  - family planning counseling;
  - marriage and/or couples counseling; ~~(the exclusion for marriage/couples counseling will not limit individual mental health counseling for an otherwise covered mental health condition);~~
  - intellectual disability;
  - pregnancy counseling;
  - vocational disabilities, ~~and-or~~
  - organic and non-organic therapies
    - including (but not limited to) crystal healing, EST, primal therapy, L-Tryptophan, vitamin therapy, religious/spiritual, etc.
- Expenses for tests to determine the presence of or degree of a person's dyslexia or learning disorder unless the visit meets the criteria for benefits payable for the diagnosis or treatment of Autism Spectrum Disorders.

Formatted: Right: 0"

Formatted: Indent: Left: 0.25", Right: 0"

Formatted: Indent: Left: 0.5", Space After: 0 pt

Formatted: Font: 12 pt, Font color: Black

Formatted: Indent: Left: 0.25", Right: 0"

Formatted: Indent: Left: 0.75", Right: 0", Space After: 0 pt, No bullets or numbering

Formatted: Right: 0"

**Complications of a non-covered service:** Treatment for complications of non-covered services is excluded. Expenses for care, services or treatment required because of complications from a treatment or service not covered under this Plan, except complications from an abortion.

**Concierge membership fees:** Membership, retainer or premiums that are paid to a concierge medical practice are not covered. Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge medical practice to have access to the medical services provided by the concierge medical practice.

**Clinical Trials:** See Experimental and Investigational in the Key Terms and Definitions section.

## Benefit Limitations and Exclusions

~~**Controlled Substance or Intoxicated:** Services/treatment which involve an injury to which a contributing cause was the insured's commission of or attempt to commit a felony, except if a result of a medical or behavioral health condition, or domestic violence, even if the condition was not diagnosed at the time of the injury. See [NRS 695G.405](#).~~

~~**Corrective Appliance, Orthotic Device Expenses, and Appliances/Durable Medical Equipment (DME):** Any items that are not. The following corrective appliances and durable medical equipment are not covered.~~

- ◆ ~~corrective appliances,~~
  - orthotic devices or orthotic braces that straighten or change the shape of a body part,
  - prosthetic appliances, or
  - durable medical equipment (as each of those terms is defined in the *Key Terms and Definitions* section)

This includes, but not limited to, personal comfort items like:

- air purifiers,
- humidifiers,
- electric heating units,
- swimming pools,
- spas,
- saunas,
- escalators,
- lifts,
- motorized modes of transportation determined to be not medically necessary,
- pillows,
- orthopedic mattresses,
- water beds, and
- air conditioners are excluded.

Expenses for cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome.

Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment are not covered.

Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.

~~**Cosmetic Services and Surgery:** The Plan excludes expenses for cosmetic services, cosmetic surgery, and any drugs used for cosmetic purposes, including but not limited to health and beauty aids. The Plan excludes expenses for cosmetic services, cosmetic surgery, and any drugs used for cosmetic purposes, including but not limited to health and beauty aids.~~

Complications resulting from cosmetic services or cosmetic surgery are not covered. This exclusion does not apply to breast reconstructive surgery or certain related treatments for members who have undergone mastectomy or other treatment for breast cancer. ~~—see~~

Formatted: No bullets or numbering

## Benefit Limitations and Exclusions

~~Mastectomy and Reconstructive Services and Breast Reconstruction After Mastectomy section above for details.~~

~~Prophylactic surgery is covered under certain circumstances. Contact the UM company for information.~~

~~Participants should use the Plan's precertification procedure to determine if a proposed surgery or service will be considered cosmetic surgery or medically necessary reconstructive services.~~

~~**Costs of Reports, Bills, etc.:** Preparation of medical reports, billing or claim forms, mailing, shipping, handling, charges for broken/missed appointments, general telephone calls not including telehealth, and photocopying fees are not covered. Expenses for preparing medical reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken/missed appointments, general telephone calls not including telehealth, or photocopying fees.~~

~~**Court-Ordered Treatment:** Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, laboratory and other diagnostic testing and other services including hospitalizations or partial hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless the Plan Administrator or its designee determines that such services are independently medically necessary.~~

Formatted: Right: 0"

~~**Court-Ordered Treatment:** Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, laboratory and other diagnostic testing and other services including hospitalizations or partial hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless the Plan Administrator or its designee determines that such services are independently medically necessary.~~

Formatted: Font: Font color: Auto

~~**Custodial Care:** Expenses for custodial care as defined in the *Key Terms and Definitions* section, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, including any service that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary. Custodial care are services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.~~

## Benefit Limitations and Exclusions

Services required to be performed by physicians, nurses or other skilled health care providers are not considered to be provided for custodial care services and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. ~~However, any services that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.~~

**Dental Services:** ~~Dental prosthetics and orthodontia not covered.~~

The following services are covered under the dental plan.

~~Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness, or injury affecting the mouth or another part of the body.~~

~~Except as described as an inclusion in the Schedule of Benefits, services involving:~~

~~treatment to the teeth;~~

- extraction of teeth;
- repair of injured teeth;
- general dental services;
- treatment of dental abscesses or granulomas;
- treatment of gingival tissues (other than for tumors);
- dental examinations;
- restoration of the mouth, teeth, or jaws because of injuries from
  - biting,
  - chewing, or
  - accidents;
- artificial implanted devices;
- braces;
- periodontal care or surgery;
- teeth prosthetics and bone grafts regardless of etiology of the disease process; and
- repairs and restorations except for:
  - appliances that are medically necessary to stabilize or repair sound and natural teeth after an injury;
  - dental and or medical care including mandibular or maxillary surgery,
  - orthodontia treatment,
  - oral surgery,
  - pre-prosthetic surgery,
  - any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth in the Schedule of Benefits.

Coverage for dental services as the result of an injury to sound and natural teeth may be extended under the medical Plan to a maximum of two (2) years following the date of the injury.

## Benefit Limitations and Exclusions

Restorations past the two-year time frame will be considered under the dental benefits described in the PEBP Self-Funded Dental PPO Plan Master Plan Document available at <https://pebp.nv.gov/>.

Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthodontia is a specific Plan exclusion.

### **Drugs, Medicines, Nutrition or Devices:**

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been prescribed for a medically necessary indication or are Experimental and/or Investigational as defined in the *Key Terms and Definitions* section.
- Non-prescribed, non-Legend and over the counter (OTC) drugs or medicines (except as preventive care medications required by the Affordable Care Act).
- Foods and nutritional supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs, and minerals (regardless of whether they can be purchased OTC or whether they require a prescription), except when provided during hospitalization; prenatal vitamins or minerals requiring a prescription;
- Special Food Product (as defined in the *Key Terms and Definitions* section), except for the benefit described as covered under Special Food Product in the *Schedule of Benefits* section or elsewhere in this document under the section titled *Obesity Care Management Program*;
- Naturopathic, Naprapathy, or homeopathic treatments/substances.
- Weight control or anorexiant, except those anorexiant used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy or where otherwise noted in this document under the section titled *Obesity Care Management Program*;
- Compounded Prescriptions in which there is not at least one ingredient that is a Legend Drug requiring a Prescription, as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, or other health care facility.
- Vaccinations, immunizations, inoculations, or preventive injections that are not covered under the Summary of Benefits section.
- Marijuana and any derivative, including CBD, THC, edibles, etc. are not a covered benefit under this Plan.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the prescription drug program.

## Benefit Limitations and Exclusions

- Drugs to enhance athletic performance such as anabolic steroids (including off-labeled growth hormone). Coverage for human growth hormone or equivalent is excluded unless specifically covered and described in the *Summary of Benefits*.
- Non-prescription male contraceptives, e.g., condoms.
- Dental products such as topical fluoride preparations and products for periodontal disease, except as a preventive service required under the Affordable Care Act.
- Hair removal or hair growth products (*i.e.*, *Propecia*, *Rogaine*, *Minoxidil*, *Eflornithine*, *etc.*).
- Vitamin A derivatives (retinoids) for dermatologic use.
- Vitamin B-12 injections (except for treatment of mental health, pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (unless otherwise specified in the Schedule of Benefits).
- Anti-aging treatments (even if FDA-Approved for other clinical indications)

**Durable Medical Equipment:** See ~~the exclusions related to~~ Corrective Appliance, ~~Orthotic Device Expenses, and Appliances.~~

**Educational Services/Health Education:** ~~Health education expenses are not covered. They include e~~Expenses for educational/vocational services, supplies or equipment including (but not limited to) computers, software, printers, books, tutoring, visual aids, auditory aides, and speech aides, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, or self-esteem, etc. (even if they are required because of an injury, illness, or disability of a covered individual).

**Electronic cigarettes:** The Plan does not cover electronic cigarettes.

**Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by ~~you or your covered dependents'~~ the covered participant's employer; or for benefits otherwise provided under this Plan or any other plan that PEBP contributes to or otherwise sponsors (e.g., HMOs).

~~Expenses Exceeding Maximum Plan Benefits:~~ Expenses that exceed any Plan benefit limitation or Plan Year maximum benefits as described in this document.

~~Expenses Exceeding Usual and Customary Charges, the Plan's Maximum Allowable Charge, Prevailing Rates and PPO Contracted Rates:~~ Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Plan's Maximum Allowable Charge, Usual and Customary Charge, prevailing rates or PPO contracted rate as defined in the *Key Terms and Definitions* section, except as required by independent dispute resolution under the No Surprises Act.

**Expenses for Which a Third-Party Is Responsible:** See "Third-Party Liability" of the Health and Welfare Wrap document that can be found on <https://pebp.nv.gov/> (NAC 287.755).

## Benefit Limitations and Exclusions

**Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided either before the patient became covered under the Plan or after the date the patient's coverage ends, except under those conditions described in COBRA Continuation Coverage.

**Experimental and/or Investigational Services:** Unless mandated by law, expenses for any medical services, supplies, drugs, or medicines that are determined by the Plan Administrator, UM company or its designee to be experimental and/or investigational services.

**Fertility and Infertility Treatment:**

Except as otherwise specified in the Schedule of Benefits section, all other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) are excluded. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy; the promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the participant's ability to become pregnant or to carry a pregnancy to term; and any payment made by or on behalf of a participant who is contemplating or has entered into a contract for surrogacy to a provider or individual related to any services potentially included in the scope of surrogacy services; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are also excluded.

**Foot/Hand Care:**

Expenses for non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and expenses for routine foot care (including but not limited to: trimming of toenails, removal of corns and callouses, preventive care with assessment of pulses, skin condition and sensation) or hand care, (including manicure and skin conditioning), unless the Plan Administrator or its designee determines such care to be medically necessary.

Routine foot care from a podiatrist for treatment of foot problems such as corns, calluses and toenails are payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

## Benefit Limitations and Exclusions

**Genetic Testing and Counseling:** Coverage is not available for tests solely for research, or for the benefit of individuals not covered under this Plan.

~~Expenses for genetic testing and counseling are excluded~~not covered, unless otherwise specified in this Plan's Schedule of Benefits.

**Growth Hormone:** ~~Coverage for off-labeled growth hormone~~ is not covered.

**Gym Fees:** ~~Fees by personal trainers, exercise programs, exercise equipment, gyms or health club memberships are not covered. Fees by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists, even if recommended by a professional to treat a medical condition.~~

**Hair:** Expenses for or related to hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Eflornithine; or for hair replacement devices, including (but not limited to) wigs, toupees and/or hairpieces or hair analysis. Patients undergoing chemotherapy may be able to receive benefits for some hair replacement devices, as set forth in the "Chemotherapy" section in the *Schedule of Benefits*.

**Hearing ~~Care~~Education:** Special education and associated ~~costs related to costs in conjunction with~~ sign language ~~education for~~ a patient or family members.

**Hearing Aids:** Over the Counter hearing aids are excluded from the Plan.

~~Hearing Aids: Over the Counter hearing aids are excluded from the Plan.~~

**Home Birth/Delivery:** ~~Home births are not covered by this Plan. Planned birth/delivery at home and associated services are not covered by this Plan. Guidelines for Perinatal Care published by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG) that the hospital, including a birthing center within the hospital complex, or a freestanding birthing center, provides the safest setting for labor, delivery, and the postpartum period. The use of other settings is not covered by this Plan. Facilities providing obstetrical care should have the services listed as essential components of a Level 1 hospital.~~

### Home Health Care:

- Expenses for any home health care services that are not medically necessary, other than part-time, intermittent skilled nursing services and supplies.
- Expenses for a homemaker, custodial care, childcare, adult care, or personal care attendant, except as provided under the Plan's hospice coverage.
- Expenses for any home health care services that is not provided by an organization or professional licensed by the state to render home health services.



## Benefit Limitations and Exclusions

- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the Summary of Benefits and Schedule of Benefits.

Expenses for any services provided substantially or primarily for the participant's convenience or the convenience of a caregiver.

**Hospital Employee, Medical Students, Interns or Residents:** Expenses for the services of an employee of a hospital, skilled nursing facility or other health care facility, when the facility is obligated to pay that employee.

**Hypnosis and Hypnotherapy:** An artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility is not covered.

**Illegal Act Exclusion:** Injuries sustained during the course/because of committing illegal acts is not covered. Expenses incurred by a covered individual for injuries resulting from commission (or attempted commission by the covered individual) of an illegal act as determined by the plan administrator which involved violence or threat of violence to another person, or in which any weapon or explosive is used by the covered individual, unless such injury is the result of a physical or mental health condition or domestic violence. The Plan Administrator's determination that this exclusion applies shall not be affected by any prosecution, or acquittal of (or failure to prosecute) the covered individual in connection with the acts involved, unless such injury is the result of a physical or mental health condition or domestic violence.

**Internet/Virtual Office Visit:** Any type of virtual visit with an out-of-network provider is not covered. Expenses related to an online internet consultation with an out-of-network physician or other health care practitioner (also called a virtual office visit/consultation), physician-patient web service or physician-patient e-mail service (including receipt of advice, treatment plan, prescription drugs or medical supplies obtained) from an online internet provider who is not a participating provider in the Plan network except as specifically provided.

Formatted: Font: Not Bold

**Maternity/Family Planning:** The following are not covered under the Plan.

Formatted: Font: Not Bold

- Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms.
- Termination of Pregnancy: Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies the health of the mother would be endangered if the fetus were carried to term and complications of such termination.
- Childbirth courses.
- Expenses related to delivery associated with a pregnant dependent child, except for expenses related to complications of pregnancy.
- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs.
- For nondurable supplies.
- Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.

Formatted: Font: Font color: Black

## Benefit Limitations and Exclusions

- ~~Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary, as defined in the Key Terms and Definitions section.~~

~~Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary, as defined in the Key Terms and Definitions section.~~

**Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required because of an injury, illness, or disability of a covered individual, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc.) is not covered.

No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

~~No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.~~

~~No Provider Recommendation or Order: Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician or other licensed provider acting within the scope of their license.~~

**Non-Emergency Hospital Admission:** Care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.

**Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses) of a health care provider are not covered. ~~participant except where otherwise specified in the Utilization Management section for organ/ tissue transplants and bariatric weight loss surgery or certain surgeries performed in a surgery center, inpatient hospital or outpatient setting as determined by the Plan Administrator or the UM company.~~

**Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by ~~you~~ participants or ~~any of your~~ covered dependents arising out of or during employment if the injury, illness, or condition is subject to coverage, in whole or in part, under any workers' compensation, or occupational disease (or similar) law.

**Orthodontia:** Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an injury or illness are not covered.

**Personal Comfort Items:** Expenses for patient convenience, including (but not limited to) care of family members while the covered individual is confined to a hospital (or other health care

**Formatted:** Font: 12 pt, Font color: Black

**Formatted:** Normal, No bullets or numbering, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers

**Formatted:** Font: 12 pt

**Formatted:** Font: 12 pt, Font color: Black

**Formatted:** Font: 12 pt

## Benefit Limitations and Exclusions

facility, or to bed at home), guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

**Private Room in a Hospital or Health Care Facility:** The use of a private room in a hospital or other health care facility, unless the facility has only private room accommodations, or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

**Prophylactic Surgery or Treatment:** Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery, as defined in the *Key Terms and Definitions* section of this document, when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for:

- Avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results, in certain circumstances; or
- Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder. Participants should use the Plan's UM company to assist in the determination of a proposed surgery to determine if it is or is not covered under this Plan.

**NOTE:** Some prophylactic surgeries may be covered under this Plan if certain criteria are met. Please refer to the *Schedule of Benefits* section. For additional information, please contact this Plan's UM company or Claims Administrator.

Prophylactic drugs are excluded.

### **Rehabilitation Therapy (Inpatient or Outpatient):**

- Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing, and related services.
- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
- Expenses for maintenance rehabilitation, as defined in the *Key Terms and Definitions* section.
- Expenses for speech therapy for functional purposes including (but not limited to) stuttering, and stammering.
- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of

## Benefit Limitations and Exclusions

daily living or for Medically Necessary treatment of a mental health or substance use disorder diagnosis.

- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency.

**Service Animals:** Purchase, training, or maintenance of any type of service animal, ~~even if designated as medically necessary~~ is not covered.

**Smoking/Tobacco Cessation:** Expenses for non-prescription (over the counter) tobacco/smoking cessation products such as nicotine gum or patches, unless prescribed by a physician. There are no benefits payable for the use of electronic cigarettes. Prescription smoking/tobacco cessation products are payable under the prescription drug benefit as described in the *Schedule of Benefits* section.

**Stand-By Physicians or Health Care Practitioners:** Expenses for any physician or other provider who did not directly provide or supervise medical services to the patient, even if the physician or practitioner was available on a stand-by basis is not covered.

**Taxes:** Sales taxes, unless specifically covered in the Plan.

**Telephone Calls:** Expenses for all telephone calls between a physician or other health care provider and any patient, other health care provider, UM company or vendor; or any representative of this Plan for any purpose whatsoever.

**Transplant (Organ and Tissue) Experimental and/or Investigational:**

Human organ and/or tissue transplants that are experimental and/or Investigational, including (but not limited to) donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post-operative services and drugs or medicines, and all complications thereof.

Non-human (Engrafted) organ and/or tissue transplants or implants, except heart valves.

- Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this Plan

**Travel Outside of the United States:** Any services received outside the United States are excluded unless deemed to be urgent or emergency care.

**Vision Care:**

Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract

## Benefit Limitations and Exclusions

surgery); and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded, except as otherwise specified in this Plan's *Summary of Benefits and Schedule of Benefits*. [There is no limit for individuals up to age 18.](#)

**War or Similar Event:** Expenses incurred because of an injury or illness due to ~~you or your covered dependent(s)~~ participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

### Weight Management and Physical Fitness:

- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs, and prescription drugs, except those services specified in the *Summary of Benefits* and *Schedule of Benefits*. Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Expenses for weight loss surgery performed without a ~~precertification~~[prior authorization](#) from the UM company will be denied.
- Expenses related to programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.
- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of an eating disorder (such as anorexia, bulimia, etc.). Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under any PEBP self-funded medical Plan (e.g., LD PPO Plan, CDHP, and Exclusive Provider Organization Plan).

### Other Benefit Exclusions

- Stress reduction therapy or cognitive behavior therapy for sleep disorders.
  - The exclusion for cognitive therapy does not apply to Medically Necessary treatment of a mental health or substance use condition.
- Sleep therapy (except for central or obstructive apnea when medically necessary and when a ~~precertification~~[prior authorization](#) has been received from the UM company), behavioral training or therapy, milieu therapy (unless the care is otherwise medically necessary), biofeedback (unless included with psychotherapy), behavior modification, sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.
- Charges that result from appetite control or any treatment of obesity, unless otherwise provided in the *Summary of Benefits* and *Schedule of Benefits*.
- Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (BEST), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.

#### Benefit Limitations and Exclusions

- Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or Chiropractor's office, or at a retail location are excluded, unless otherwise specified in the *Summary of Benefits and Schedule of Benefits*.

## Claims Administration

### How Benefits are Paid

~~A claim is an invoice or bill that is submitted by a medical provider to Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP's third-party claims administrator TPA directly after participants have received a service. Each claim has unique codes that describe the service participants received. There are three types of claims: medical, dental, and pharmacy. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When deductibles, coinsurance or copayments apply, you participants are responsible for paying you their share of these charges.~~

~~When participants receive care from an in-network provider, that provider will submit the claim to the TPA, but if participants receive care from an out-of-network provider, that provider may bill participants directly. If this occurs,~~

~~if a health care provider does not submit a claim directly to PEBP's third-party claims administrator and instead sends the bill to you, you participants should follow the steps outlined in this section regarding How to File a Claim. If, at the time you submit your claim, you furnish evidence acceptable to the Plan administrator or its designee (PEBP's third-party claims administrator) that you or your covered dependent paid some or all those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan Year Deductible and Coinsurance amounts are met.~~

### How to File a Claim

All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

Most providers send their bills directly to the PEBP's ~~claims administrator TPA~~; however, for providers who do not bill the Plan directly, you participants may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's ~~third-party claims administrator TPA~~ or PEBP's website ~~(see the Participant Contact Guide in this document for details on address, phone, and website).~~
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you participants what documents or medical information is necessary to support the claim. You A physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you participants can attach the itemized bill for professional services if it contains all the following information:

## Medical Claims Administration

- A description of the services or supplies provided including ~~appropriate-applicable~~ procedure codes.
- Details of the charges for those services or supplies.
- ~~Appropriate-d~~The correct diagnosis code/s.
- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

~~Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Claims Administrator. This can reduce costs to you and the Plan.~~ Complete a separate claim form for each ~~person-provider~~ for whom Plan benefits are being requested. ~~If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.~~

To ~~assure~~ensure that medical, pharmacy or dental expenses ~~you~~participants incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny Deductible and Out-of-Pocket Maximum credit or payment to a provider if the provider's bill does not include necessary information such as:

- Itemization of services;
- Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10;
- Date(s) of service;
- Place of service;
- Provider's Tax Identification Number;
- Provider's signature;
- Operative report;
- Patient ledger; or
- Emergency room notes, if applicable.

Providers such as hospitals and facilities that bill for single or bulk items such as orthopedic devices/implants or other types of biomaterials shall provide ~~to the third-party claim's administrator~~ a copy of the manufacturer's/organization's invoice (that directly supplied the device/implant/biomaterial to the healthcare provider) ~~to the TPA~~. This Plan will deny payment for such medical devices until a copy of the invoice is provided to ~~this Plan's Claims Administrator~~the TPA.

Formatted: Right: 0"

Claims are processed by the ~~third-party claims administrator~~TPA in the order that they are received. ~~Participants will know within 30 business days of receipt of the claim if it is accepted or denied. However, claim processing may take much longer if the claim was not completed correctly or if all necessary information was not provided with the claim.~~



Medical Claims Administration

<u>Steps in claims processing</u>	<u>Pass</u>	<u>Fail</u>
<u>Was the claim sent on the correct claims form?</u>	<u>Move to the next step.</u>	<u>Claim denies. The provider must resubmit it in the correct claim form.</u>
<u>Is there a date of service?</u>		
<u>Is there a provider ID?</u>		
<u>Is there a primary diagnosis code?</u>		
<u>Is there a procedure code?</u>		
<u>Is there a cost for the service?</u>		
<u>Is the claim for a covered individual?</u>	<u>Move to the next step.</u>	<u>Claim denies.</u>
<u>Is the medical service date within 12 months of the claim submission.</u>	<u>Move to the next step.</u>	<u>Claim denies.</u>
<u>Was the provider in-network.</u>	<u>Apply negotiated price/rate.</u>	<u>Apply out of network coverage. In some cases, the claim denies if out-of-network is not allowed for the services.</u>
<u>Is the service covered by the plan?</u>	<u>Move to the next step.</u>	<u>Claim denies.</u>
<u>Does the service meet medical necessity?</u>	<u>Move to the next step.</u>	<u>Claim denies.</u>
<u>If required, was there a prior authorization for the service?</u>	<u>Move to the next step.</u>	<u>Claim denies.</u>

The last component of claims processing is verification of the participant's coinsurance status; has the member met their deductible, what portion in the member's responsibility.

Once the claim has been processed, an Explanation of Benefits (EOB) will be provided to participants. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to participants Deductible, if participants out-of-pocket maximum has been reached, if certain services were denied and why, amounts participants need to pay to the provider, etc.

It is ~~you~~ participants' responsibility to maintain copies of ~~the~~ EOBs. They cannot be reproduced. ~~documents provided to you by PEBP's third-party claims administrator or prescription drug administrator. Copies of EOB documents are available on the Claims Administrator's website but cannot be reproduced. PEBP and its third-party claims administrator do not provide printed copies of EOB documents outside of the original mailing.~~

Medical Claims Administration

**Where to Send the Claim Form**

Send the completed claim form, the bill ~~you~~[participants](#) received (retain a copy for ~~you~~[their](#) records) and any other required information to the Claims Administrator at the address listed in the *Participant Contact Guide* in this document.

## Appeals

~~Participants have the right to appeal an claim or a Utilization Management. You have the right to ask PEBP or its designees to reconsider a claim or Utilization Management.~~ Adverse Benefit Determination resulting in a denial, reduction, termination, failure to provide or make payments (in whole or in part) for a service or treatment, rescission of coverage (retroactive cancellation), or HRA claim.

~~All participants will receive an EOB for each processed claim. The noticeEOB will explain the reasons why for the Adverse Benefit Determination, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal. When applicable, the noticeEOB will explain what additional information is required from participants and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.~~ Discretionary Authority of PEBP and Designee

Formatted: Font: Bold, Underline

Formatted: Font: 12 pt

Formatted: Space After: 0 pt

Formatted: Font: Bold

Formatted: Font: Bold

### Level 1 Claim Appeal (NRS 287.670):

~~In carrying out their respective responsibilities under the Plan, PEBP and its designees have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in this document.~~

### Claims and HRA Appeals

#### *Written Notice of Adverse Benefit Determination*

~~The Plan or its designee, the third party administrator, will notify you in writing on an Explanation of Benefits (EOB) of an Adverse Claim Determination resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal. When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.~~

You will be provided with:

- ~~(a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;~~
- ~~(b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;~~

## Appeals

- ~~(c) a full and fair review that considers all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;~~
- ~~(d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.~~

~~Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.~~

~~If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.~~

*Level 1 Claim Appeal*

[NAC 287.670](#)

Participants have 180 days of the date they received the Explanation of Benefits (EOB) to request a Level 1 Claim Appeal. Participants forfeit the right to submit a Level 1 Claim appeal after 180 days have passed. Level 1 Claim appeals must be sent to PEBP's TPA.

The Level 1 Claim appeal must be in writing and include:

~~If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third party administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause can be demonstrated. The written request for appeal must include:~~

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation why the claim is being appealed.

~~You have the right to review documents applicable to the denial and to submit your own comments in writing. The third party administrator~~The TPA will review your participants' claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process ~~you~~the request for appeal, it will be requested promptly.

## Appeals

The ~~third-party administrator~~TPA will issue a ~~decision of your~~ Level 1 Claim Appeal ~~decision~~ in writing within 20 days after receipt of ~~your~~ request for appeal. The Appeal Decision shall include an explanation of the appeal determination and references to Plan rules, Master Plan Documents, or other relevant documentation.

~~You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:~~

- ~~(a) information that is sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);~~
- ~~(b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2<sup>nd</sup> level of appeal or external review (when external review is applicable);~~
- ~~(c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;~~
- ~~(d) reference the specific Plan provision(s) on which the determination is based;~~
- ~~(e) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;~~
- ~~(f) an explanation of the Plan's appeal process and Level 2 appeal process and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;~~
- ~~(g) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;~~
- ~~(h) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;~~
- ~~(i) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and~~
- ~~(j) disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).~~

~~The notification~~ Appeal Decision will explain the steps necessary ~~if you wish~~ to proceed to a Level 2 Appeal if ~~you~~ participants are not satisfied with the response ~~at Level 1 of the Level 1 Claim Appeal.~~

## Appeals

*Level 2 Claim Appeal (NRS 287. 880):*

Level 2 Claim Appeals must be sent NAC 287.680

~~if you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal~~ to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request forms* are available at <https://pebp.nv.gov/> or by ~~request by~~ contacting PEBP Customer Service. ~~Furthermore, you are welcome to submit Level 2 Claim Appeals online through a form that can be found under the subheading "Filing an Appeal" under PEBP's contact us web page.~~

A Level 2 Appeal must be submitted to PEBP within 35 days after ~~you receipt of receive~~ the Level 1 Appeal determination. ~~Your~~The Level 2 Appeal request must include a copy of:

- Any document submitted with ~~you~~the Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support ~~you~~the participants request.

The Executive Officer or designee will use all resources available to ensure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal ~~decision~~Decision will be ~~given~~provided to ~~you~~participants, in writing, by certified mail within 30 days ~~after of receipt the Level 2 Appeal request is received~~ by the Executive Officer or designee.

The Appeal Decision shall include an explanation of the appeal determination and references to Plan rules, Master Plan Documents, or other relevant documentation.

The Appeal Decision will explain the steps necessary to proceed to an External Review if participants are not satisfied with the response of the Level 2 Claim Appeal.

~~A Level 2 Appeal determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.~~

Formatted: Justified

*External Claim Review*

The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that are considered experimental and investigation.

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process.

The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim. The independent review organization will use medical necessity as a component of their review which means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness,

## Appeals

injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.

Formatted: Normal

### NAC 287.690

#### Standard Request

~~An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.~~

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. ~~An External Review Request Form is available on the PEBP website at <https://pebp.nv.gov/>.~~ The OCHA will assign an independent external review organization within five 5 days after receiving the request.

#### A Request for External Claim Review must include:

- completed and signed External Review Request Form.
- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

#### A Request for External Claim Review must include:

- ~~• completed and signed External Review Request Form.~~
- ~~• a copy of the EOB(s) related to the claim(s) being reviewed.~~
- ~~• a detailed written explanation why the external review is being requested; and~~
- ~~• any additional supporting documentation.~~

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance  
7150 Pollock Dr  
Las Vegas, NV 89119  
Phone: (702) 486-3587,  
(888) 333-1597

## Appeals

### Web:

[https://adsd.nv.gov/Programs/CHA/Office\\_for\\_Consumer\\_Health\\_Assistance\\_\(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

### Discretionary Authority of PEBP and Designee

In carrying out their respective responsibilities under the Plan, PEBP and its designees have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in this document.

### Appealing a Utilization Management Determination

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.

Pursuant to applicable provisions of [NRS Chapter 695G](#), you have the following appeal processes for any adverse benefit determination made during the precertification, concurrent review, retrospective review, or case management. An appeal may be initiated by the participant, treating provider, parent, legal guardian, or person authorized to make health care decisions by a power of attorney.

The UM company will utilize a physician (other than the physician who rendered the original decision) to review the appeal. This physician is Board Certified in the area under review and is in active practice. Refer to the [Participant Contact Guide](#) for the UM company's contact information.

### Internal UM Appeal Review

#### Expedited Internal UM Appeal Review

You may request an expedited appeal review of a denied precertification of a hospital admission; availability of care, continued stay or health care service for which you received emergency services but have not been discharged from the facility providing the care; or if the physician certifies that failure to proceed in an expedited manner may jeopardize your life or health or the life or health of your covered dependent or the ability for you or your covered dependent to regain maximum function.



## Appeals

~~Requests for an expedited internal UM appeal review may be made by telephone or any other reasonable means to the UM company that will ensure the timely receipt of the information required to complete the appeal process. If your physician requests a consultation with the reviewing physician, this will occur within one business day. The UM company will decide on an expedited appeal within 72 hours of receipt of the information needed to complete the appeal. The results of the determination of an expedited appeal will be provided immediately to the managing physician by phone and in writing to the patient, managing physician, facility, and the third-party claim's administrator.~~

~~If the appeal review request is denied, the UM company will provide the member with an adverse benefit determination letter including the clinical rationale for the non-certification decision and the member may pursue an external appeal as described in [NRS 695G.241](#) – [NRS 695G.275](#).~~

~~*Standard Internal UM Appeal Review*~~*Prior Authorization/Utilization Management Appeal (NRS 695G)*

~~If you participants have a denied precertification/prior authorization request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue) and you do not qualify for an expedited appeal, you participants may request a standard appeal review/an appeal. Requests for standard appeal review may be made by writing to the UM company.~~

~~Requests for standard appeal review/an appeal must be made within 180 days of the date of the denial/non-certification. Appeals must be sent to PEBP's TPA. Actual medical records are encouraged to be provided to assist the reviewer. Standard appealsAppeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service treatment will be completed within 20 days of receipt of the request. The results of the determination of a standard appeal will be provided in writing to the patient/participant, managing physician, facility, and third-party claim's administrator.~~

~~A participant or their designee can choose to bypass the internal appeals process from adverse benefit determinations resulting from the UM company and request a n external review. review by an external review organization.~~

~~*Expedited Appeals (Level 1 and Prior Authorization/Utilization Management)*~~*External UM Appeal Review*

~~Requests for an expedited internal UM appeal review may be made by telephone or any other reasonable means to the UM company that will ensure the timely receipt of the information required to complete the appeal process. If a physician requests a consultation with the reviewing physician, this will occur within one business day. The UM company will decide on an expedited appeal within 72 hours of receipt of the information needed to complete the appeal. The results of the determination of an expedited appeal will be provided immediately to the~~

Formatted: Space After: 0 pt

Formatted: Left, Space After: 0 pt

Formatted: Space After: 0 pt

## Appeals

managing physician by phone and in writing to the patient, managing physician, facility, and the third-party claim's administrator.

An external review may be requested by a participant and/or the participant's treating physician after you have exhausted the internal UM appeal review process. This means you may have the right to have the Plan Administrator or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgement as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

### Standard Internal UM Appeal Review

If participants have a denied prior authorization request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue) and participants do not qualify for an expedited appeal, participants may request a standard appeal review. Requests for standard appeal review may be made by writing to the UM company.

Requests for standard appeal review must be made within 180 days of the date of the denial/non-certification. Actual medical records are encouraged to be provided to assist the reviewer. Standard appeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service treatment will be completed within 20 days of receipt of the request. The results of the determination of a standard appeal will be provided in writing to the patient, managing physician, facility, and third-party claim's administrator.

A participant or their designee can choose to bypass the internal appeals process from adverse benefit determinations resulting from the UM company and request a review by an external review organization.

### External UM Appeal Review

An external review may be requested by a participant and/or the participant's treating physician after participants have exhausted the internal UM appeal review process. This means participants may have the right to have the Plan Administrator or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgement as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment participants requested.

### Expedited Request for External Review (Pre-Service Urgent UM Appeal)

NRS 287.04335

For adverse benefit determinations resulting from the UM company, a participant or their designee can choose to bypass the internal UM appeal process and request a review by an external review organization.

## Appeals

Expedited external review is available only if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination and the patient's treating provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered individual or would jeopardize the covered individual's ability to regain maximum function. Pursuant to NRS 695G.271, the Office for Consumer Health Assistance (OCHA) will approve or deny a request for an external review of an adverse determination not later than 72 hours after receipt from the provider. If OCHA determines the request qualifies for expedited review, a final of the external review will be made by the external review organization within 72 hours of receipt and the provider and participant will be notified within 24 hours.

A participant may file a request for an expedited external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. An expedited external review request form, which includes a certification of treating provider for expedited consideration can be found on the PEBP website at <https://pebp.nv.gov/>.

The request must be submitted to:

[Office for Consumer Health Assistance](#)

[7150 Pollock Dr](#)

[Las Vegas, NV 89119](#)

[Phone: \(702\) 486-3587, \(888\) 333-1597](#)

[Web:](#)

[https://adsd.nv.gov/Programs/CHA/Office\\_for\\_Consumer\\_Health\\_Assistance\\_\(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

### Standard Request for External UM Review

A standard request for external UM review may be filed with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. A standard external review request form can be found on the PEBP website at <https://pebp.nv.gov/>.

A standard external review decision will be made within 45 days of OCHA's receipt of the request.

As with the expedited external review, a standard external review must be submitted to the Office for Consumer Health Assistance at the contact information listed above.

### Experimental and/or Investigational Claim/UM External Review

If participants received a denial for a service, durable medical equipment, procedure, or other therapy because the third-party administrator or the UM company determined it to be experimental and/or investigational, participants may request an external review. To proceed with the experimental and/or investigational external review, participants must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.

## Appeals

A “Physician Certification of Experimental/Investigational /Denials” is located under “Forms” on the PEBP website at <https://pebp.nv.gov/>.

After this form is completed by the treating physician, it should be attached to the Request for External Review” form and submitted to the Office for Consumer Health Assistance at:

Office for Consumer Health Assistance

7150 Pollock Dr

Las Vegas, NV 89119

Phone: (702) 486-3587, (888) 333-1597

Web:

[https://adsd.nv.gov/Programs/CHA/Office for Consumer Health Assistance \(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

*Expedited Request for External Review (Pre-Service Urgent UM Appeal)*  
[NRS 287.04335](#)

~~For adverse benefit determinations resulting from the UM company, a participant or their designee can choose to bypass the internal UM appeal process and request a review by an external review organization.~~

~~Expedited external review is available only if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination and the patient’s treating provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered individual or would jeopardize the covered individual’s ability to regain maximum function. Pursuant to [NRS 695G.271](#), the Office for Consumer Health Assistance (OCHA) will approve or deny a request for an external review of an adverse determination not later than 72 hours after receipt from the provider. If OCHA determines the request qualifies for expedited review, a final of the external review will be made by the external review organization within 72 hours of receipt and the provider and participant will be notified within 24 hours.~~

~~A participant may file a request for an expedited external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. An expedited external review request form, which includes a certification of treating provider for expedited consideration can be found on the PEBP website at <https://pebp.nv.gov/>.~~

~~The request must be submitted to:~~

~~Office for Consumer Health Assistance~~

~~7150 Pollock Dr~~

~~Las Vegas, NV 89119~~

~~Phone: (702) 486-3587,~~

~~(888) 333-1597~~

Formatted: Normal

## Appeals

### Web:

[https://adsd.nv.gov/Programs/CHA/Office\\_for\\_Consumer\\_Health\\_Assistance\\_\(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)

#### *Standard Request for External UM Review*

~~A standard request for external UM review may be filed with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. A standard external review request form can be found on the PEBP website at <https://pebp.nv.gov/>.~~

~~A standard external review decision will be made within 45 days of OCHA's receipt of the request.~~

~~As with the expedited external review, a standard external review must be submitted to the Office for Consumer Health Assistance at the contact information listed above.~~

#### *Experimental and/or Investigational Claim/UM External Review*

~~If you received a denial for a service, durable medical equipment, procedure, or other therapy because the third party administrator or the UM company determined it to be experimental and/or investigational, or subject to the No Surprises Act, or rescission of coverage, you may request an external review. To proceed with the experimental and/or investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.~~

~~A "Physician Certification of Experimental/Investigational/Denials" is located under "Forms" on the PEBP website at <https://pebp.nv.gov/>.~~

~~After this form is completed by the treating physician, it should be attached to the Request for External Review" form and submitted to the Office for Consumer Health Assistance at:~~

~~Office for Consumer Health Assistance~~

~~7150 Pollock Dr~~

~~Las Vegas, NV 89119~~

~~Phone: (702) 486-3587,~~

~~(888) 333-1597~~

~~Web: [https://adsd.nv.gov/Programs/CHA/Office\\_for\\_Consumer\\_Health\\_Assistance\\_\(OCHA\)/](https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/)~~

#### *Prescription Drug Review and Appeals*

~~The PBM offers two types of reviews, a clinical review and an administrative review. A clinical review is initiated by a health care professional and an administrative review is initiated by the participant. A participant has the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. The Pharmacy Benefit Manager reviews both clinical and~~

## Appeals

~~administrative coverage review requests, including those cases related to specialty drugs dispensed through Accredo specialty pharmacy.~~

### *Clinical Coverage Review*

~~The initial clinical coverage review is a request for coverage or medication that is based on clinical conditions of coverage that are set by this Plan—for example, medications that require a prior authorization. To make an initial determination for a clinical coverage review request, the prescribing physician must submit specific information for review.~~

### *How to Request a Clinical Coverage Review*

~~The preferred method to request an initial~~To initiate a clinical review, a health care professional may contact the PBM by phone or in writing using a Benefit Coverage Review Form. ~~is for the prescribing physician to submit the prior authorization request electronically. Alternately, the participant's prescribing physician or pharmacist may call Express Scripts at 1-800-753-2851 or the prescriber may submit a request in writing using a Benefit Coverage Review Form, which can be obtained by calling Express Scripts Member Services at 1-855-889-7708.~~ (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

### *Administrative Coverage Review*

~~The initial~~To initiate an administrative coverage review, ~~is a request for coverage of a medication that is based on the Plan's benefit design.~~

### *How to Request an Administrative Coverage Review*

~~To request an initial administrative coverage review,~~ the participant must submit the request in writing to ~~Express Scripts to the attention of~~ the Benefit Coverage Review Department ~~(see Participant Contact Guide section).~~

~~For an administrative coverage review request, the participant must submit information to the pharmacy benefits manager to support the request.~~

If the patient's situation meets the definition of urgent under the law, an urgent expedited review may be requested and conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent expedited situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy, or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by calling Express Scripts at 1-800-753-2851, the PBM.

Formatted: Normal, Justified, Space After: 12 pt

Formatted: Space After: 12 pt

Formatted: Space After: 12 pt

## Appeals

If the necessary information is provided to [Express Scripts](#) ~~the PBM~~ so that a determination can be made, the initial determination and notification for a clinical coverage or administrative coverage review will be made within the timeframe below:

- Standard Pre-Service: 15 days for retail pharmacy and five (5) days for home delivery; and
- Standard Post-Service: 30 days.

### *Level 1 Appeal or Urgent Appeal*

When an initial administrative or clinical coverage review request has been denied, a request for appeal of the denial may be submitted by the participant within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to [Express Scripts](#) ~~the~~ Benefit Coverage Review Department:

- Name of patient.
- Participant ID number.
- Phone number.
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the initial adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including physician/prescriber statements/letters, bills, or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone ~~at 1-800-753-2851 or fax 1-877-852-4070 to Express Scripts~~. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

~~All level 1 appeals are reviewed by either a~~ [Express Scripts](#) ~~completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are by~~ [Express Scripts](#)' pharmacist, [a](#) physician, [a](#) panel of clinicians, [a](#) trained prior authorization staff member, or an independent third-party prescription drug utilization management company.

### Level 1 Appeal Decisions and Notifications

[Express Scripts](#) ~~The PBM~~ will render Level 1 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 20 days; and

## Appeals

- Urgent\*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the ~~patient and prescriber~~[participant and the health care professional](#) together with an opportunity to respond prior to issuance of any final adverse benefit determination.

### *Level 2 Appeal*

When a Level 1 Appeal has been denied, a request for a Level 2 Appeal may be submitted by the participant within 35 days from receipt of notice of the Level 1 Appeal denial. To initiate a Level 2 Appeal, ~~you~~[participants](#) must request by mail or fax to the ~~appropriate~~[correct](#) Clinical Coverage or Administrative Coverage Review Request department.

An urgent Level 2 Appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax to the ~~appropriate~~[correct](#) Clinical Coverage or Administrative Coverage Review Request department ~~(see the Participant Contact Guide section)~~. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

### Level 2 Appeal Decisions and Notifications

~~Express Scripts~~[The PBM](#) will render Level 2 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 30 days; and
- Urgent\*: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

### *External Reviews (Pharmacy)*

~~The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental and investigation. Generally, a~~All internal appeal rights must be exhausted prior to requesting an external review. [The Pharmacy Benefits Manager handles all external reviews under pharmacy. An external review must be requested with 4 \(four\) months after the date of the Level 2 Appeal denial. \(If the date that is 4 \(four\) months from that date is a Saturday, Sunday, or a holiday, the deadline will be the next business day\).](#)~~The external review will be conducted by an independent~~



## Appeals

~~review organization with medical experts that were not involved in the prior determination of the claim.~~

~~To submit an external review, the request must be mailed or faxed to the independent review organization (see *Participant Contact Guide*) within 4 (four) months of the date of the Level 2 Appeal denial. (If the date that is 4 (four) months from that date is a Saturday, Sunday, or a holiday, the deadline will be the next business day).~~

~~Standard External Review: the pharmacy benefit manager will review the external review request within 5 (five) business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and the patient participant will be notified within 1 (one) business day of the decision.~~

~~If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO, and the Appeal information will be compiled and be sent to the IRO within 5 (five) business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgement or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the pharmacy benefit manager for reconsideration.The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, participant the Plan and the pharmacy benefit manager written notice of its decision.~~

~~-If the IRO has determined that the claim does not involve medical judgement or rescission, meet the qualifications of an external review, the IRO will notify the claimant participant in writing that the claim is ineligible for a full external review.~~

### *Urgent External Review*

~~Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. The Pharmacy Benefit Manager shall review every external appeal request to determine if it meets the level of an urgent situation. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations that could seriously jeopardize the life or health or the ability for the patient participant to regarding maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.~~

~~If the claim review is eligible for urgent processing meets the criteria to be urgent, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO.The IRO will review the claim within 72 hours from receipt of the request and will send the claimant participant written notice of its decision.~~

Appeals

[Timeframes for an external review may be adjusted if more information is requested by the IRO.](#)

## Coordination of Benefits (COB)

~~For the purposes of this COB section, the word "plan" refers to any group or individual medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual either on an individual basis or as part of a group of employees, retirees or other individuals.~~ Which Benefits are Subject to Coordination?

Formatted: Space After: 0 pt

~~When Participants participants have medical, dental or vision coverage from more than one some other source, benefits a are determined using Coordination of Benefits (COB) determination is used to identify which payer will pay first (i.e., the primary plan) and which payer will pay second (i.e., the secondary plan). COB operates so that one of the plans (i.e., the primary plan) will pay its benefits first. The other plan or policy, (i.e., the secondary plan) may then provide additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.~~

Formatted: Font: 12 pt

Formatted: Normal

~~Participants must let the TPA, or its designee, know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the participant is still required to meet their PEBP Plan Year medical and dental deductibles.~~

~~**This Plan's prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.**~~

### Plan Type

~~Participants must let the Plan Administrator, or its designee, know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and dental deductibles. This Plan's prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.~~

Formatted: Font: 14 pt

Formatted: Space After: 0 pt

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.25", Space After: 0 pt, Bulleted + Level: 2 + Aligned at: 0.38" + Indent at: 0.63"

- ~~• A Participant participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such fully fully insured plan~~

Formatted: List Paragraph, Left, Space After: 0 pt

Formatted: List Paragraph, Left, Indent: Left: 0.25", Bulleted + Level: 2 + Aligned at: 0.38" + Indent at: 0.63"

and the rules and procedures described in such fully insured plan’s applicable Summary of Insurance.

- A ~~Participant~~ participant in a self-insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures set forth herein. PEBP delegates to the third-party administrator of such self-insured plan the duty to administer and interpret the COB provisions of this document and to adopt, document and communicate any rules and procedures necessary ~~or appropriate~~ to implement the COB procedures, as set forth below.

Formatted: Indent: Left: 0.38", Space After: 0 pt

Formatted: Font: 12 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

~~This Plan’s prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.~~

Formatted: Space After: 0 pt

Formatted: Font: Bold

Which Plan Pays First: Order of Benefit COB Determination Rules

PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), to determine the primary plan and the secondary plan, which are commonly used by insured and self-insured plans. Any plan that does not use these same rules will always pays its benefits first be the primary plan.

Formatted: Font: 10.5 pt

Formatted: Normal

When two plans cover the same person, the following The order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

Formatted: Space After: 0 pt

These rules are:

Formatted: Space After: 0 pt

**Rule 1: Non-Dependent/Dependent**

Formatted: Space After: 0 pt

The plan that covers a person other than as a dependent (e.g., as an employee, retiree, member, or subscriber) is primary and the plan that covers the person as a dependent is secondary. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

- Secondary to the plan covering the person as a dependent;
- Primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);
- Then the order of benefits is reversed, so that the plan covering the person as a dependent will pay first; and the plan covering the person other than as a dependent (e.g., as a retired employee) pays second.

Formatted: Indent: Left: 0.5", Space After: 0 pt, No bullets or numbering

This rule applies when both spouses are employed and cover each other as dependents under their respective plans. The plan covering the person as an employee pays first, and the plan covering the same person as a dependent will pay benefits second.

Formatted: Space After: 0 pt

**Rule 2: Dependent Child Covered Under More Than One Plan**

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

- The parents are married;
- The parents are not separated (whether they ever have been married); or
- A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- If both parents have the same birthday, the plan that has covered one of the parents for a longer period pays first, and the plan that has covered the other parent for the shorter period of time pays second.
- The word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

Formatted: Indent: Left: 0.5", Space After: 0 pt, No bullets or numbering

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

Formatted: Space After: 0 pt

If the parents are not married, or are separated (whether they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- The plan of the custodial parent pays first; and
- The plan of the spouse of the custodial parent pays second; and
- The plan of the non-custodial parent pays third; and
- The plan of the spouse of the non-custodial parent pays last.

**Rule 3: Retired Employee**

The plan that covers a person, as a retired employee or as a retired employee's dependent pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Formatted: Space After: 0 pt

If a person is covered as a retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule (1) Non-Dependent/Dependent rather than by this rule.

Formatted: Space After: 0 pt

**Rule 4: Continuation Coverage**

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member, or subscriber (or as that person’s dependent) pays first, and the plan providing continuation coverage to that same person pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Formatted: Space After: 0 pt

If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member, or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Formatted: Space After: 0 pt

**Rule 5: Longer/Shorter Length of Coverage**

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period pays first; and the plan that covered the person for the shorter period of time pays second. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan.

Formatted: Space After: 0 pt

Administration of COB

~~To administer COB, the Plan~~ In order to make a COB determination, PEBP reserves the right to:

- Exchange information with other plans involved in paying claims;
- Require that ~~Participants—participants~~ or ~~Participants’—participants’~~ health care provider(s) furnish any necessary information;
- Reimburse any plan that made payments this Plan should have made; or
- Recover any overpayment from a Participant’s hospital, physician, dentist, other health care provider, other insurance company, or a Participant.

Formatted: Indent: Left: 0.75", Space After: 0 pt, No bullets or numbering

~~If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount the Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be benefits under this Plan, and~~ Once a payment is made, this Plan will be fully discharged from any liability it may have to the extent of such payment.

This Plan follows the customary COB rule that the medical program coordinates with only other medical plans or programs (and not with any dental plan or program), and the dental program coordinates only with other dental plans or programs. There is no cross coordination of a medical plan to a dental plan. (and not with any other medical plan or program).

When PEBP is the primary plan, it will consider the reasonable value of each service to be both the allowable expense, and the benefits paid. The reasonable value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

Formatted: Space After: 0 pt

## Appeals

~~This Plan follows the customary COB rule that the medical program coordinates with only other medical plans or programs (and not with any dental plan or program), and the dental program coordinates only with other dental plans or programs (and not with any other medical plan or program). Therefore, when this Plan~~When PEBP is secondary, it will pay secondary medical benefits. In addition, only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

~~If this Plan is primary, and if the coordinating secondary plan is a health maintenance organization (HMO), Exclusive Provider Organization (EPO) or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.~~

~~If this Plan is secondary, and~~ if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary Plan.

~~If this Plan is~~When PEBP is determined to be secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, ~~this Plan~~it will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to rights the ~~Participant~~ participant may have against the other plan, and the ~~Participant~~ participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

This Plan does not coordinate pharmacy benefits when PEBP is the secondary or tertiary payor.

### Coordination with Medicare

Coordination with Medicare is not applicable for retirees and their dependents who are eligible for Medicare Part A and Medicare Part B and who are required to transition to the Medicare Exchange. ~~The Enrollment and Eligibility Master Plan Document includes information regarding enrollment in the Medicare Exchange.~~

### Entitlement to Medicare Coverage

When a ~~Participant~~ participant reaches Medicare eligible age, the Participant must enroll in ~~the~~ Medicare ~~and transition to the Medicare Exchange.~~ ~~plan for which the Participant is eligible.~~ Generally, anyone age 65 years or older is entitled to Medicare Part A and Medicare Part B coverage

~~–~~Anyone under age 65 years who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

### When the Participant Is Not Eligible for Premium Free Medicare Part A

Formatted: Space After: 0 pt

Formatted: Space After: 0 pt

Formatted: Space After: 0 pt

Formatted: Space After: 0 pt

Formatted: Space After: 0 pt

Formatted: Space After: 0 pt

Formatted: Font: Not Italic

Appeals

~~This Plan will pay Part A services as primary. The Participant must enroll in Medicare Part B and PEBP will be the secondary payer for Medicare Part B services. This Plan will always be secondary to Medicare Part B, whether or not a Participant has enrolled.~~

Formatted: Font: Not Italic  
Formatted: Space After: 0 pt

~~-When this Plan is secondary, it will assume that Medicare has paid 80% of Medicare Part A and Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part A and Part B expenses.~~

~~for services that would have been covered by Part A when a Participant is not eligible for Premium Free Medicare Part A. However, a Participant must enroll in Medicare Part B and PEBP will be the secondary payer for Medicare Part B services. This Plan will always be secondary to Medicare Part B, whether or not a Participant has enrolled. This Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.~~

How Much This Plan Pays When It Is Secondary to Medicare

~~When the Participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays as secondary to Medicare, with the Medicare negotiated allowable fee taking precedence. If a service is not covered under Medicare but is covered under this Plan, this Plan will pay as Primary with the Plan's allowable fee for the service taking precedence.~~

Formatted: Space After: 0 pt

~~When the Retiree or the Retiree's covered Spouse or Domestic Partner is enrolled in Medicare Part B, this Plan will pay secondary to Medicare Part B.~~

Formatted: Space After: 0 pt

~~If eligible Retirees or their covered Spouses or Domestic Partners are not enrolled in Part B, this Plan will estimate Medicare's Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.~~

Coverage Under Medicare and This Plan When a Participant has End-Stage Renal Disease (ESRD)

Formatted: Space After: 0 pt

~~If, while actively employed, a Participant participant becomes entitled to Medicare because when diagnosed with of end-stage renal disease (ESRD). In this case, this Plan pays first is the primary and Medicare pays second for:~~

- ~~the first 30 months starting the earlier of the month in which of Medicare ESRD coverage begins, or~~
- ~~the first month in which the individual receives a kidney transplant.~~

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Normal, No bullets or numbering

Formatted: Font: 12 pt

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 12 pt

Formatted: List Paragraph

This plan becomes secondary:

- ~~Then, starting with the 31st month after the start of Medicare ESRD coverage, or~~
- ~~the first month after the individual receives a kidney transplant, Medicare pays first, and this Plan pays second.~~



If a Participant is under age 65 years and receiving Medicare ESRD benefits the Participant will not be required to transition to PEBP's Medicare Exchange program. When a Participant reaches age 65 years, the Participant will be transitioned to the Medicare Exchange ~~in accordance with PEBP's eligibility requirements as stated in the Enrollment and Eligibility Master Plan Document.~~

Formatted: Space After: 0 pt

*How Much This Plan Pays When It Is Secondary to Medicare*

~~When the Participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays as secondary to Medicare, with the Medicare negotiated allowable fee taking precedence. If a service is not covered under Medicare but is covered under this Plan, this Plan will pay as Primary with the Plan's allowable fee for the service taking precedence.~~

~~When the Retiree or the Retiree's covered Spouse or Domestic Partner is enrolled in Medicare Part B, this Plan will pay secondary to Medicare Part B.~~

~~If eligible Retirees or their covered Spouses or Domestic Partners are not enrolled in Part B, this Plan will estimate Medicare's Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.~~

*When the Participant Enters into a Medicare Private Contract*

A Medicare ~~Participant~~ participant is entitled to enter into a Medicare private contract with certain health care practitioners ~~under which he or she agrees that~~ in which no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare Participant enters into such a contract, this Plan will not pay any benefits for any health care services and/or supplies the Medicare Participant receives pursuant to it.

Coordination with Other Government Programs

Formatted: Font: 13 pt

- **Medicaid:** If a ~~Participant~~ participant is covered by both this Plan and Medicaid, this Plan pays first, and Medicaid pays second.
- **Tricare:** If a ~~Participant~~ participant or their covered Dependent is covered by this Plan and Tricare (the program that provides health care services to active or retired armed services personnel and their eligible Dependents), this Plan pays first, and Tricare pays second. For an Employee called to active duty for more than 30 days, Tricare is primary, and this Plan is secondary.
- **Veterans Affairs Facility Services:** If a ~~Participant~~ participant receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan at the in-network benefit level at the usual and customary charge, only to the extent those services are medically necessary and are not excluded by the Plan.
- **Worker's Compensation:** ~~This~~ This Plan does not provide benefits if the expenses are covered by workers' compensation or occupational disease law. If a Participant contests the application of workers' compensation law for the illness or injury for which expenses

## Appeals

are incurred, this Plan will pay benefits, subject to its right to recover those payments ~~if and when~~ if it is determined that they are covered under a Workers' Compensation or occupational disease law. However, before such payment ~~will be~~ is made, a Participant must execute a Subrogation and reimbursement agreement (described in the Third-Party Liability Section 4.5) that is acceptable to the Plan Administrator or its designee.

## Subrogation and Third-Party Recovery

~~Subrogation in healthcare is a legal process that allows health insurance companies to recover costs from third parties who are responsible for illness or injury due to negligence by the third party. applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "injury"). These damages or claims arising from the injury, irrespective of the way they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). All payments made by the Plan for which it claims a right of subrogation are referred to as subrogated payments.~~

~~Participants must comply with any and all recovery efforts of the Plan and do whatever is necessary or requested to secure and protect the subrogation rights of the Plan.~~

Formatted: Font: 12 pt

~~The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. All payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury.~~

~~The Participant must cooperate fully, always, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested to secure and protect the subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:~~

- ~~(1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of subrogation.~~
- ~~(2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and~~
- ~~(3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.~~

~~Refer to the separate *Health and Welfare Benefits Wrap Plan* document available at <https://pebp.nv.gov/> for more information regarding third-party liability and subrogation.~~

## Participant Contact Guide

Participant Contact Guide	
<p><b>Public Employees' Benefits Program (PEBP)</b>            3427 Goni Road, Ste 109            Carson City, NV 89706            Customer Service:            (775) 684-7000, (702) 486-3100, or (800) 326-5496            Fax: (775) 684-7028  <a href="https://pebp.nv.gov/">https://pebp.nv.gov/</a></p>	<p><b>Plan Administrator</b></p> <ul style="list-style-type: none"> <li>• Enrollment and eligibility</li> <li>• COBRA information and premium payments</li> <li>• Level 2 claim appeals</li> <li>• External review coordination</li> </ul>
<p><b>UMR</b>  <u>Claims Submission</u>            P O Box 30541            Salt Lake City, UT 84130-0541            EDI #39026</p> <p><u>Appeal of Claims</u>            P O Box 30546            Salt Lake City, UT 84130-0546</p> <p><u>Customer Service</u>            (888) 763-8232  <a href="http://www.UMR.com">www.UMR.com</a></p> <p><u>Diabetes Care Management form submission</u>            UMR            27 Corporate Hill Drive            Little Rock, AR 77205 Fax: 800-458-0701            Email: <a href="mailto:diabetes@UMR.com">diabetes@UMR.com</a></p>	<p><b>Third-party Claims Administrator/Third-party Administrator/PPO Network/ Disease Management Administrator</b></p> <ul style="list-style-type: none"> <li>• Claim submission</li> <li>• Claim status inquiries</li> <li>• Level 1 claim appeals</li> <li>• Verification of eligibility</li> <li>• Plan Benefit Information</li> <li>• CDHP &amp; Dental only ID Cards</li> <li>• Obesity Care Management Program</li> <li>• Disease Care Management Program</li> <li>• Sierra Health-Care Options (SHO) – Southern Nevada PPO Network</li> <li>• UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network</li> <li>• Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada</li> </ul>
<p><b>Sierra Health-Care Options, Inc</b>            PO BOX 15645            Las Vegas, NV 89144-5648            Customer Service : 888-323-1461            Fax : 800-288-2264</p>	<p><b>Utilization Management and Case Management Company</b></p> <ul style="list-style-type: none"> <li>• Pre-Certification/Prior Authorization</li> <li>• Utilization Management</li> <li>• Case Management</li> <li>• Transplants</li> </ul>

## Participant Contact Guide

<p><b><a href="#">Express-Scripts</a>The PBM Pharmacy</b></p> <p><b>Customer Service</b> (855) 889-7708 www.Express-Scripts.com</p> <p><b>Accredo Patient Customer Service:</b> (800) 803-2523</p> <p><b>Accredo Physician Service Line</b> (800) 987-4904 option 5</p> <p><b><a href="#">Express-Scripts</a>The PBM / Accredo Prior Authorization</b> (800) 753-2851 Electronic option: <a href="http://express-scripts.com/PA">express-scripts.com/PA</a></p> <p><b>Specialty Medication SaveonSP copay assistance</b> (800) 683-1074 <a href="http://www.saveonsp.com/pebp">www.saveonsp.com/pebp</a></p>	<p><b>Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and EPO Plan</b></p> <ul style="list-style-type: none"> <li>• Prescription drug information</li> <li>• Retail network pharmacies</li> <li>• Prior authorization</li> <li>• Price a Medication tool</li> <li>• Home Delivery service and Mail Order forms</li> <li>• Preferred Mail Order for diabetic supplies</li> <li>• Accredo Specialty Drug Services</li> <li>• Coverage and Clinical reviews</li> <li>• Appeals</li> <li>• External Review Requests</li> <li>• Copay/Deductible/Coinsurance assistance</li> </ul>
<p><b>HSA Bank</b></p> <p>HRA Claim Submission PO Box 2744 Fargo, ND 58108-2744 <a href="mailto:hsaforms@hsabank.com">hsaforms@hsabank.com</a> Fax: 855-764-5689 www.hsabank.com Customer Service: 833-228-9364 <a href="mailto:askus@hsabank.com">askus@hsabank.com</a> <a href="http://myaccounts.hsabank.com">myaccounts.hsabank.com</a></p>	<p><b>HSA and HRA Claims Administrator</b></p> <ul style="list-style-type: none"> <li>• HSA/HRA Claims and claim appeals</li> </ul>
<p><b>Diversified Dental Services</b></p> <p>5470 Kietzke Lane, Ste 300 Reno, NV 89511 <a href="mailto:ProviderRelations@ddsppo.com">ProviderRelations@ddsppo.com</a> 1-866-270-8326 <a href="http://diversifieddental.com">diversifieddental.com</a></p>	<p><b>PPO Dental Network</b></p> <ul style="list-style-type: none"> <li>• Statewide PPO Dental Providers</li> <li>• Dental Provider directory</li> <li>• National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network</li> </ul>
<p><b>Health Plan of Nevada</b> (702) 242-7300 or (877) 545-7378</p>	<p><b>Southern Nevada Health Maintenance Organization (HMO)</b></p>

Participant Contact Guide	
<a href="http://www.myhpnstateofnevada.com/">www.myhpnstateofnevada.com/</a>	<ul style="list-style-type: none"> <li>• Medical claims/provider network</li> </ul>
<b>VIA Benefits</b> 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888)598-7545 <a href="https://my.viabenefits.com/pebp">https://my.viabenefits.com/pebp</a> Phone: (888) 598-7545 Fax: (402) 231-4310	<b>Medicare Exchange and Medicare HRA administrator</b> <ul style="list-style-type: none"> <li>• Medigap (Supplemental) plans</li> <li>• Medicare Advantage Plans (HMO and PPO)</li> <li>• HRA claims administrator</li> </ul>
<b>United Healthcare Specialty Benefits</b> Group Number: 370074 Customer Service: 1-888-763-8232 UnitedHealthcare Specialty Benefits P.O. Box 7149 Portland, ME 04112-7149	<ul style="list-style-type: none"> <li>• Basic Life Insurance for eligible active and retirees</li> <li>• Member Assistance Program</li> <li>• Global Travel Assistance</li> </ul>
<b>Office for Consumer Health Assistance</b> 7150 Pollock Dr Las Vegas, NV 89119 Customer Service: (702) 486-3587 or (888) 333-1597 <a href="https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/">https://adsd.nv.gov/Programs/CHA/Office for Consumer Health Assistance (OCHA)/</a>	<b>Consumer Health Assistance</b> <ul style="list-style-type: none"> <li>• Concerns and problems related to coverage</li> <li>• Provider billing issues</li> <li>• External review information</li> </ul>
<b>Corestream</b> PEBP+ Customer Care: (775) 249-0716 E-mail: <a href="mailto:pebpcustomercare@corestream.com">pebpcustomercare@corestream.com</a> <a href="http://www.corestream.com">www.corestream.com</a>  <u>Voluntary Life, Critical Illness, Accident, and Hospital Indemnity Insurance</u> The Standard Insurance Company (888) 288-1270 <a href="http://www.standard.com/mybenefits/nevada">www.standard.com/mybenefits/nevada</a>	<b>PEBP+ Voluntary Benefits Administrator</b> <ul style="list-style-type: none"> <li>• Accident Insurance</li> <li>• Auto Insurance</li> <li>• Critical Illness</li> <li>• Disability Insurance (Long-term and Short-term)</li> <li>• Home Insurance</li> <li>• Hospital Indemnity</li> <li>• Identity Theft</li> <li>• Legal Services</li> <li>• Life Insurance (Supplemental)</li> <li>• Pet Insurance</li> <li>• Vision Care</li> </ul>

## Key Terms and Definitions

The following terms or phrases are used throughout this MPD. These terms or phrases have the following meanings. These terms and definitions do not, and should not be interpreted to, extend coverage under the Plan.

**Accident:** A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

**Active Rehabilitation:** refers to therapy in which a patient, who can learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

**Actively Engaged:**

- Participation in regular office visits with your provider. The frequency of the office visits will be determined by your provider who will in turn report this information to the third party administrator for monitoring.
- Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss provider including but not limited to routine exercise, proper nutrition and diet, and pharmacotherapy if prescribed. Commitment to your weight loss treatment will be measured by the third party administrator who will review monthly progress reports submitted by the provider; and
- Losing weight at a rate determined by the weight loss provider.

**Activities of Daily Living:** Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding, or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

**Acupuncture:** A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

When benefits for the services of an acupuncturist are payable by this Plan, the acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, be certified by the National Certification Commission for Acupuncturists (NCCA).

**Adverse Benefit Determination:** Means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care

## Key Terms and Definitions

~~setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.~~

~~**Air Ambulance:** A medical transport by a rotary wing air ambulance, as defined in [42 CFR 414.605](#), or fixed wing air ambulance, as defined in [42 CFR 414.605](#), for patients.~~

~~**Allogenic:** Refers to transplants of organs, tissues, or cells from one person to another person. Heart Transplants are always Allogenic.~~

~~**Allowable Expenses:** The Maximum Allowable Charge for any medically necessary, eligible item of expense, at least a portion of which is covered under the Plan. When some other non-Medicare plan pays first in accordance with the application to benefit determinations provision in the *Coordination of Benefits* section, this Plan's allowable expenses shall in no event exceed the other non-Medicare plan's allowable expenses.~~

~~When some other non-Medicare plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of each service rendered, by determining the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other non-Medicare plan include the benefits that would have been payable had claim been duly made.~~

~~**Ambulance:** A vehicle or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.~~

~~**Ambulatory Surgical Facility/Center:** A specialized facility that is established, equipped, operated, and staffed primarily for performing surgical procedures and which fully meets one of the following two tests:~~

- ~~It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or~~

~~Where licensing is not required, it meets all the following requirements:~~

- ~~It is operated under the supervision of a licensed physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area.~~
- ~~It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthesiologist or an anesthesiologist who is administering the anesthetic, and that the anesthesiologist or anesthesiologist remain present throughout the surgical procedure.~~
- ~~It provides at least one operating room and at least one post-anesthesia recovery room.~~



## Key Terms and Definitions

- ~~It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.~~
- ~~It has trained personnel and necessary equipment to handle emergency situations.~~
- ~~It has immediate access to a blood bank or blood supplies.~~
- ~~It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and~~
- ~~It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or x-rays), an operative report and a discharge summary.~~

~~An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.~~

~~**Ancillary Services/Charges:** Charges for services provided by a hospital or other facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.~~

~~**Ancillary services,** for purposes of the No Surprises Act, are, with respect to an in-network health care facility:~~

- ~~Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;~~
- ~~Items and services provided by assistant surgeons, hospitalists, and intensivists;~~
- ~~Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and~~
- ~~Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.~~

~~**Anesthesia:** The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional, or local anesthesia). Anesthetics are commonly administered by injection or inhalation.~~

~~**Annual/Annually:** For the purposes of this Plan, annual and annually refers to the 12-month period starting July 1 through June 30.~~

~~**Appliance (Dental):** A device to provide or restore function or provide a therapeutic (healing) effect.~~

## Key Terms and Definitions

~~**Appropriate:** See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.~~

~~**Approved Clinical Trial:** A phase I, II, III, or IV trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted.~~

~~An Approved Clinical Trial's study must be:~~

- ~~(1) approved or funded by one or more of:
  - ~~(a) the National Institutes of Health (NIH),~~
  - ~~(b) the Centers for Disease Control and Prevention (CDC),~~
  - ~~(c) the Agency for Health Care Research and Quality (AHCRO),~~
  - ~~(d) the Centers for Medicare and Medicaid Services (CMS),~~
  - ~~(e) a cooperative group or center of the NIH, CDC, AHCRO, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA),~~
  - ~~(f) a qualified non-governmental research entity identified by NIH guidelines for grants; or~~
  - ~~(g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;~~~~
- ~~(2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or~~
- ~~(3) a drug trial that is exempt from investigational new drug application requirements.~~

~~**Assistant Surgeon:** A medically qualified doctor who assists the surgeon of record perform a procedure.~~

~~**Autism Spectrum Disorder:** A condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined.~~

~~**Autologous:** Refers to transplants of organs, tissues, or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.~~

~~**Average Wholesale Price (AWP):** The average price at which drugs are purchased at the wholesale level.~~

~~**Bariatric Surgery Center of Excellence:** A provider that has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).~~

## Key Terms and Definitions

**Base Plan:** The self-funded Consumer-Driven Health Plan (CDHP); the base plan is also defined as the “default plan” where applicable in this document and other materials produced by PEBB.

**Behavioral Health Disorder:** Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause.

~~Behavioral health disorders covered under this Plan may include, but are not limited to depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods and is provided by behavioral health practitioners as defined in this section. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the *Benefit Limitations and Exclusions* section.~~

**Behavioral Health Practitioner:** A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a master’s degree, or other provider who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

**Behavioral Health Treatment:** Services, including room and board, given by a behavioral health treatment facility or area of a hospital that provides behavioral or mental health or substance abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the illness that is identified under the DSM code is considered a behavioral health treatment for the purposes of this Plan.

**Behavioral Health Treatment Facility:** A specialized facility that is established, equipped, operated, and staffed primarily for providing a program for diagnosis, evaluation, and effective treatment of behavioral health disorders and which fully meets one of the following two tests:

- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements: has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the direction of a full-time registered nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological, and social needs of the patient.

~~A behavioral health treatment facility that qualifies as a hospital is covered by this Plan as a hospital and not a behavioral health treatment facility. A transitional facility, group home,~~

## Key Terms and Definitions

~~halfway house or temporary shelter is not a behavioral health treatment facility under this Plan unless it meets the requirements above in the definition of behavioral health treatment facility.~~

~~**Benefit, Benefit Payment, Plan Benefit:** The amount of money payable for a claim, based on the usual and customary charge, subject to the Plan's Maximum Allowable Charge, or negotiated fee schedule, after calculation of all Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.~~

~~**Birth (or Birthing) Center:** A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:~~

- ~~• It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or~~
- ~~• Where licensing is not required, it meets all the following requirements:~~
- ~~• It is operated and equipped in accordance with any applicable state law for providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.~~
- ~~• It is equipped to perform routine diagnostic and laboratory examinations, including (but not limited) to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.~~
- ~~• It has available to handle foreseeable emergencies, trained personnel, and necessary equipment, including (but not limited to) oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.~~
- ~~• It provides at least two beds or two birthing rooms.~~
- ~~• It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.~~
- ~~• It has a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.~~
- ~~• It has trained personnel and necessary equipment to handle emergency situations.~~
- ~~• It has immediate access to a blood bank or blood supplies.~~
- ~~• It has the capacity to administer local anesthetic and to perform minor surgery.~~
- ~~• It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.~~
- ~~• It is expected to discharge or transfer patients within 48 hours following delivery.~~

~~A birth (or birthing) center that is part of a hospital, as defined in this section, will be a birth (or birthing) center for the purposes of this Plan.~~

~~**Business Day:** Refers to all weekdays, except Saturday or Sunday, Nevada holiday, or federal holiday.~~

## Key Terms and Definitions

**Case Management:** A process administered by the UM company in which its medical professionals work with the patient, family, caregivers, providers, Claims Administrator, Pharmacy Benefit Manager and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential providers.

**Cardiac Rehabilitation:** Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open heart surgery.

**Certified Surgical Assistant:** A person who does not hold a valid health care license as an RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon, and who acts within the scope of his/her license or certification. Such individuals are payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

**Chemical Dependency:** This is another term for Substance Abuse. (See also the definitions of Behavioral Health Disorders and Substance Abuse).

**Child(ren):** See the definition of Dependent Child(ren).

**Chiropractor:** A person who holds the degree of Doctor of Chiropractic (DC) and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal column (vertebrae); and who acts within the scope of his or her license.

**Chiropractic Services:** PEBP considers chiropractic services to be medically necessary when all the following criteria are met:

- participant has objective medical findings of a neuro-musculoskeletal disorder;
- and
- a clearly defined treatment plan has been established including treatment and discharge goals; and
- services are not for maintenance purposes.

## Key Terms and Definitions

**Christian Science Practitioner:** ~~Christian Science is a system of religious teaching based on an interpretation of scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings.~~

**Chronic Medication Synchronization:** ~~“Chronic medication” means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent, or lasting indefinitely. “Synchronization” means the alignment of the dispensing of multiple medications by a single contracted pharmacy for improving a patient’s adherence to a prescribed course of medication. This includes providing coverage for less than a 30-day supply to enable synchronization.~~

**Claims Administrator:** ~~The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.~~

**Clinical Trials:** ~~See *Experimental and Investigational* in the *Key Terms and Definitions* section.~~

**Coinsurance:** ~~That portion of *Eligible Medical Expenses* for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses more than the Plan’s Deductible. The Coinsurance varies depending on whether In-Network or Out-of-Network providers are used.~~

**Complications of Pregnancy:** ~~Any condition that requires hospital confinement for medical treatment, and if the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or, any condition that requires hospital confinement and if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.~~

**Compound Drugs:** ~~Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.~~

**Concierge Medicine:** ~~Is a relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of all medical or dental care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care, and direct practice medicine. Most concierge medicine practices do not bill insurance.~~

**Concurrent Review:** ~~A managed care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the utilization management company conduct ongoing assessment of the~~

## Key Terms and Definitions

~~health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility.~~

~~**Continuing Care Patient:** An individual who, with respect to a provider or facility:~~

- ~~• is undergoing a course of treatment for a serious and complex condition from the provider or facility;~~
- ~~• is undergoing a course of institutional or inpatient care from the provider or facility;~~
- ~~• is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;~~
- ~~• is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or~~
- ~~• is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.~~

~~**Convalescent Care Facility:** See the definition of *Skilled Nursing Facility*.~~

~~**Coordination of Benefits (COB):** The rules and procedures applicable to the determination of how Plan benefits are payable when a person is covered by two or more health care plans.~~

~~**Copayment, Copay:** The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. This can be in addition to Coinsurance amounts due on the same incurred charges. Copayments are limited to certain benefits under this program.~~

~~**Corrective Appliances:** The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or device) and Prosthetic Appliance (or device).~~

~~**Cosmetic Surgery or Treatment:** Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator, UM company, or its designee.~~

~~**Cost Efficient:** See the definition of medically necessary for the definition of cost efficient as it applies to medical services that are medically necessary.~~

~~**Cost Share or Cost Sharing:** The amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under the plan.~~

## Key Terms and Definitions

~~**Cost-Sharing Amount** for Emergency and Non-emergency Services at PPO Facilities performed by out-of-network Providers and air ambulance services from out-of-network providers will be calculated consistent with the federal No Surprises Act.~~

~~**Covered Individual:** Any employee or retiree (as those terms are defined in this Plan), and that person's eligible spouse or dependent child who has completed all required formalities for enrollment for coverage under the Plan and is covered by the Plan.~~

~~**Covered Medical Expenses:** See the definition of *Eligible Medical Expenses*.~~

~~**Custodial Care:** Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.~~

~~**Customary Charge:** See the definition of Usual and Customary Charge.~~

~~**Deductible:** The amount of eligible medical, prescription drug and dental expenses you are responsible for paying before the Plan begins to pay benefits. The dental Deductibles are discussed in the separate PPO Dental Master Plan Document.~~

~~**Dental:** As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the Temporomandibular Joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies coverage is provided in the PPO Dental Plan (refer to the separate PPO Dental Plan MPD available at <https://pebp.nv.gov/>) and are not covered under the medical expense coverage of this Plan unless the medical Plan specifically indicates otherwise in the *Schedule of Benefits*.~~

~~**Dependent:** Any of the following individuals: Dependent child(ren), spouse or domestic partner as those terms are defined in this document.~~

~~**Dependent Child(ren):** For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:~~

- ~~• natural child,~~



## Key Terms and Definitions

- ~~child(ren) of a domestic partner,~~
- ~~stepchild,~~
- ~~legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced);~~
- ~~child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN), or~~
- ~~any other person who:~~
  - ~~(1) Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner, and~~
  - ~~(2) Is unmarried.~~

**Disability:** ~~A determination by the Plan Administrator or its designee (after evaluation by a physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as intellectual disability, cerebral palsy, epilepsy, neurological disorder, or psychosis.~~

**Domestic Partner:** ~~A person whose domestic partnership with another has been legally registered or recognized as set forth in [NRS Chapter 122A](#).~~

**Drug:** ~~See the definition for prescription drug.~~

- **Durable Medical Equipment:** ~~Equipment which can withstand repeated use, is primarily and customarily used for a medical purpose, is generally not useful in the absence of an injury or illness; is not disposable or non-durable, and is appropriate for the patient's home.~~

~~Durable medical equipment includes (but is not limited to) apnea monitors, augmentation devices, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.~~

**Elective Hospital Admission, Service or Procedure:** ~~Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.~~

**Eligible Medical Expenses:** ~~Expenses for medical services or supplies, but only to the extent that they are medically necessary; the charges for them are usual and customary and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule; coverage for the services or supplies is not excluded (as provided in the *Benefit Limitations and Exclusions* section); and the Plan Year maximum benefits for those services or supplies has not been reached.~~

## Key Terms and Definitions

~~**Emergency:** See the definition for Medical Emergency.~~

~~**Emergency Medical Condition:** A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.~~

~~**Emergency Care:** Medical and health services provided for an Emergency Medical Condition as defined above.~~

~~**Emergency Services** means the following:~~

- ~~• An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and~~
- ~~• Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).~~

~~Emergency Services furnished by an emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post-stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:~~

- ~~• The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or~~
- ~~• The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and~~
- ~~• The participant or beneficiary gives informed consent to continued treatment by the out-of-network provider, acknowledging that the participant or beneficiary understands that continued treatment by the out-of-network provider may result in greater cost to the participant or beneficiary.~~

~~**Emergency Surgery:** A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness, or within 24 hours of an accidental injury causing a life-threatening situation.~~

## Key Terms and Definitions

~~**Employee:** Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.~~

~~**Employer:** Unless specifically indicated otherwise when used in this document, employer refers to an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.~~

~~**Enteral Formulas:** Specialized liquid nutritional products designed to provide nutrition directly into the gastrointestinal tract.~~

~~**Exclusions:** Specific conditions, circumstances, and limitations, as set forth in the *Benefit Limitations and Exclusions* section for which the Plan does not provide Plan benefits.~~

~~**Experimental and/or Investigational Services:** 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.~~

~~Unless mandated by law, the Plan Administrator or its designee has the discretion and authority to determine if a service or supply is, or should be, classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:~~

- ~~• The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply.~~
- ~~• The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.~~
- ~~• In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.~~
- ~~• With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device~~

## Key Terms and Definitions

~~application has been submitted and filed with the FDA. However, a drug will not be considered experimental and/or investigational if it is:~~

- ~~○ Approved by the FDA as an “Investigational new drug for treatment use”; or~~
- ~~○ Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life threatening disease,” as that term is defined in FDA regulations; or~~
- ~~○ Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.~~
- ~~○ The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.~~

~~In determining if a service or supply is or should be classified as experimental and/or investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for precertification under the Plan’s utilization management program:~~

- ~~● Medical records of the covered person.~~
- ~~● The consent document signed, or required to be signed, to receive the prescribed service or supply.~~
- ~~● Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply.~~
- ~~● Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person’s diagnosis, including (but not limited to) “United States Pharmacopoeia Dispensing Information”; and “American Hospital Formulary Service”.~~
- ~~● The published opinions of the American Medical Association (AMA), such as “The AMA Drug Evaluations” and “The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.,” or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.~~
- ~~● Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.~~
- ~~● The latest edition of “The Medicare Coverage Issues Manual.”~~

~~NOTE: To determine how to obtain a precertification of any procedure that might be deemed to be experimental and/or investigational, see *Precertification in the Utilization Management* section.~~

## Key Terms and Definitions

**Explanation of Benefits (EOB):** When a claim is processed by the claims administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your Deductible, if your out-of-pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

**Extended Care Facility:** See the definition of Skilled Nursing Facility.

**Expedited Appeal:** If a participant appeals a decision regarding a denied request for precertification (pre-service claim) for an urgent care claim, the participant or participant's authorized representative can request an expedited appeal, either orally or in writing. Decisions regarding an expedited appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

**External Review:** An independent review of an adverse benefit determination conducted by an external review organization.

**External Review Organization:** An organization that (1) conducts an external review of a final adverse benefit determination; and (2) is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.

**Federal Legend Drugs:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

**Food and Drug Administration (FDA):** The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

**Free Standing Laboratory Facility:** Free standing laboratory facilities are stand-alone facilities that are not affiliated with a hospital system. Examples of preferred free standing laboratory facilities include Labor Corp or Quest.

**Formulary:** A list of generic and brand name drug products available for use by participants. This is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

**Gender Dysphoria:** Distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

- (1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.
- (2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire

## Key Terms and Definitions

~~to prevent the development of anticipated secondary sex characteristics in young adolescents.~~

~~(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.~~

~~(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.~~

~~(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.~~

~~(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.~~

**Generic/ Generic Drug:** A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the pharmacist as being generic. (See also the Prescription Drug section of the *Schedule of Benefits* and the *Prescription Drug* subsection of the *Medical Exclusion* section).

**Genetic Counseling:** Counseling services provided before or in the absence of genetic testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of genetic testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman.

**Genetic Information:** Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from genetic testing, or that may be inferred from a person's family medical history.

**Genetic Testing:** Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations. Tests that assist the health care practitioner in determining the appropriate course of action or treatment for a medical condition.

**Government Provided Services (Tricare/CHAMPUS, VA, etc.):** Expenses for health care services provided to a covered participant that federal, state, or local law (e.g., Tricare/Champus, VA, except the Medicaid program), expenses for care required by a public entity and care for which there would not normally be a charge.

## Key Terms and Definitions

**Health Care Facility:** (for non-emergency services) is each of the following:

- A hospital (as defined in [section 1861\(e\) of the Social Security Act](#));
- A hospital outpatient department;
- A critical access hospital (as defined in [section 1861\(mm\)\(1\) of the Social Security Act](#)); and
- An ambulatory surgical center described in [section 1833\(i\)\(1\)\(A\) of the Social Security Act](#)

**Health Care Practitioner:** 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, or other provider 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.

**Health Care Provider:** A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* section).

**Health Reimbursement Arrangement (HRA):** A Health Reimbursement Arrangement (HRA) is an employer-funded spending account that can be used to pay qualified medical expenses. The HRA is 100% funded by the employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted or insurance coverage kicks in. The contribution amount per employee is set by the employer, and the employer determines what the funds can be used to cover and if the dollars can be rolled over to the next year. In most cases, if the employee leaves the employer, they cannot take remaining HRA funds with them.

**Health Savings Account (HSA):** An account that allows individuals to pay for current health expenses and save for future qualified medical and Retiree health expenses on a tax-free basis.

**HIPAA:** Health Insurance Portability and Accountability Act of 1996. Federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

**HIPAA Special Enrollment:** Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

**Home Health Care:** Intermittent skilled nursing care services provided by a licensed home health care agency (as those terms are defined in this section).

**Home Health Care Agency:** An agency or organization that provides a program of Home Health Care and meets one of the following three tests:

## Key Terms and Definitions

- ~~It is approved by Medicare; or~~
- ~~It is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or~~
- ~~If licensing is not required, it meets all the following requirements:~~
- ~~It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or registered nurse to the home.~~
- ~~It has a full-time administrator.~~
- ~~It is run according to rules established by a group of professional health care providers including physicians and registered nurses.~~
- ~~It maintains written clinical records of services provided to all patients.~~
- ~~Its staff includes at least one registered nurse, or it has nursing care by a registered nurse available.~~
- ~~Its employees are bonded.~~
- ~~It maintains malpractice insurance coverage.~~

~~**Homeopathy:** A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." See also the *Exclusions* section of this document regarding homeopathic treatment and services. When the services of homeopaths are payable by this Plan (e.g., an office visit), the homeopath must be properly licensed to practice homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post-graduate courses or training in a program approved by the American Institute of Homeopathy.~~

~~**Hospice:** An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a limited life expectancy. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family.~~

~~A hospice agency must meet one of the following tests:~~

- ~~It is approved by Medicare; or is licensed as a hospice agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or~~
- ~~If licensing is not required, it meets all the following requirements:~~
  - a. ~~It provides 24-hour a day, 7-day a week service.~~
  - b. ~~It is under the direct supervision of a duly qualified physician.~~



## Key Terms and Definitions

- ~~e.—It has a full-time administrator.~~
- ~~d.—It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.~~
- ~~e.—The main purpose of the agency is to provide hospice services.~~
- ~~f.—It maintains written records of services provided to the patient.~~
- ~~g.—It maintains malpractice insurance coverage.~~
- ~~h.—A hospice agency that is part of a hospital will be considered a hospice agency for the purposes of this Plan.~~

**Hospital:** A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that:

- ~~• Is legally operated in the jurisdiction where it is located.~~
- ~~• Is engaged mainly in providing inpatient medical care and treatment for injury and illness in return for compensation.~~
- ~~• Has organized facilities for diagnosis and major surgery on its premises.~~
- ~~• Is supervised by a staff of at least two physicians.~~
- ~~• Has 24-hour-a-day nursing service by registered nurses; and~~
- ~~• Is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or skilled nursing facility or similar institution; or a Long-Term Acute Care Facility (LTAC).~~

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, birth (or birthing) center, hospice, skilled nursing facility, sub-acute care facility, or other place for rest, custodial care, or the aged shall not be regarded as a hospital for any purpose related to this Plan.

**Illness:** Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician, and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be an illness only for coverage under this Plan. However, infertility is not an illness for coverage under this Plan.

**Independent Freestanding Emergency Department:** A health care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

**Inherited Metabolic Disorder:** A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates, or fats, as diagnosed by a physician using standard blood, urine, spinal fluid, tissue, or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis

## Key Terms and Definitions

~~of Galactosemia is not an Inherited Metabolic Disorder under this Plan. See Special Food Products.~~

~~**Injury:** Any damage to a body part resulting from trauma from an external source.~~

~~**Injury to Teeth:** An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to sound and natural teeth are payable under the medical Plan.~~

~~**In Network Provider:** Means an In Network provider that the network or one of its rental networks have contracted with or have arrangements with to provide health services to covered individuals. An In Network provider has agreed to charge participants a discounted rate. To determine if a provider is an In Network provider log on to <https://pebp.nv.gov/>. You may also call the number on the back of your ID card and a customer service representative can help you locate an In Network provider.~~

~~**In Network Services:** Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out of Network services that are provided by a health care provider that is not a member of the PPO network.~~

~~**In Network Contracted Rate:** The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the In Network contracted amount may be applied to Out of Network provider charges.~~

~~**Inpatient Services:** Services provided in a hospital or other health care facility during the period when charges are made for room and board.~~

~~**Intensive Care Unit:** A section, ward, or wing within the hospital which:~~

- ~~• Is separated from other hospital facilities.~~
- ~~• Is operated exclusively for providing professional care and treatment for critically ill patients.~~
- ~~• Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use.~~
- ~~• Provides room and board; and~~
- ~~• Provides constant observation and care by registered nurses or other specially trained hospital personnel.~~

~~**Intensive Outpatient Program:** An intensive outpatient program (IOP) is a kind of treatment service and support program used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification. IOP operates on a small scale and does not require the intensive residential or partial day services typically offered by the larger, more comprehensive treatment facilities.~~

## Key Terms and Definitions

~~**Maintenance Care:** Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.~~

~~**Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and or preserve the patient's functional level. Maintenance rehabilitation is not covered by the Plan.~~

~~**Managed Care:** Procedures designed to help control health care costs by avoiding unnecessary services or services that are costlier than others that can achieve the same result.~~

~~**Maximum Amount; Maximum Allowable Charge:** The benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Plan Administrator considering and after having analyzed:~~

- ~~• The reasonable and appropriate amount.~~
- ~~• The terms of the Plan;~~
- ~~• Plan negotiated and contractual rates with provider(s);~~
- ~~• The actual billed charges for the covered services; and~~
- ~~• Unusual circumstances or complications requiring additional time, skill, and experience in connection with a service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s);~~
- ~~• Medicare Allowable~~

~~The Plan will reimburse the actual charge(s) if they are less than the Plan's Maximum Allowable Charge amount(s). The Plan has the discretionary authority to decide if a charge is reasonable and appropriate, as well as medically necessary. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.~~

~~**Medical management technique:** A practice used to control the cost or use of health care services, prescription drugs, or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.~~

~~**Medically Necessary:** Health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:~~

- ~~1. Provided in accordance with generally accepted standards of medical practice;~~
- ~~2. Clinically appropriate with regard to type, frequency, extent, location and duration;~~

## Key Terms and Definitions

3. ~~Not primarily provided for the convenience of the patient, physician or other provider of health care;~~
4. ~~Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and~~
5. ~~The most clinically appropriate level of health care that may be safely provided to the insured.~~

A medical or dental service or supply will be appropriate if:

- ~~It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.~~
- ~~It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.~~
- ~~A medical or dental service or supply will be cost efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility.~~
- ~~The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.~~
- ~~A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.~~

**Medically Necessary for External Review:** ~~Means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.~~

## Key Terms and Definitions

~~**Medicare:** The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.~~

~~**Medicare Part A:** Hospital insurance provided by the federal government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.~~

~~**Medicare Part B:** Medical insurance provided by the federal government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.~~

~~**Medicare Part D:** Prescription drug coverage subsidized by the federal government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.~~

~~**Medi Span:** A national drug pricing information database for drug pricing analysis and comparison.~~

~~**Mental Disorder; Mental and Nervous Disorder:** See the definition of Behavioral Health Disorder.~~

~~**Midwife, Nurse Midwife:** A person legally licensed as a Midwife or certified as a Certified Nurse Midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.~~

~~**Morbid Obesity:** Characterized by body mass index >40 kg/m(2) as defined by the National Library of Medicine.~~

~~**Naturopathy:** A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage, or herbal tea. Note: Naturopathy providers, treatment, services, or substances are not a payable benefit under this Plan.~~

~~**No Surprises Act** means the federal No Surprises Act (Public Law 116-260, Division BB).~~

~~**Nondurable Supplies:** Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap, or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the *Schedule of Benefits* are covered by this Plan. All others are not.~~

## Key Terms and Definitions

**Non-Network:** See *Out-of-Network*.

**Non-PPO emergency facility:** An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

**Non-PPO Provider or Non-Participating Provider:** A health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

**Nurse:** A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

**Nurse Anesthetist:** A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA) and authorized to administer Anesthesia in collaboration with a physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

**Nurse Practitioner:** A person legally licensed as a Nurse Practitioner (NP), or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners under the laws of the state or jurisdiction where the services are rendered.

**Occupational Therapist:** A person legally licensed as a professional occupational therapist who acts within the scope of their license and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills to regain independence.

**Office Visit:** A direct personal contact between a physician or other health care practitioner and a patient in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is an office visit for the purposes of this Plan.

## Key Terms and Definitions

**Open Enrollment Period:** The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage.

**Oral Surgery:** The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

**Orthognathic Services:** Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism, Retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

**Orthotic (Appliance or Device):** A type of corrective appliance or device, either customized or available “over the counter,” designed to support a weakened body part, including (but not limited to) crutches, custom designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical Plan, this definition does not include dental orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

**Other Prescription Drugs:** Drugs that require a prescription under state law but not under federal law.

**Out of Network Rate:** With respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system

**Out of Network Services (Non Network):** Services provided by a health care provider that is not a member of the Plan’s Preferred Provider Organization (PPO), as distinguished from In-Network services that are provided by a health care provider that is a member of the PPO. Greater expense could be incurred by the participant when using Out-of-Network providers.

**Out of Pocket Maximum (OPM):** The maximum amount of Coinsurance each covered person or family is responsible for paying during a Plan Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of eligible covered expenses for the remainder of the Plan Year. See the section on Out-of-Pocket Maximum in the *Medical Expense Coverage* section for details about what expenses do not count toward the Out-of-Pocket Maximum.

**Outpatient Hospital Laboratory and Outpatient Hospital-Based Laboratory Draw Station:** Outpatient hospital-based laboratory facilities include lab services performed in a hospital outpatient setting. Outpatient hospital-based laboratory draw stations are hospital-affiliated

## Key Terms and Definitions

whereby the draw station collects specimens and sends them to the central hospital lab for processing.

**Outpatient Services:** Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

**Partial Hospitalization Service:** Also known as PHP, is a type of program used to treat mental illness and substance abuse in which the patient continues to reside at home but commutes to a treatment center up to seven days a week. This service model focuses on the overall treatment of the individual and is intended to avert or reduce in-patient hospitalization. Services are typically provided in either a hospital setting or by a free-standing community mental health center. Treatment during a typical day may include group therapy, psych-educational groups, skill building, individual therapy, and psychopharmacological assessments, and check-ins. Programs are available for the treatment of alcoholism and substance abuse, Alzheimer's disease, anorexia and bulimia, depression, bipolar disorder, anxiety disorders, schizophrenia, and other mental illnesses.

**Participant:** The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse or dependent of a retiree.

**Participating Provider:** A health care provider who participates in the Plan's Preferred Provider Organization (PPO).

**Passive Rehabilitation:** Refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until the patient can achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be medically necessary for the purposes of this Plan.

**Pharmacy:** A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Pharmacist:** A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

**Physical Therapy:** Rehabilitation directed at restoring function following disease, injury, surgery, or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform Activities of daily living such as walking and getting in and out of bed.



## Key Terms and Definitions

**Physician:** A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

**Physician Assistant (PA):** A person legally licensed as a physician assistant, who acts within the scope of his or her license and acts under the supervision of a physician to examine patients; establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising physician; under the laws of the state or jurisdiction where the services are rendered.

**Plan, The Plan, This Plan:** In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

**Plan Administrator:** The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

**Plan Year:** Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, all Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

**Plan Year Deductible:** The amount you must pay each Plan Year before the Plan pays benefits.

**Plan Year Maximum Benefits:** The maximum benefits payable each Plan Year for certain medical expenses incurred by any covered Plan participant (or covered family member of the Plan participant).

**Podiatrist:** A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

**Pre-Admission Testing:** Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis, 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury.

**Precertification (preauthorization, prior authorization):** Is a process used by the UM company and Pharmacy Benefit Manager to determine if a prescribed procedure, including, but not limited to inpatient admission, concurrent review, DME, outpatient services, or medication are medically necessary before the services and supplies are received. A precertification is not a guarantee of payment.

## Key Terms and Definitions

~~**Preferred Provider Organization (PPO):** A group or network of health care providers (e.g., hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted or reduced rates.~~

~~**Prescribed for a Medically Necessary Indication:** The term medically necessary indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.~~

~~**Prescription Drugs:** For the purposes of this Plan, prescription drugs include:~~

- ~~• Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug, and Cosmetic Act requires to be labeled, "Caution—Federal law prohibits dispensing without prescription".~~
- ~~• Other prescription drugs: drugs that require a prescription under state law but not under federal law; or~~
- ~~• Compound drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.~~

~~**Prescription Prior Authorization (PA):** Also known as "coverage review," this is a process the Plan's Pharmacy Benefit Manager might use to decide if your prescribed medicine will be covered. The Plan uses this to help control costs and to ensure the medicine being prescribed is an effective treatment for the condition.~~

~~**Primary Care Doctor or Primary Care Physician (PCP):** A physician or group of physicians who:~~

- ~~— 1. — Provides initial and primary health care services to an insured;~~
- ~~— 2. — Maintains the continuity of care for the insured; and~~
- ~~— 3. — May refer the insured to a specialized provider of health care.~~

~~This may include a physician in family practice, internal medicine, pediatrics, obstetrics and gynecology.~~

~~**Prognathism:** The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.~~

~~**Program:** Means the Public Employees' Benefits Program.~~

~~**Prophylactic Surgery:** A surgical procedure performed for~~

- ~~• avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or~~

## Key Terms and Definitions

- ~~treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages.~~

~~An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.~~

**Prophylaxis:** The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth are performed by a dentist or dental hygienist.

**Prospective Payment System (PPS):** This Plan follows CMS's Prospective Payment System (PPS) where the Plan's payment is based on a predetermined, fixed amount payable to a facility for inpatient or outpatient hospital services. The Plan will not allow separate reimbursement for specific HCPCS supplies, DME, orthotics, prosthetics, biological, and drugs billed on a HCFA claim form by any physician or other qualified healthcare professional in the following facility POS (place of service) 19, 21, 22, 23, and 24, see the following POS descriptions:

- ~~**POS 19 Off Campus – Outpatient Hospital:** A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.~~
- ~~**POS 21 Inpatient Hospital:** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.~~
- ~~**POS 22 On Campus – Outpatient Hospital:** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision physicians to patients admitted for a variety of medical conditions.~~
- ~~**POS 23 Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness and injury is provided.~~
- ~~**POS 24 Ambulatory Surgery Center:** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.~~

**Prosthetic Appliance (or Device):** A type of corrective appliance or device designed to replace all or part of a missing body part, including (but not limited to) artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

## Key Terms and Definitions

**Provider:** A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* Section).

**Qualified Individual:** A covered individual who is eligible, according to clinical trial protocol, to participate in an approved clinical trial and either: (i) the referring health care professional is an in-network provider and has concluded that the covered individual's participation in the clinical trial would be appropriate; or (ii) the covered individual provided medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

**Qualified Medical Child Support Orders (QMCSO):** QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce and also include a National Medical Support Notice. 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:

- Specifies your last known name and address and the child's last known name and address.
- Describes the type of coverage to be provided, or how the type of coverage will be determined.
- States the period to which it applies; and
- 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.

**Qualifying Payment Amount (QPA)** means the amount calculated using the methodology described in 29 CFR 716.6(c).

**Quantity Limit:** The maximum amount of a medication the Plan covers during a period of time. These limits are set for safety reasons and to help reduce costs.

**Reasonable and/or Reasonableness:** Means charges for services or supplies which are necessary for the care and treatment of an illness or injury. The determination that charges are reasonable will be made by the Plan Administrator taking into consideration the following:

- The facts and circumstances giving rise to the need for the service or supply.
- Industry standards and practices as they are related to similar scenarios; and

## Key Terms and Definitions

- ~~The cause of the injury or illness necessitating the service or charge.~~

~~The Plan Administrator's determination will consider but will not be limited to evidence based guidelines, and the findings and assessments of the following entities:~~

- ~~The National Medical Associations, Societies, and Organizations;~~
- ~~The Centers for Medicare and Medicaid Services (CMS);~~
- ~~Centers for Disease Control and Prevention; and~~
- ~~The Food and Drug Administration.~~

~~To be reasonable, charges must follow generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether a charge is reasonable. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charges that are not reasonable and therefore not eligible for payment by the Plan.~~

~~**Reconstructive Surgery:** A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease, or tumor, or for breast reconstruction following a total or partial mastectomy.~~

~~**Reference Based Pricing/Reference Price:** A methodology that determines the cost for a covered service based on a market or industry benchmark or reference price. The Plan Administrator may utilize this method in determining the Maximum Allowable Charge.~~

~~**Rehabilitation Therapy:** Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, or medically necessary treatment of a behavioral health condition, and that is performed by a licensed therapist acting within the scope of his or her license. See the *Schedule of Benefits* and the *Exclusions* section of this document to determine the extent to which rehabilitation therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.~~

~~**Reimbursable Payments:** Payments made by this Plan for benefits, including any payment for a covered pre-existing condition that are or become the responsibility of another party under the subrogation provisions as described in this MPD.~~

~~**Rescission:** A cancellation or discontinuance of coverage under the Plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the Plan if~~

- ~~The cancellation or discontinuance of coverage has only a prospective effect; or~~

## Key Terms and Definitions

- ~~• The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage~~

**Retiree:** Unless specifically indicated otherwise, when used in this document, Retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

**Retrognathism:** The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

**Retrospective Review:** Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule.

**Second Opinion:** A consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

**Serious and Complex Condition:** With respect to a participant, beneficiary, or enrollee under the Plan one of the following:

- ~~• in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;~~
- ~~in the case of a chronic illness or condition, a condition that is—~~
- is life threatening, degenerative, potentially disabling, or congenital; and
- requires specialized medical care over a prolonged period of time.

**Service Area:** The geographic area serviced by the In-Network providers who have agreements with the Plan's network.

**Sickle Cell Disease:** An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable.

**Significantly Inferior Coverage:** The PEBP Board has defined Significantly Inferior Coverage as either:

- ~~• A mini-med or other limited benefit plan; or~~
- ~~• Catastrophic coverage plans with a Deductible equal to or greater than \$5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement.~~

## Key Terms and Definitions

**Skilled Nursing Care:** Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less than daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

**Skilled Nursing Facility or Extended Care/Skilled Nursing Facility:** A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, sick people or people with disabilities, and that meets all the following requirements:

- Is licensed pursuant to state and local laws.
- Is operated primarily for providing skilled nursing care and treatment for individuals convalescing from injury or illness.
- Is approved by and is a participating facility with Medicare.
- Has organized facilities for medical treatment.
- Provides 24 hour a day nursing service under the full time supervision of a physician or registered nurse.
- Maintains daily clinical records on each patient.
- Has available the services of a physician under an established agreement.
- Provides appropriate methods for dispensing and administering drugs and medicines.
- Has transfer arrangements with one or more hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one physician; and
- Is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

A skilled nursing facility that is part of a hospital, as defined in this document, will be considered a skilled nursing facility for the purposes of this Plan.

**Special Food Product:** A food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

**Specialist Physician:** A doctor who has completed advanced education and training in a specific field of medicine and who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

**Specialty Care Unit:** A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment,

## Key Terms and Definitions

~~and care provided by Registered nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).~~

**Speech Therapy:** ~~Rehabilitation directed at treating defects and disorders of spoken and written communication;~~

**Spinal Manipulation / Chiropractic Care:** ~~The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by physicians.~~

**Spouse:** ~~The employee's lawful spouse. The Plan will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.~~

**Standard Plan Benefits (Standard Benefits):** ~~Standard Plan Benefits or Standard Benefits under this Plan means the participant is covered under the Plan's Standard Benefits and is not eligible for enhanced benefits due to non-participating and or engaging in the Diabetes Care Management or Obesity Care and Overweight Management Programs.~~

**State:** ~~When capitalized in this document, the term State means the State of Nevada.~~

**Step Therapy:** ~~see also "Medical Management technique." A process designed to help control high medicine costs. If the Plan applies step therapy to your medication, it will require that you try a lower cost medication that is proven effective to treat your condition, before it will cover a higher cost medicine. If the lower cost medicine does not treat your condition effectively, the Plan's coverage will "step" you to a higher cost medicine to find a medicine that treats your condition effectively at the lowest possible cost.~~

~~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](#).~~

**Sub-acute Care Facility:** ~~A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide sub-acute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, to the patient's home or to a suitable skilled nursing facility, and that meets all of the following requirements:~~

- ~~• It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Sub-Acute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and~~
- ~~• It maintains on its premises all facilities necessary for medical care and treatment; and~~



## Key Terms and Definitions

- ~~It provides services under the supervision of physicians; and~~
- ~~It provides nursing services by or under the supervision of a licensed Registered Nurse; and~~
- ~~It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and~~
- ~~It is not a hotel or motel.~~

~~**Substance Abuse:** A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of behavioral health disorders and chemical dependency.~~

~~**Surgery/Surgeries:** Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the claims administrator will determine which multiple surgical procedures will be considered as primary, secondary, bilateral, add-on, or separate (incidental) procedures for determining benefits under this Plan.~~

### ~~Multiple Surgical Procedure Allowances:~~

- ~~Primary procedure, bilateral primary procedure, or add-on to primary procedure: usual and customary, subject to the Plan's Maximum Allowable Charge or negotiated fee.~~
- ~~Secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.~~
- ~~Bilateral secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.~~
- ~~Add-on to secondary procedure in same operative area: limited to 100% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.~~
- ~~Separate (incidental) procedure in same operative area as any of the above: not covered.~~
- ~~Separate operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.~~

~~**Telehealth:** Telehealth means the delivery of services from a provider of health care to a patient at a different location using information and audio-visual communication technology, not including facsimile, or electronic mail.~~

## Key Terms and Definitions

~~Telehealth is a general term used to describe clinical services provided to patients through electronic communications not through a vendor. This can be patient-to-physician. Examples include patient consultation with a specialist that is out of the patient's geographical area or patient has a virtual visit with their primary care physician. Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health.~~

~~**Telemedicine:** Telemedicine (vendor/virtual visit) is the practice of medicine using technology to deliver care at a distance via electronic communications through a vendor.~~

~~**Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome:**~~

~~The Temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring, or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.~~

~~**Termination:** Includes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.~~

~~**Therapist:** A person trained in and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy. *See the Occupational, Physical and Speech Therapy* section.~~

~~**Tortfeasor:** Means an individual or entity who commits a wrongful act, either intentionally or through negligence, which injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.~~

~~**Transplant, Transplantation:** The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. (See the *Schedule of Benefits and Exclusions* section for additional information regarding transplants. See also the *Utilization Management* section of this document for information about precertification requirements for transplantation services).~~

~~**Xerographic:** Refers to transplants of organs, tissues, or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xerographic transplants are not covered by this Plan, except heart valves.~~

## Key Terms and Definitions

**Urgent Care:** Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate, even though health and life are not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include (but are not limited to) fever, sprains, bone, or joint injuries, continuing diarrhea, vomiting, or bladder infections.

**Urgent Care Claim:** Means a claim for benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not urgent care claims could seriously jeopardize the participant's life, health, or the ability to regain maximum function by waiting for a routine appeal decision. An urgent care claim also means a claim for benefits that, in the opinion of a physician with knowledge of the participant's medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for precertification of an urgent care service was denied, the participant could request an expedited appeal for the urgent care claim.

**Urgent Care Facility:** A public or private hospital-based or free-standing facility, which includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance when the facility is open.

**Usual and Customary:** Covered expenses which are identified by PEBP, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) most patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, country, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made.

To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

## Key Terms and Definitions

~~The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, subject to the Plan’s Maximum Allowable Charge or negotiated fee schedule for any procedure, service, or supply, and whether a specific procedure, service or supply is usual and customary. Usual and customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, Average Wholesale Price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.~~

~~**Utilization Management (UM):** A managed care process to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include (but is not limited to): precertification; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM, utilization review services, UR services, utilization management, concurrent review, or retro review services) are provided by licensed health care professionals employed by the utilization management company operating under a contract with the Plan.~~

~~**Utilization Management Company (UM company):** The independent utilization management organization, 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 the Plan’s utilization management services.~~

~~**Visit:** See the definition of office visit.~~

~~**Well Baby Care; Well Child Care:** Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary, even though they are not provided because of illness, injury, or congenital defect. The Plan’s coverage of well baby care is described under *Preventive Care/Wellness Services* and in the *Schedule of Benefits*.~~

~~**You, Your:** When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.~~