NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
Quality.
Affordability.

CONSUMER DRIVEN HEALTH PLAN MASTER PLAN DOCUMENT

PLAN YEAR 2023

(EFFECTIVE JULY 1, 2022 – JUNE 30, 2023)

Public Employees' Benefits Program
901 S. Stewart Street, Suite 1001
Carson City, Nevada 89701

Table of Contents

Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Cover Page, Welcome Page, and Participant Contact Guide
Updated PEBP Phone number information to include 702-486-3100.

Page 19: **Out-of-Country Medical, Prescription and Vision Purchases**
Removed references to The Standard, PEBP's prior basic life insurance vendor.

Page 23: **Health Reimbursement Arrangement**
Clarified: PEBP and its vendor require direct deposit for HRA reimbursements.

Page 136 -138: **Participant Contact Guide**
Updated the Fax Number for Utilization Management Company from 800-288-2264 to 800-282-8845.

Added United Healthcare for Basic Life Insurance

Diversified Dental Services the contact information was updated.

- Added bullet point reflecting Principal Dental Network for providers outside of Nevada.

Page 71: **Preventive Care/Wellness Benefits;** Explanations and Limitations

Clarified "routine gynecological" by adding "Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination."

Page 63: **Maternity and Newborn Services**; Explanations and Limitations

Added "When the member has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days (NRS 689B.033). If employee-only coverage is maintained, individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period."

Page 66: **Obesity Care Management**
Removed Meal Replacement Therapy to comply with IRS Regulation 213(d) and IRS Publication 502

Page 80: **Travel Expenses**
Updated travel to comply with IRS Regulation 213(d) and IRS Publication 502. Added citation, removed references to meals, and removed sections for in-state and out of state travel.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). 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.

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) with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA), Premier Plan, 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.

All PEBP participants choosing the Consumer Driven Health Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the Active Employee Health and Welfare Wrap Plan, Retiree Health and Welfare Wrap Plan, Section 125 Document, and the PEBP Enrollment and Eligibility Master Plan Document. These documents are available at www.pebp.state.nv.us or by calling 775-684-7000, 702-486-3100, or 1-800-326-5496.

Master Plan Documents are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted in the Active Employee Health and Welfare Plan Document and Retiree Health and Welfare Wrap Plan Document 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

Introduction

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).

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 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 and 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.

This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code (NAC) 287 as amended and certain provisions of NRS 695G and NRS 689B. The Plan Sponsor certifies that this Article incorporates the provisions set forth in 45 CFR Section 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii).

The Plan described in this document is effective **July 1, 2022**, and unless stated differently, replaces all other CDHP medical and prescription drug benefit plan documents/summary plan descriptions previously provided to you.

All 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 *Benefit Limitations and Explanations*, 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 and Responsibilities* section describes your rights and responsibilities as a participant of the CDHP.
- 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 Medical Benefits, Schedule of Prescription Drug Benefits, Key Terms and Definitions*, 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 that 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 Procedure* 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.

Accessing Other Benefit Information:

You will also want to access the following documents for information related to 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 at www.pebp.state.nv.us.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan (CDHP) Master 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
- Premier Plan Master Plan Document
- Premier 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

Participant Rights and Responsibilities

You have the right to:

- Participate with your health care professionals in your health care decisions and have your health care professionals give you information about your condition and your treatment options.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your 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 and responsibilities.
- 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 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 physician(s) of the medical consequences.

You have the responsibility to:

- Establish a patient relationship with a participating primary care physician and a participating dental care provider. (Note: This Plan does not require you to designate a primary care physician.)
- Take personal responsibility for your overall health by adhering to healthy lifestyle choices. Understand that you are solely responsible for the consequences of unhealthy lifestyle choices.
    - If you use tobacco products, seek advice regarding how to quit.
    - Maintain a healthy weight through diet and exercise.
    - Take medications as prescribed by your health care provider.
    - Talk to your health care provider about preventive medical care.
    - Understand the wellness/preventive benefits offered by the Plan.
    - Visit your health care provider(s) as recommended.
- Choose In-Network participating provider(s) to provide your medical care.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your health care providers.
- Read all materials concerning your health benefits or ask for assistance if you need it.
- Supply information PEBP and/or your health care professionals need to provide care.
- Follow your physician's recommended treatment plan and ask questions if you do not fully understand your treatment plan and what is expected of you.
- Follow the Plan's guidelines, provisions, policies, and procedures.

- Inform PEBP if you experience any life changes such as a name change, change of address or changes to your coverage status because of marriage, divorce, death, domestic partnership, birth of a child(ren) or adoption of a child(ren).
- Provide PEBP with accurate and complete information needed to administer your health benefit plan, including if you or a covered dependent has other health benefit coverage.
- Retain copies of the documents provided to you from PEBP and PEBP's vendors. These documents include but are not limited to copies of:
    - The Explanation of Benefits (EOB) from PEBP's claims administrator. Duplicates of your EOB's may not be available to you. It is important that you store these documents with your other important paperwork.
    - Your enrollment forms and/or other eligibility documents submitted to PEBP.
    - Your medical, vision and dental bills.
    - Copies of your HSA contributions, distributions, and tax forms.

The plan is committed to:

- Recognizing and respecting you as a participant.
- Encouraging open discussion between you and your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and the Plan's network (participating) providers.
- Sharing the Plan's expectations of you as a participant.

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 receive coverage for many medically necessary services and supplies, subject to any Benefit Limitations and Explanations and *Exclusions*. This is an open access PPO Plan and does not require a referral to see a specialist.

The Plan includes:

- Coverage for participants residing nationwide (in- and outside of Nevada).
- 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 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 your E-PEBP member portal account at www.pebp.state.nv.us.

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**
Individual (self-only coverage)	$1,500	$4,000	$1,500	$10,600
Family	Family: $3,000 Individual family member: $2,800	Family: $8,000 Individual family Member: $6,850	Family: $3,000 Individual family member: $2,800	$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.				

Deductibles

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

- **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 all covered family members. The In-Network Family Deductible includes a "Individual Family Member" embedded Deductible. This means one single member of the family is only required to meet the Individual Family Member Deductible before the Plan starts to pay Coinsurance for that member.

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

During the Plan Year, you are responsible for paying for your eligible medical and prescription drug expenses (except eligible Preventive Services provided In-Network) out of pocket until you have met your Deductible. Deductible credit is only applied for eligible medical and prescription drug expenses and in the order in which the claims are received by the Plan. Non-eligible medical and prescription drug expenses do not count toward the Deductible.

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 **$1,500**. 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.

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 **$1,500**. Participants are responsible for paying Out-of-Pocket for eligible medical (prescription 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 **$3,000** and includes a **$2,800** embedded "Individual Family Member" Deductible. 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 **$3,000** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **$2,800** "Individual Family Member" Deductible (under no circumstances will one single family member be required to pay more than **$2,800** toward the **$3,000** Family Deductible). The **$3,000** In-Network Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including "Individual Family Member" 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.

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 **$3,000** and includes a **$2,800** "Individual Family Member" Deductible. 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 **$3,000** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **$2,800** "Individual Family Member" Deductible (under no circumstances will one single family member be required to pay more than **$2,800** toward the **$3,000** Out-of-Network Family Deductible). The **$3,000** Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including "Individual Family Member" 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.

Coinsurance

Coinsurance is the percentage of costs that generally 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.

Out-of-Pocket Maximums

In-Network Out-of-Pocket Maximums

The In-Network Out-of-Pocket Maximum (OOP Maximum) is the maximum amount you 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 OOP Maximum. The OOP Maximum for:

- 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.

Once an Individual or Family satisfies the OOP Maximum, the Plan will pay 100% of all 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 apply to the Deductible and Coinsurance will apply to the OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges and amounts 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.

For this section only, all references to the OOP Maximum, 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 (OOP Maximum) is the maximum amount you 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 OOP Maximum. The OOP Maximum 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.)

Once the OOP Maximum is met, the Plan will pay 100% of all 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 OOP Maximum 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 all covered family members.

Only Eligible Medical Expenses that apply to the Deductible and Coinsurance will apply to the OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, 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.

All 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 OOP Maximum.

Description of In-Network and Out-of-Network

Provider Network

The Plan or its designee arranges for providers to participate in a PPO network. For more information, see the Participant Contact Guide section of this document. 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 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 should always verify the network status of a provider. A provider's status may change. You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another In-Network provider. You can verify the provider's status by calling the third-party administrator or on the PEBP website in the Find a Provider section.

It is possible that you might not be able to obtain specific services from an In-Network provider. The provider network is subject to change. Or you might find that an In-Network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available, you 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 provider for only some 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.

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 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 Deductible and 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 Coinsurance 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 Coinsurance you are responsible for paying) as payment

in full. The In-Network health care provider generally deals with the Plan 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.

Out-of-Network (non-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 Deductibles and Coinsurance. 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 avoided by using In-Network Providers.

Out-of-Network Benefit Exceptions

If there is no In-Network provider within 50-miles of 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. All benefits that fall under this category must be approved prior to receipt of the care and are subject to any Plan limitations or *Exclusions* set forth in this MPD.

If you are traveling outside your network and you need medical care, you should contact the third-party administrator at the telephone number appearing on your medical identification card for assistance in locating the nearest In-Network provider. If you need emergency care, however, go ahead and get the care you need. The Plan will pay your claim for Eligible Medical Expenses at the In-Network provider level, subject to the Plan's Maximum Allowable Charge.

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 physician. Eligible Medical Expenses that are provided as a result of Urgent or Emergent care provided by In-Network providers are paid at the In-Network benefit level. Out-of-Network Urgent and Emergent care for Eligible Medical Expenses are paid at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge.

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 must be notified within two business days or on the same day of admission if reasonably possible. The UM company may elect 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 utilization management 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.

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 or emergency room.
- 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.

Other Providers

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 located at www.pebp.state.nv.us.

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 www.pebp.state.nv.us 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.

Directories of Network Providers

You can obtain network provider information by calling the applicable network at the telephone number shown in the *Participant Contact Guide* section of this document. You can also view the Directory of Health Care Providers on the PEBP website at *www.pebp.state.nv.us*.

Physicians and health care providers who participate in the Plan's networks are added and deleted periodically during the year. You can confirm whether a health care provider is a member of your network by calling the applicable network at the telephone number listed in the *Participant Contact Guide* or by accessing the provider directory on the PEBP website. Participants are encouraged to confirm the In-Network participation status of a provider prior to receiving services.

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services, and supplies. The expenses for which you are covered are called *Eligible Medical Expenses*. Eligible medical expenses are limited to the covered benefits specified in the Schedule of Medical 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 *Exclusions* section).
- Charges for services or supplies that do not exceed the limited overall or Plan Year maximum benefits as shown in the *Schedule of Medical Benefits*.

Generally, the Plan will not reimburse you for all *Eligible Medical Expenses*. Usually, you will have to pay some portion of costs, known as cost-sharing such as Coinsurance toward the amounts you incur for *Eligible Medical Expenses*. However, once you 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 Medical 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.

Non-Eligible Medical Expenses

Non-eligible medical expenses are expenses that are excluded from the Plan and do not accumulate towards your Deductible and Out-of-Pocket Maximum.

This Plan does not pay benefits equal to all the medical expenses you may incur. You 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 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 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 may have to pay a greater percentage of those costs. The additional amount you may have to pay is in addition to your 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 not 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 your specific coverage tier. You are responsible for paying these expenses out of your 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 Medical Benefits*.

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, 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 45th 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

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

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 may be required to pay for medical and vision care services and submit your receipts to this Plan's third-party 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 regulations determined by the FDA. Out-of-country medication purchases are only eligible for reimbursement while traveling outside of the United States.

The third-party claims administrator may require a written notice from you or your designated representative explaining why you received the medical services from an out of country provider 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, you must complete the following: Proof of payment from you to the provider of service (typically your 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 reserve the right to request additional information. If the provider will accept payment directly from the claim's administrator, you must also provide the following:

- 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 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.

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

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 can use to pay or reimburse yourself for certain medical expenses you incur.

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 unless there is no account activity for a 3-year period then the funds will be considered abandoned per NRS 120A.500 and subject to forfeiture by the State). Contributions to the HSA grow 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.

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 your tax return and not claimed as a tax dependent on someone else's return.

You must be an eligible individual to qualify for an HSA. Employees may <u>not</u> 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 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).
- 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 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 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.

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.

HSA Contributions for Eligible Active Employees	
Active Employees	**Contribution**
Participant Only	***$600**

*HSA contribution provided to HSA eligible active employees enrolled in the CDHP on **July 1, 2022**. New hires effective **August 1, 2022,** and later receive a pro-rated contribution based on their CDHP coverage effective date. For **Plan Year 2023**, 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.

Calendar Year 2022 HSA Contribution Limits	
Individual	**Family** (two or more HSA eligible family members)
$3,650	**$7,300**
Total contributions (combined employee/employer) cannot exceed the **2022 calendar year limit**. 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. For example, if one employee is covering an HSA eligible dependent and the other employee is covered as self-only, the maximum for the entire family is **$7,300**. Employees aged 55 years and older at the end of the tax year may contribute an additional $1,000 to the HSA.	
Calendar Year 2023 HSA Contribution Limits	
Individual	**Family** (two or more HSA eligible family members)
$3,850	**$7,750**
Total contributions (combined employee/employer) cannot exceed the **2023 calendar year limit**. 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. For example, if one employee is covering an HSA eligible dependent and the other employee is covered as self-only, the maximum for the entire family is **$7,750**. 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

PEBP and its vendor require direct deposit for HRA reimbursements.

Active Employees and Retirees

This section provides summary information only. For more detailed information regarding this important benefit, see Internal Revenue Service (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, it 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.

The CDHP's HRA may only be used to pay or reimburse qualified Out-of-Pocket health care expenses incurred by:

- the participant; or
- the participant's spouse; or
- participant's dependent(s) who could be claimed on the participant's annual tax return; and
- enrolled in the CDHP (or other non-HRA coverage).

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 older children who cannot be claimed on the participant's tax return, regardless of whether PEBP provides coverage for the dependent.

The entire annual PEBP base contribution for **Plan Year 2023** will be available for use at the beginning of the Plan Year on or about **July 1, 2022** (subject to certain limitations). Participants who initially become eligible for PEBP coverage after **July 1, 2022**, 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 HRA. If the annual funds in the CDHP HRA are exhausted, neither PEBP nor the participant will contribute any additional funds.

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.

CDHP HRA funds are not portable; participants cannot use CDHP HRA funds if they are no longer covered by the CDHP HRA. If a participant terminates their CDHP coverage, the remaining balance in the CDHP HRA account will revert to PEBP. Participants enrolled in the CDHP HRA who change plans during the Open Enrollment period to the CDHP with an HSA, Low Deductible PPO Plan, Premier Plan, Health Plan of Nevada, and retirees who transition coverage to the Via Benefits Medicare exchange will forfeit any remaining funds in their CDHP HRA account.

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 the CDHP plan; or
- Continue CDHP coverage under COBRA.
    - If a participant elects COBRA coverage, the CDHP 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 CDHP.

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, all claim requests must be submitted to the third-party claims 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.

When your CDHP coverage ends, and you are an HRA participant you will have one year (12 months) from the date your coverage ends to file a claim for reimbursement from your HRA for eligible claims incurred during your coverage period. 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/retirees enrolled in the CDHP on **July 1, 2022**. For **Plan Year 2023**, dependents are not eligible for PEBP HRA contributions. New hires

effective **August 1, 2022,** 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.

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

Utilization Management

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. However, if you do not follow these procedures, Plan benefits are reduced, and you will be responsible for paying more out of pocket.

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 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 *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.

Regardless of whether 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, does not mean the recommended services or supplies will be considered medically necessary for determining coverage under the Plan.

Benefits payable by the Plan may be affected by the determination of the UM company. Regardless of the UM company's determination, all treatment decisions are between you and your physician or other provider. You should follow whatever course of treatment you and your physician, or other provider, believe to be the most appropriate, even if:

- The UM company does not authorize a proposed surgery or other proposed medical treatment as medically necessary; or
- The Plan will not pay regular benefits for a hospitalization or confinement in a skilled nursing or sub-acute facility because the UM company does not authorize a proposed confinement.

PEBP, the third-party claim administrator, 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 heath care professionals.

Delivery of Services

You are entitled to receive medically necessary medical care and services as specified in this Plan's *Schedule of Medical Benefits*. These include medical, surgical, diagnostic, therapeutic, and preventive services. 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. 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 precertification according to the utilization management and quality assurance protocols, if applicable.

Concurrent Review

Concurrent Review (continued stay) is the ongoing assessment of the 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 inpatient facility, the UM company monitors your stay by contacting your physician or other providers to assure that continuation of medical services in the facility are 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, and or advising your physician or other providers of various options and alternatives for your medical care available under this Plan.

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, all 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 UM determination* section).

Retrospective Review

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; and case management: The process whereby the patient, the patient's family, physician, or other providers work together with the Plan Administrator or its designee under the guidance of the UM company to coordinate a quality, timely and cost-effective treatment plan.

Case Management

Case management is a voluntary process administered by the UM company. Its medical professionals work with the patient, the patient's family, caregivers, providers, the third-party claims administrator, and the Plan Administrator or its designee 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, or when assistance is needed to guide the patient through a maze of potential providers.

The case manager will work directly with your 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 physician or other providers and may contact you or your family to assist in making plans for continued health care services or obtaining information to facilitate those services.

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 www.pebp.state.nv.us.

Precertification (Prior Authorization) Process

Precertification 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, 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 service may not be covered, 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.

Precertification 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 lowest cost.

A precertification is required for referrals to physicians and providers for certain services. All 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.

Failure to obtain precertification may result in your benefits being reduced or denied (see the *Failure to Follow Required Utilization Management Procedures* in this section).

Services Requiring Precertification (Prior Authorization)

All Inpatient Admissions

- Acute; observation; and same day surgeries
- Long-Term Acute Care
- Rehabilitation
- Mental Health / Substance Use Disorder
- Transplant including all pre-transplant related expenses
- Skilled Nursing facility and sub-acute facility
- Residential Treatment Facility, including outpatient partial hospitalization programs, and partial residential treatment programs for mental health/substance use disorder/behavioral health services
- Hospice (inpatient/outpatient) exceeding 185 days
- Obstetric – (precertification only required if days exceed 48 hours for vaginal delivery or 96 hours for a C-section)

Outpatient and Physician - Surgery

- Back Surgeries and hardware related to surgery
- Total Hip and Knee Surgeries
- All remaining Hip and Knee Surgeries
- Biopsies (excluding skin, colonoscopy and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Vascular Access Devices for the Infusion of Chemotherapy (e.g., PICC and Central Lines)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Creation and Revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for Dialysis
- 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 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)

Outpatient and Physician – Diagnostic Services

- CT for non-orthopedic
- MRI for non-orthopedic
- PET Scan
- Capsule endoscopy
- Genetic Testing (including BRCA)
- Sleep Study

Outpatient and Physician – Continuing Care Services

- Dialysis
- Chemotherapy (including oral)
- 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
- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables exceeding $2,000, and infusions excluding services reviewed by the PBM
- Mental Health and Substance Abuse Intensive Outpatient Program
- Vein Therapy
- Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a combined visit limit of 90 visits per Plan Year

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 that a prudent person would believe 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 must be notified of an emergency hospital admission within one business day so the UM company can conduct a *concurrent review*. Your physician or the hospital should call the UM company to initiate the concurrent review. 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 UM, such as concurrent review.

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. You or your physician must call the UM company at the telephone number shown in the ***Participant Contact Guide*** to request precertification. 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, your physician, the hospital or other provider, and the third-party claims administrator 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 your 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 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 UM Determination* section).

Second Opinion

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

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

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).

Hospital Admission

You are responsible for notifying the UM company is notified at least 5 (five) business days before an inpatient admission to obtain pre-certification.

Your physician or other provider may notify the UM company, 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 for hospital admission as not covered or they determine that the services do not meet the UM company's medical necessity criteria, the Plan's third-party administrator will only pay benefits for inpatient that has been pre-certified.

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 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 your Out-of-Pocket Maximum, if applicable.

Emergency and Urgent Hospital Admission

This includes all complications of pregnancy

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 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 your Out-of-Pocket Maximum.

Confinement in an Out-of-Network Hospital Following an Emergency Admission

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 elect 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.

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.

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

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

However, if you choose to use a non-exclusive provider, the Plan will pay benefits in accordance with its cost threshold or Maximum Allowable Charge. You 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 your Deductible (if applicable) or Out-of-Pocket Maximum.

Inpatient or Outpatient Surgery

You 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.

Your physician or other provider may notify the UM company, but it is your 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 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 choose to receive your infusion at a non-exclusive hospital or infusion center, you will be responsible for any amount that exceeds this Plan's established cost threshold. Amounts exceeding this Plan's established cost threshold will not apply to your annual Deductible or Out-of-Pocket Maximum.

Air/Flight Schedule Inter-Facility Transfer

All inter-facility transport services require precertification. 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 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 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 the transport is deemed medically necessary. The following conditions apply:

Article 1 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

Article 2 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 Air Ambulance Services for details on plan benefits, coverage, and the Plan's Maximum Allowable Charge.

Gender-Related Surgery

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

- Notification to the participant that the precertification process begins with the initial contact to the UM company.
- Documenting that the participant meets the criteria specified in the Treatment of Gender Dysphoria section below; and
- Advising participants of providers who specialize in this type of treatment to include genital surgery and surgery to treat gender dysphoria.

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 with 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 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 or attempt to notify 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.

Coronavirus (COVID-19) Benefits

Benefit Description

COVID-19 Plan Benefits
Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (see *Key Terms and Definitions*) Benefits apply during the Coronavirus Pandemic unless otherwise mandated by federal or state law, or as stated below in the Explanations and Limitations.

Explanations and Limitations
Coronavirus (COVID-19) Pandemic Benefits

The following benefits will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network during the national public health emergency period.

- **COVID-19 Diagnostic Testing:** virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person may have been infected with the virus, and according to the FDA, antibody tests should not be used to diagnose current infection.
    - Medically appropriate, FDA-authorized, COVID-19 testing when ordered by a physician or health care professional for purposes of diagnosis or treatment.
    - Diagnostic testing is different than COVID-19 screening/surveillance testing.
- **COVID-19 Related Diagnostic Testing Visit:** COVID-19 testing related visits such as urgent care, emergency room, physician's office, telemedicine, and telehealth visits.
- **COVID-19 Preventive Health Services:** In accordance with the following, the Plan covers qualifying coronavirus disease 2019 (COVID-19) preventive services at 100% of the Plan's Maximum Allowable Charge for In-Network and Out-of-Network providers without any cost sharing (Copayment, Deductible, or Coinsurance):
    - An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; or (B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- **Laboratory Services Related to Covid-19**
    - COVID-19 Diagnostic Testing: virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person may have been infected with the virus, and according to the FDA, antibody tests should not be used to diagnose current infection. Covid-19 Diagnostic Testing will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network in accordance with the CARES Act or until the last date of the national public health emergency period.
    - COVID-19 Screening/Surveillance Testing**:** COVID testing conducted for purposes other than diagnostic (including, but not limited to, employer mandated, travel, social/entertainment purposes) is not a covered benefit.

All benefits are subject to cost-sharing unless otherwise stated.

Schedule of Medical Benefits

The *Schedule of Medical Benefits* provides a description of benefits, including certain limitations under this Plan. All covered services must be medically necessary and are subject to exclusions and limitations as described herein. Precertification is required for many services, plan benefit limitations apply to certain benefit categories, and out-of-network 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 Medical 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 of Medical 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 precertification requirements), *Exclusions*, *Key Terms and Definitions* and other sections that may apply to a specific benefit.

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

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
Explanations and Limitations Acupuncture and Acupressure • Covered if performed by a licensed MD, DO, Acupuncturist (as defined in the *Key Terms and Definitions* section), or Oriental Medicine Doctor. • Supporting documentation establishing medical necessity will be required after 15 visits in a Plan Year, maximum 100 visits per lifetime.		

Benefit Description	In-Network	Out-of-Network
• Maintenance services are not a covered benefit.		
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
Explanations and Limitations Allergy Services • Allergy services are covered only when ordered by a physician. • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast; Desensitization and hypo-sensitization (allergy shots given at periodic intervals); Allergy antigen solution.		

Benefit Description	In-Network	Out-of-Network
Ambulance		
Ground Ambulance	Plan pays 80% after Plan Year Deductible	Play pays 80% of Maximum Allowable Charge after Plan Year Deductible
Air Ambulance	Plan pays the lessor of 80% of the PPO allowable or 80% of the Maximum Allowable Charge after Plan Year Deductible*	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible*
Explanations and Limitations Ground and Air Ambulance Services 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, subject to the Plan's Maximum Allowable Charge. Out-of-Network providers do not have a contract with this Plan's provider network and may balance bill the member for any amounts exceeding the Plan's Maximum Allowable Charge as defined in the section. Transportation by a professional ground ambulance to a local hospital or transfer to the nearest facility having the capability to treat the condition. Air Ambulance (fixed wing/rotary) Inter-Facility Transfer • Inter-facility patient air transport, for participants if there is a life-threatening situation or it is deemed to be medically necessary.		

Benefit Description	In-Network	Out-of-Network
Ambulance		
Ground Ambulance	Plan pays 80% after Plan Year Deductible	Play pays 80% of Maximum Allowable Charge after Plan Year Deductible
Air Ambulance	Plan pays the lessor of 80% of the PPO allowable or 80% of the Maximum Allowable Charge after Plan Year Deductible*	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible*

Explanations and Limitations

Ground and Air Ambulance Services

- 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.
  - 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 form or related to inter-facility patient transport via any form of flight.
  - Non-compliance penalties imposed for failure to obtain precertification will not apply to the Plan Year Deductible or Out-of-Pocket Maximum.
  - As part of the precertification 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.

Air Ambulance (fixed wing/rotary) Emergency

- Includes coverage for 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.
- Emergency air ambulance services must meet the following criteria:
  - 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 transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.
- The Plan Administrator retains the discretionary 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, or the charges exceed the Maximum Allowable Charge for air ambulance services, which for this section only shall mean 250 percent of the applicable Medicare rate for Out-of-Network providers, or the lessor of the PPO contracted rate or 250 percent of the applicable Medicare rate for In-Network providers. All air ambulance services will be evaluated for reasonableness.

Benefit Description	In-Network	Out-of-Network
Ambulance		
Ground Ambulance	Plan pays 80% after Plan Year Deductible	Play pays 80% of Maximum Allowable Charge after Plan Year Deductible
Air Ambulance	Plan pays the lessor of 80% of the PPO allowable or 80% of the Maximum Allowable Charge after Plan Year Deductible*	Plan pays 80% of the Maximum Allowable Charge after Plan Year Deductible*
Explanations and Limitations Ground and Air Ambulance Services All Ambulance Services: Any amounts exceeding the Plan's maximum allowable charge shall be the participant's responsibility and will not be applied to the annual Out-of-Pocket Maximum. See the *Utilization Management* section for air ambulance precertification requirements.		

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
Explanations and Limitations Autism Spectrum Disorders Services The Plan provides benefits for autism spectrum disorders in accordance with NRS 695G.1645 [effective January 1, 2019], including coverage of screening for and diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders for covered dependents to the age of 18 years or, if enrolled in high school, until the dependent reaches the age of 22 years. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription drug care, psychiatric care, psychological care, behavioral therapy, or therapeutic care that is: • Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and • Provided for a person diagnosed with an autism spectrum disorder by a licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist, or behavior analyst. See the *Utilization Management* section for precertification requirements for outpatient habilitative or rehabilitative therapy (physical, speech, occupational therapies) exceeding a combined 90 visits per Plan		

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
Explanations and Limitations Autism Spectrum Disorders Services		
Year. Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.		

Benefit Description	In-Network	Out-of-Network
Bariatric/Weight Loss Surgery	Plan pays 80% after Plan Year Deductible	Not Covered
Explanation and Limitations Bariatric/Weight Loss Surgery		

Bariatric weight loss surgery benefits, pre-and post-surgery, are available only when performed at an In-Network Bariatric Surgery Center of Excellence facility, by an In-Network surgeon and all ancillary providers. 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 all bariatric surgery services providers are In-Network and facilities chosen to provide services are In-Network. Participants can verify the network status of any provider, including a facility, by calling the third-party claims administrator. For more information regarding Bariatric Surgery Centers of Excellence, see the *Key Terms and Definitions*.

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. 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.

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 precertification requirements. For the Plan to consider your bariatric surgery at the In-Network benefit level; you will have to begin the precertification process again with the appropriate In-Network providers.

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:

Benefit Description	In-Network	Out-of-Network
Bariatric/Weight Loss Surgery	Plan pays 80% after Plan Year Deductible	Not Covered

Explanation and Limitations

Bariatric/Weight Loss Surgery

- Patient has a BMI exceeding 40kg/m^2; or
- Patient's BMI is greater than 35 kg/m^2 and two or more clinically serious conditions exist (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension (high blood pressure), cardiomyopathy, musculoskeletal dysfunction, joint replacement, GERD, hypertriglyceridemia or hypercholesteremia, back pain, urinary incontinence, renal failure, arthritis).

Surgical intervention indicated because patient has met all the following:

- Patient is well-informed and motivated and has failed previous non-surgical weight loss attempts.
- No thyroid disorder (excluding thyroid problems currently being successfully treated) found by your physician [e.g., an endocrine (hormone) disorder].
- Must have obtained full growth and be over the age of 18 years.
- Documentation of a pre-operative psychological evaluation by a licensed clinical psychologist or psychiatrist within the last 90 days to determine if the patient has the emotional stability to follow through with the medical regimen that must accompany the surgery.
- Documentation of a physician-supervised nutrition and exercise program, including:
  - Compliance for six consecutive months or longer within the 12-month period prior to the scheduled bariatric surgery, including dietician consultation, low calorie diet, increased physical activity, and behavioral modification.
  - The physician-supervised nutrition and exercise program must meet all the following criteria:
    - Bariatric surgeon/physician-supervised and progress documented by the medical record.
    - Administered as part of the surgical preparative regimen.
    - Nutrition consultation, including nutrition program such as low-calorie diet or MediFast, OptiFast, documented in the medical records.
    - Must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists, with a substantial face-to-face component (must not be entirely remote).
    - Must agree to attend monthly support meetings for one-year post-surgery (provided by an In-Network provider). If support meetings are not available within 50 miles of the participant's residence, an allowance may be granted for online support meetings.

Bariatric/weight loss surgery benefits are not available if any *one or more* of the following conditions are present:

- Untreated major depression or psychosis.
- Binge-eating disorders.
- Current drug or alcohol abuse.
- Severe cardiac disease with prohibitive anesthetic risks.
- Severe coagulopathy.

Benefit Description	In-Network	Out-of-Network
Bariatric/Weight Loss Surgery	Plan pays 80% after Plan Year Deductible	Not Covered

Explanation and Limitations
Bariatric/Weight Loss Surgery

- Inability to comply with nutritional requirements including life-long vitamin replacement.

Pre-surgery Precertification Requirements:
The participant and/or bariatric weight loss surgeon must contact the utilization management company to begin the process for bariatric surgery. The initial contact with the UM company will include:

- Notifying the participant that the precertification process begins with the initial contact to utilization management company.
- Notifying the participant that precertification requests presented to the utilization management company before the surgery intervention requirements above have been completed will be denied. A precertification request may be reconsidered upon completion of the surgery intervention requirements.
- Notifying the participant of the requirement to access and participate in a weight management and nutrition program.
- Documenting participant completion of the associated assessments required to be considered for the procedure.
- Educating the participant on how to access *Preventive Care/Wellness Services* and how to proceed with meeting the clinical indications listed.
- Advising participants of Centers of Excellence in bariatric surgery provider in their geographic area.

Travel Expenses:
This Plan provides reimbursement of certain costs associated with travel and hotel 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 hotel accommodations for bariatric/weight loss surgery not performed at a Center of Excellence are not covered.

Benefit Description	In-Network	Out-of-Network
Behavioral Health Services 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

Precertification is required for all inpatient admissions, including residential treatment facilities, outpatient partial hospitalization programs, and partial residential treatment programs.

Services and supplies for treatment of alcoholism, chemical dependency or drug addiction are covered. Treatment must have a physician's order, include a treatment, and discharge plan. All 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.
Behavioral health services payable by this Plan include:

- Outpatient visits
- Acute inpatient admission
- Partial day treatment
- Partial hospitalization
- Intensive outpatient program
- Day treatment
- Psychological testing
- Detoxification

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.

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, inpatient treatment.

The provider must be licensed or approved by the state in which the services are provided. All 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.

Outpatient prescription drugs for behavioral health payable under the prescription drug benefits.

Benefit Description	In-Network	Out-of-Network
Behavioral Health Services 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

For information regarding precertification requirements, benefits, and exclusions, refer to the *Utilization Management*, *Key Terms and Definitions*, and *Exclusions* sections.

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

Explanations and Limitations
Blood Transfusions

- Blood transfusions, blood products and equipment for its administration.
- Services are covered only when ordered by a physician.
- Expenses related to autologous blood donation (patient's own blood) are covered.

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

Explanations and Limitations
Chemotherapy

- Chemotherapy drugs and supplies administered under the direction of a physician in a hospital, health care facility, physician's office or at home. Covered when ordered by a physician; chemotherapy must be pre-certified by the UM company.
- Orally administered chemotherapy drugs: Participant will pay 100% of the cost for preferred generic and preferred formulary brand orally administered chemotherapy drugs purchased from In-Network retail, mail order, and the Specialty Drug pharmacy until the Deductible is met. After the Deductible is met, the participant's maximum cost per prescription will not exceed $100. For more information, see *Schedule of Prescription Drug Benefits* and *Key Terms and Definitions* section.
- Patients undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year (excluding sales tax).

Chiropractic Services Office visit and spinal manipulation services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Chiropractic Services

- Services are covered if performed by a licensed MD, DO, or Chiropractor.
- Must have objective medical findings establishing a neuro-musculoskeletal disorder.
- Must have a clearly defined treatment plan including treatment and discharge goals.
- Limited to a maximum of 20 visits per Plan Year.
- Maintenance services are not a covered benefit.

X-rays performed in conjunction with chiropractic services are payable under the Radiology Services section of this *Schedule of Medical Benefits*.

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

Explanations and Limitations
Clinical Trials

- Nevada law allows some clinical trials taking place in Nevada to be covered if certain criteria are met. For example, Cancer or Chronic Fatigue syndrome clinical trials. See "Experimental and or Investigational" in the *Key Terms and Definitions* section.
- Precertification must be obtained from the UM company.

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
***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)

Explanations and Limitations
Corrective Appliances and Hearing Aids

- 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. Repair,

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
***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)

Explanations and Limitations

Corrective Appliances and Hearing Aids

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.

- 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).
- 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. Soft lenses or sclera shells intended as corneal bandages for patients without the lens of the eye (aphakic).

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.

***Hearing aids:** Air conduction hearing aids are considered medically necessary when one or more of the following hearing loss criteria are met in either or both ears:

- Hearing thresholds 40 dB HL or greater at two or more of these frequencies: 500, 1000, 2000, 3000, 4000 Hz; or
- Hearing thresholds 26 dB HL or greater at three of these frequencies; or
- For high frequency hearing loss, defined as loss occurring only above 2000 Hz: a. Hearing thresholds of 26 dB HL or greater at three or more of these frequencies: 2000, 3000, 4000, 6000 or 8000 Hz
- Speech recognition less than 80 percent in either or both ears regardless of hearing threshold level.

Participants who meet the above hearing loss criteria: Each air conduction hearing aid is subject to Deductible, then the Plan pays 80% up to a maximum benefit of $1,500 per device, per device, per each ear, every three years.

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.

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
***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)
Explanations and Limitations Corrective Appliances and 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.		

Benefit Description	In-Network		Out-of-Network
Diabetes Care Management Disease Program (DCM) (Enhanced Benefits) *			
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
Laboratory Test (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
	Express Advantage Network Retail 30-Day Supply	**Smart90 Retail or ESI Home Delivery** 90-Day Supply	
Preferred Generic	$5 Copay	$15 Copay	Not covered
Preferred Brand	$25 Copay	$75 Copay	Not covered
Non-Preferred Brand	Not covered		Not covered
Diabetic Supplies (test strips, insulin syringes, alcohol pads, and lancets)	**ESI Home Delivery Pharmacy**: 90-Day Supply $50 Copay per supply item or the lessor of actual cost		Not covered
Blood Glucose Monitor	**ESI Home Delivery**: $0 Copay (limited to one per Plan Year)		Not covered

Explanations and Limitations

Diabetes Care Management Disease program (enhanced benefits)

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 actively engaged in the program. To enroll:

- Obtain the DCM form by logging into the E-PEBP Portal at www.pebp.state.nv.us, or contact the third-party claims administrator to request the DCM enrollment form. Complete the required information and have your physician sign the form. Send the form to the third-party claims' administrator for processing.
- 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.

Benefit Description	In-Network	Out-of-Network
Diabetes Care Management Disease Program (DCM) (Enhanced Benefits) *		

- Annually, to continue receiving the DCM enhanced benefits for the next plan year, a new DCM form must be completed, signed by both you and your physician, and submitted to the third-party claims' administrator for processing.

Enrolled DCM participants must comply with all the following requirements to receive the enhanced benefits:

- Complete two office visits each Plan Year for a primary diagnosis of diabetes with your primary care physician or endocrinologist.
- Comply with the diabetes medications as prescribed by your physician.
- Complete the appropriate laboratory testing as ordered by your physician.
- Must remain compliant with your physician's prescribed treatment plan in the Diabetes Care Management program.

Enhanced In-Network benefits in the DCM Program include:

- 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).
- Two routine laboratory blood services such as the hemoglobin (A1c) test are paid at the 100% benefit level per Plan Year (additional lab services are subject to deductible and coinsurance).
- 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.
- One glucose monitor, per Plan Year at $0 copayment available through the Pharmacy Benefit Manager.
- 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.
- Copayments for Tier 1 (Generic) and Tier 2 (Preferred Brand) drugs apply to the Plan Year Deductible and Out-of-Pocket Maximum.
- Copayments made while enrolled in the DCM program apply to the Plan Year Deductible and Out of Pocket Maximum.

 Laboratory services must be performed at an independent (non-hospital-based laboratory) to be covered by this Plan. Refer to the Laboratories services in the Schedule of Medical Benefits.

Other limitations:

- Diabetes Medications: Express Advantage Network (EAN) Pharmacies, Smart90 Retail, and Express Scripts Home Delivery Program requirements apply. Refer to the *Schedule of Prescription Drug Benefits* for coverage limitations, cost implications and details regarding these programs.
- 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.

Benefit Description	In-Network	Out-of-Network
Diabetes Care Management Disease Program (DCM) (Enhanced Benefits) *		
• Specialty medications are not eligible for enhanced benefits under this program and are subject to the standard CDHP benefits. • This Plan does not coordinate prescription drug benefits. • Medications purchased at Out-of-Network pharmacies are not covered under this Plan.		
Diabetes Education Services	This Plan pays 80% after Plan Year Deductible	Not Covered
Explanations and Limitations Diabetes Education Services • 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 requires modification of self-management techniques. • Some diabetic supplies are payable under the *Prescription Drug* section of this document. Please contact the prescription drug Plan Administrator for more information. • This Plan pays enhanced benefits for participants enrolled in and actively engaged in the Diabetes Care Management (DCM). For information regarding the DCM program and the enhanced benefits, refer to the Disease Management section and to the *Schedule of Medical Benefits* for the Diabetes Care Management Program.		

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

Explanations and Limitations
Dialysis

- Hemodialysis or peritoneal dialysis and supplies.
- Covered when ordered by a physician and administered in a hospital, health care facility, and physician's office or at home. Outpatient, inpatient or home dialysis must be prior authorized by PEBP's utilization management company.
- See the *Utilization Management* information.

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

Explanations and Limitations
Durable Medical Equipment (DME)

- DME requires precertification by the UM company when the cost is expected to exceed $1,000.
- Rental of DME to cover Medicare guidelines concerning rental to purchase criteria.
- 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.
- DME, including 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.
- Certain blood glucose monitors are covered under this Plan. In-Network, the Plan pays 80% after the Plan Year Deductible.
- Participants enrolled in and actively engaged 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 *Diabetes Care Management Disease Program (DCM) (Enhanced Benefits) ** pumps are eligible for purchase and must be prior authorized by the UM company.

- Rental to purchase following Medicare guidelines for certain lifelong DME. Examples of lifelong durable medical equipment include CPAP and BiPAP machines, and electric wheelchairs for paralysis. 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.

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*.

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

- Hospital Emergency Room (ER) for a medical emergency; use of an Urgent Care facility; Ancillary charges (such as lab or x-ray) performed during the ER or Urgent Care Visit. See also the Ambulance section of this *Schedule of Medical Benefits*.
- In-Network and Out-of-Network expenses for Emergency room services are covered at the In-Network Benefit level, subject to Usual and Customary fees and the Plan's Maximum Allowable Charge, when those services are for a Medical Emergency, as that term is defined below:
    - Medical emergency means the sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child, impairment of a bodily function or dysfunction of any bodily organ or part.
- If you need emergency medical care and cannot arrange for care from an In-Network provider, the Plan will pay your claims at the In-Network level, subject to the Plan's Maximum Allowable Charge regardless of the provider's network status.
- If you receive services at an In-Network facility, but the physician is Out-of-Network, the physician reimbursement will be subject to the Plan's Maximum Allowable Charge.
- You are not required to obtain a precertification before receiving emergency medical care; however, you must notify the UM company of an inpatient hospital admission within one (1) business day so the UM company can conduct a concurrent review. Refer to the *Failure to Follow UM Procedures* in the *Utilization Management* section for penalties associated with emergency inpatient hospital admissions.

Benefit Description	In-Network	Out-of-Network
Family Planning, Fertility, Sexual Dysfunction Services and Male Contraception	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Family Planning, Fertility, Sexual Dysfunction Services and Male Contraception

- Only diagnostic procedures for fertility and infertility are payable for the employee and spouse/domestic partner.
- No coverage for the treatment of fertility or infertility. See the *Exclusions* section *for* drugs, medicines, and nutrition; fertility and infertility; maternity services; and sexual dysfunction services.
- Diagnostic procedures for fertility and infertility are subject to the Plan Year Deductible.
- Medical or surgical treatment for sexual dysfunction: There are some limits on sexual dysfunction drugs such as Viagra or Muse and are subject to the Plan Year Deductible. For more information, contact the pharmacy benefit manager.
- Procedures related to sexual dysfunction because of a medical diagnosis or procedure to treat a medical diagnosis may be covered. See the *Exclusions* section of this document for more information.
- 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.
- Male surgical sterilization is subject to the Plan Year Deductible and Coinsurance.
- Male contraception such as condoms are not covered under this Plan.

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

Explanations and Limitations

Treatment of Gender Dysphoria

This Plan provides certain benefits to individuals seeking medical services for the treatment of gender dysphoria.

- Benefit coverage includes related mental health, hormone therapy, prescription drug therapy, and surgeries to treat gender dysphoria.
- Benefits are conditioned upon adherence to the requirements listed in this Plan document such as obtaining precertification for applicable services. Other mandatory requirements include a mental health evaluation and mental health treatment to confirm a diagnosis of gender dysphoria.
- Precertification is required for all services related to gender dysphoria (excluding mental health services). The precertification requirement applies to medical treatment related to hormone therapy and prescription drug therapy by the pharmacy benefit manager. Precertification for genital reassignment surgery must be completed by the UM company to determine medical necessity. Refer to the *Utilization Management* section for more information.
- Benefits for genital surgery is limited to one genital surgery per lifetime while covered under any PEBP-sponsored plan. The Plan does not cover gender surgery reversals.
- When reviewing services for appropriateness of care and medical necessity, the UM company may refer to guidelines published by organizations such as the World Professional Associations for Transgender Health (WPATH), Aetna, Cigna, United HealthCare, Medicare, and Blue Cross/Blue Shield.
- Pre-certification is required
  - The UM company will explain the required criteria that must be met and documented in the medical record; and
  - May assist with identifying providers who specialize in surgeries to treat gender dysphoria.
  - A nurse case manager will be assigned to the participant and will assist with the complex medical services to ensure continuity of care.

Mental Health Services

If a member is diagnosed with gender dysphoria and prior to submitting a recommendation for hormone and surgical treatment, the mental health professional's evaluation should document the following for the gender reassignment patient:

- The member's general identifying characteristics.
- The initial and evolving gender, sexual, and psychiatric diagnosis of the member.
- Details regarding the type and duration of psychotherapy or evaluation the member underwent.
- The mental health professional's rationale for hormone therapy and surgery.
- The degree to which the member has followed the standards of care and likelihood of continued compliance.
- Surgeries to treat gender dysphoria must be pre-authorized.

Mental health coverages do NOT require precertification.

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

Explanations and Limitations

Treatment of Gender Dysphoria

Benefit coverage includes transgender and associated co-morbid psychiatric diagnoses provided as any other outpatient mental health service under the Plan.

To determine which procedure may or may not be covered, the member should consult with their nurse case manager who works for this Plan's UM company.

Hormone Therapy Coverage

Hormone therapy coverage requires precertification. Benefits for oral and self-injectable hormone replacement treatment therapies must be obtained through an In-Network pharmacy or mail order pharmacy.

Hormone therapy for individuals preparing for surgeries to treat gender dysphoria is medically necessary when all the following criteria are met:

- Persistent, well-documented Gender Dysphoria.
- Capacity to make fully informed decision and to consent for treatment.
- Must be at least 18 years old (age of majority).
- Demonstrate knowledge of what hormones can and cannot do as well as their social benefits and risks.
- Document real-life experience of at least three months prior to the administration of hormones; or
- Undergo a period of psychotherapy of a duration specified by a mental health professional whose specialty is working with individuals with gender dysphoria (usually a minimum of three months).

The Plan limits a member to one genital surgery in an individual's lifetime while covered under any current or previous PEBP Plan.

Reversals of surgery to treat gender dysphoria will not be covered.

Benefit Description	In-Network	Out-of-Network
Genetic Testing and Counseling	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

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
  - BRCA1 and BRCA 2 testing may be covered under the Preventive/Wellness benefit when indicated after genetic counseling in accordance with the USPSTF A & B recommendation.

This list is not all inclusive for what genetic tests may be covered. Contact the UM company for coverage details and precertification requirements for covered genetic testing.

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

Benefit Description	In-Network	Out-of-Network
Hearing Aids		

Explanations and Limitations

Hearing Aids

See *Corrective Appliances*, above.

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 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.
- 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.
- Enteral formulas for use at home (including parenteral nutrition and nutritional supplements) are payable as mandated by law. (See Special Foots in the *Key Terms and Definitions* section.
- 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 *Exclusions* section related to home health care and custodial care, including personal care and childcare.

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 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 6 months or less as certified by patient's medical physician, and the member is not receiving any curative treatment.

Hospice benefits (inpatient and outpatient):

Precertification required for both inpatient and outpatient hospice services exceeding 185 days.

Outpatient bereavement counseling services provided by a licensed social worker or a licensed pastoral care counselor for the patient's immediate family (covered spouse and or dependent children) as 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.

See Hospice Care in the *Key Terms and Definitions* section for additional information.

Benefit Description	In-Network	Out-of-Network
Hospital Services (Inpatient)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Hospital Services (Inpatient)

Elective hospitalization is subject to precertification. All hospitalization is subject to concurrent review. See the *Utilization Management* section for more information.

- Room and board and facility fees in a semiprivate room with general nursing services; Specialty Care Units (e.g., intensive care unit, cardiac care unit); lab, x-ray, and diagnostic services; related medically necessary ancillary services (e.g., prescriptions, supplies).
- Newborn care and circumcision.
- Elective hospitalization is subject to precertification. All hospitalization is subject to concurrent review. See the *Utilization Management* section for more information.
- 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.
- Outpatient services with an observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement under this Plan.
- Under the following circumstances, the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services:

Benefit Description	In-Network	Out-of-Network
Hospital Services (Inpatient)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Hospital Services (Inpatient)
• Under the following circumstances, the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services.
  • Dental general anesthesia for a dependent child when services are rendered in a hospital or outpatient surgical facility, when dependent child is being referred because in the opinion of the dentist, the child:
  • Is under age 18 and has a physical, mental, or medically compromising condition; or
  • 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.
  • Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.
  • No payment is extended toward the dentist or the assistant dental provider under this Plan.
• No coverage for non-emergency hospital admission: No coverage for 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.
• 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.		

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		
Free-standing lab facility Preferred non-hospital-based lab facilities: Lab Corp or Quest	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Outpatient hospital-based lab facility and hospital-based lab draw station Lab services for pre-admission testing, urgent care, and emergency room only	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations		

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		

Laboratory Outpatient Services

- 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.

Free-standing, non-hospital -based laboratory facility: 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:

  - Medically necessary routine labs when ordered by a physician as part of comprehensive medical care.
  - Preventive laboratory services such as but not limited to basic metabolic panel, lipid, or general health panel. Refer to the *Preventive Care/Wellness Services* for information regarding benefits for screening tests and preventive lab testing.

- **Outpatient hospital-based lab facilities and hospital-based lab draw stations:** 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.
- If a free-standing, non-hospital-based outpatient laboratory facility not available within 50 miles of your residence, you may use a hospital-based laboratory facility or hospital-based draw station.
- See the *Key Terms and Definitions* section for the definitions of *Free-standing Laboratory Facility* and *Outpatient Hospital-Based* Laboratory and *Outpatient Hospital-Based Laboratory Draw Station.*

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

Explanations and Limitations

Maternity and Newborn Services

- This Plan covers hospital and birth (birthing) center charges and physician and midwife fees for medically necessary maternity services.
- Prenatal and delivery is covered for a female employee or spouse only. For covered dependent children, only prenatal coverage is provided for maternity, except for complications of pregnancy for the dependent child (see the definition of Complications of Pregnancy in the *Key Terms and Definitions* section of this document).
- Some preventive prenatal services such as obstetrical office visits, breastfeeding support, screening for gestational diabetes, blood type and Rh lab services, and ultrasounds for female participants,

female spouses, and female 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 consists of 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 Medical 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.
- 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 (NRS 689B.033). If employee-only coverage is maintained, individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.

Benefit Description	In-Network	Out-of-Network
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

Explanations and Limitations

Nondurable Supplies

Coverage is provided for up to a 31-day supply per month of:

- Sterile surgical supplies used immediately after surgery.
- Supplies needed to operate, or use covered durable medical equipment or corrective appliances.
- Supplies needed for use by skilled home health or home infusion personnel, but only during their required services.

To determine what nondurable medical supplies are covered, see the definition of Nondurable Supplies in the *Key Terms Definitions* section.

Please see the *Participant Contact Guide* for information regarding the preferred diabetic supplies mail

order program.

Diabetic supplies are also payable under the prescription drug benefit, see the section on *prescription drug benefits* in this document for more information.

Benefit Description	In-Network		Out-of-Network
Obesity and Overweight 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
Meal Replacement Therapy	Plan pays 50% of the cost, up to $50/month, not subject to and does not apply to Deductible		Not covered
Weight loss medications	Express Advantage Network Retail 30-Day Supply	Smart90 Retail or ESI Home Delivery 90-Day Supply	
Preferred Generic	*$5 Copay	$15 Copay	Not covered
Preferred Brand	Not covered		Not covered
Non-Preferred Brand	Not covered		Not covered

Explanations and Limitations

Obesity and Overweight Care Disease Management Program (Enhanced Benefits)

Express Advantage Network (EAN) Pharmacies: Copayments apply if you fill your prescription at a EAN retail pharmacy. If you fill your prescription at a non-EAN retail pharmacy, you will pay an additional $10 per prescription. If you currently use a non-EAN pharmacy and you want to avoid the $10 upcharge, call an EAN pharmacy to transfer your prescription. Certain weight loss medications may not be available in 90-day supply. Contact Express-Scripts for information about your prescribed medication.

Benefit Description	In-Network	Out-of-Network
Obesity and Overweight Care Disease Management Program (Enhanced Benefits)		

The Obesity and Overweight Care Management **(**OCM) Program is a disease management program that provides enhanced benefits to participants who have been diagnosed as obese or overweight by their physician, who meet the criteria in this section, and have enrolled in the OCM Program.

The OCM Program is a voluntary opt-in program that requires enrollment with the third-party claims administrator to determine if you meet the criteria for participation in the program. If the third-party claims administrator determines you to be eligible for the program, the effective date of enrollment and enhanced benefits is determined by the third-party claims administrator. For enrollment information, contact the third-party claims administrator listed in the *Participant Contact Guide*.

How to enroll in the OCM Program:

- Contact the third-party claims administrator for a list of In-Network weight loss providers. The list of In-Network weight loss providers and the *OCM Enrollment and Evaluation Form* may be obtained by logging into the E-PEBP Portal at *www.pebp.state.nv.us* and selecting UMR.
- Schedule an appointment with a provider from the list of participating In-Network weight loss providers.
- Attend your scheduled appointment and have your provider complete, sign and submit the *Enrollment and Evaluation Form* to the third-party claims administrator's address or fax number provided on the form.
- The third-party claims administrator will review the information submitted by your provider and if the information indicates that you meet the criteria for the weight loss program benefits, the third-party claims administrator will enroll you in the program and notify the Pharmacy Benefit Manager of your enrollment.
- If you do not meet the criteria for the weight loss program and enhanced benefits, the third-party claims administrator will notify of the denial of the OCM Program's enhanced benefits.

OCM Program participation criteria for adults 18 years and older and services must be provided by:

- An In-Network provider who specializes in weight loss services.
- An In-Network provider who is certified by the American Board of Bariatric Medicine (ABBM).
- An In-Network provider who is in training to become certified by the American Board of Bariatric Medicine (ABBM); or
- If no provider as described above is available within 50 miles of a participant's residence, any In-Network provider.

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:

- Coronary artery disease.
- Diabetes mellitus type 2.
- 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).
- Obesity-hypoventilation syndrome.

Benefit Description	In-Network	Out-of-Network
Obesity and Overweight Care Disease Management Program (Enhanced Benefits)		

- Obstructive sleep apnea.
- Cholesterol and fat levels measured (Dyslipidemia):
  - HDL cholesterol less than 35 mg/dL.
  - LDL cholesterol greater than or equal to 160 mg/dL; or
  - Serum triglyceride levels greater than or equal to 400 mg/dL.

For children ages two to 18 years:

- All the above criteria.
- Services must be provided by an In-Network provider who specializes in childhood obesity; and
- Child must present a BMI ≥ 85th percentile for age and gender.

Engagement in the OCM Program:
In addition to meeting the criteria above, you must remain actively engaged by complying with the treatment plan established by you and weight loss provider.

Monitoring Engagement in the OCM Program:
Your OCM provider must submit monthly reports to include your weight loss (weight, BMI, and waist circumference) and your compliance with the treatment plan. Submission of these reports will be a requirement for payment under the OCM Program's enhanced benefits. If your monthly weight loss reports are not received by the third-party claim's administrator, your benefits under this program will end, and your 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.

You and your weight loss provider will determine your final weight loss goal when you initially start participating in the OCM Program. Once you have met your 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. Ongoing maintenance care will be subject to the standard CDHP benefits.

Laboratory Services:
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.

Nutritional Counseling Services:
The frequency of nutritional counseling services will be determined by the claims administrator and based on your weight loss provider's recommendation and medical necessity.

Weight Loss Medications:

Benefit Description	In-Network	Out-of-Network
Obesity and Overweight Care Disease Management Program (Enhanced Benefits)		
• The Plan covers certain only short-term use obesity/weight loss generic medications as identified by the Plan's pharmacy benefits manager. 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. • Copayment for a 31-90-day supply is subject to three times the listed 30-day retail copayment. • This Plan does not coordinate prescription drug plan benefits. • Medications purchased at non-participating pharmacies are not covered under this Plan. Other limitations: • Weight loss medications: Express Advantage Network (EAN) Pharmacies, Smart90 Retail, and Express Scripts Home Delivery Program requirements apply. Refer to the *Schedule of Prescription Drug Benefits* for coverage limitations, cost implications and details regarding these programs.		

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

Explanations and Limitations
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 sound and natural 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 sound and natural teeth must be provided by a dentist or physician and is limited to restoration of sound and natural teeth to a functional level, as determined by the Plan Administrator or its designee (see the definition of "Sound and Natural Teeth" in the *Key Terms and Definitions* section).
- Coverage for dental services as the result of an injury to sound and natural teeth will be extended under the medical plan to a maximum of two years following the date of injury. 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 www.pebp.state.nv.us.
- 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*.
- Oral or craniofacial surgery is limited to surgical procedures to remove tumors, cysts, abscess

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

including dental abscess and cellulitis, or for acute injury.

- *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.

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

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

Explanations and Limitations
Outpatient Surgery Facility

- See the *UM* section for precertification requirements.
- Outpatient ambulatory surgical facility/surgical center.
- Physician fees payable under the physician services section of this *Schedule of Medical Benefits*.
- 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.
- Outpatient facility fees and anesthesia associated with medical necessary dental services for a dependent child when the child is being referred by the dentist, and the following criteria are met:
  - Is under age 18 and has a physical, mental, or medically compromising condition; or
  - 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.
  - 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 *www.pebp.state.nv.us*.

Benefit Description	In-Network	Out-of-Network
Physician and Other Health Care Practitioner Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Physician and Other Health Care Practitioner Services

This benefit includes physician and health care practitioner's fees for services provided in a hospital, emergency room, urgent care center, a health care practitioner's office or at home. Physician and health care practitioners include, but are not limited to the following:

- Surgeon
- Assistant surgeon (if medically necessary)
- Anesthesia by physicians and Certified Registered Nurse Anesthetists (CRNA)
- Pathologist; Radiologist
- Physician Assistant; Nurse Practitioner; Nurse Midwife
- Homeopathic Physicians, Christian Science Practitioners, Oriental Medicine Doctor (OMD) only for Acupuncture
- Podiatrist
- Psychologist, Psychiatrist, Licensed Clinical Social Worker

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 *Key Terms and Definitions* section.

Assistant surgeon fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. A Certified Surgical Assistant (see *Key Terms and Definitions* section) is payable as an assistant surgeon.

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.

No coverage is provided for prophylactic surgery or treatment as defined in the *Key Terms and Definitions* section and as explained in the *Exclusions* section, unless otherwise specified in this document.

No coverage for homeopathic treatments, supplies, remedies, or substances.

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
Colorectal Cancer Screening (Colonoscopy/bowel prep, or Cologuard)	Plan pays 100%, not subject to Deductible	Not Covered
Women's Preventive Services *Well-woman visits; screening for gestational diabetes; human*	Plan pays 100%, not subject to Deductible	Not Covered

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
papillomavirus testing; counseling/screening: human immune deficiency virus, interpersonal and domestic violence		
BRCA Risk Assessment and Genetic Counseling/Testing	Plan pays 100%; not subject to Deductible	Not Covered
BRCA Risk Assessment and Genetic Counseling/Testing in accordance with the USPSTF A & B guidelines; BRCA testing requires Precertification.		
Breastfeeding Support/Equipment*	Plan pays 100%, Not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible
*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. *Contact the third-party claims administrator for 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.*		
Contraceptives / Family Planning (females only)	Plan pays 100%, not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible; pharmacy not covered
Contraceptives/Family Planning: This Plan complies with NRS 695G.1715; required provision concerning coverage for up to a 12-month supply of FDA approved contraceptive methods, including sterilization procedures, and patient education and counseling for all women with reproductive capacity. The FDA requires the services, including over-the-counter products/methods to be prescribed by a physician.		
• *Elective sterilization* • *Surgical sterilization implant* • *Implantable rods* • *Copper-based intrauterine devices* • *Progesterone-based intrauterine devices* • *Injections*	• *Progestin-based drugs* • *Extended/continuous -regimen drugs* • *Estrogen and progestin-based patches* • *Vaginal contraceptive rings* • *Combined estrogen- and progestin-based drugs*	• *Diaphragms w/spermicide* • *Sponges w/spermicide* • *Cervical caps w/spermicide* • *female condoms* • *Spermicide*	• *Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and Ulipristal acetate for emergency contraception*

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

The following is a list of examples of preventive care services. For a full list of the most up-to-date preventive services, visit the websites listed in the Explanation and Limitations section below:

- *Physical exam, screening lab and x-rays*
- *Well child visits*
- *Adult/child routine immunizations*
- *Mammogram – annual screening (2-D or 3-D)**
- *Colorectal cancer screening***
- *Human Papillomavirus vaccine (NRS 695G.171)*
- *Pelvic exam/Pap smear/breast exam*
- *Prostate screening (NRS 695G.177)*
- *Hypertension screening*
- *Routine hearing exam*
- *Skin Cancer screening*
- *Osteoporosis screening*
- *Healthy Diet/Physical Activity Counseling****
- *Obesity Screening and Counseling*
- *Depression Screening*
- *Breastfeeding support*
- *Prenatal obstetrical office visits*
- *Smoking/tobacco cessation*

Explanations and Limitations

Preventive Care/Wellness Benefits

Many preventive care services are provided as part of physical exams. These include regular checkups and well-child exams. Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination. Preventive care focuses on evaluating your current health status when you are symptom free and allows you to obtain early diagnosis and treatment to help avoid more serious health problems. During your preventive care visit, your doctor will determine what tests, health screenings and immunizations are right for you based on many factors such as your age, gender, overall health status, personal health history and your current health condition. 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*.

Preventive care services identified through the following links is recommended services. It is up to the participant and their physician or provider of care to determine which services to provide. Unless otherwise mandated by the Patient Protection and Affordable Care Act (PPACA) or in accordance with applicable Nevada Revised Statutes, the Plan Administrator has the authority to determine which services, including frequency and quantity limits will be covered at the 100% wellness benefit.

This Plan covers recommended preventive care services 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 do have service quantity limitations.

*Mammogram: The first 2-D or 3-D mammogram of the Plan Year is covered at 100% for women aged 40 years and older, regardless of diagnosis, or beginning at age 35 for members with a high-risk of breast cancer. **Colorectal cancer screening: For adults aged 45 years and older who are at average risk of

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

colorectal cancer in accordance with the American Cancer Society's qualified recommendations; or beginning at age 40 for members with a high-risk of colorectal cancer.

***Healthy Diet/Physical Activity Counseling and Obesity Screening/Counseling 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 3 Healthy Diet/Physical Activity Counseling or Obesity Screening/Counseling visits per Plan Year. Additional visits are subject to deductible and co-insurance.

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. Benefits for over-the-counter products are limited to those that are FDA approved and recommendations 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 purchase receipt for the product with your physician's written prescription attached to the Prescription Drug Reimbursement Claim Form (this form is located at www.pebp.state.nv.us).
- 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.
- Second-line therapies such as clonidine hydrochloride and nortriptyline hydrochloride are sometimes used in the management of smoking/tobacco-cessation; 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.
- The Plan does not cover electronic cigarettes.

For more information, please visit or contact the third-party claims administrator.
Preventive Services for Adults and Families: Visit the U.S. Preventive Services Task Force at *https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/*

Preventive Services for Women, Including Pregnant Women: Visit Human Resources & Services Administration (HRSA) at *https://www.hrsa.gov/womens-guidelines/index.html*

Vaccines & Immunizations for infants, children, teens, and adults: Visit the U.S. Department of Health & Human Services at *https://www.cdc.gov/vaccines/index.html*

Preventive Health Services: Visit HealthCare.gov at *https://www.healthcare.gov/coverage/preventive-care-benefits/*

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

American Cancer Society /Colorectal Screening: *https://www.cancer.org/*

Preventive screening services are subject to age, frequency, quantity, and other guidelines in accordance with the following national organizations:
United States Preventive Services Task Force (USPSTF) A & B Recommendations and Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act; Patient Protection and Affordable Care Act of 2010 (PPACA); Health Resources and Services Administration (HRSA); the *Centers for Disease Control (CDC); Advisory Committee on Immunization Practices (ACIP); Health and Human Services (HHS); Women's Preventive Services Initiative (WPSI);* and as mandated by NRS 287.0433.

This Plan complies with SB233, Sections 54-57 and AB249, Section 25 [2017 Legislative Session] as related to contraceptive methods, utilization management, step therapy, precertification, categorization of prescription drugs (meaning Preferred Generic, Preferred Brand and Non-Preferred Brands), and cost-sharing. For more information, refer to SB233 or AB249 at https://www.leg.state.nv.us/Session/79th2017/Reports/

Benefit Description	In-Network	Out-of-Network
Radiology (X-Ray), Nuclear Medicine & Radiation Therapy Services (Outpatient)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Radiology (X-Ray), Nuclear Medicine & Radiation Therapy Services (Outpatient)

The Plan covers medically necessary specialty radiology when ordered by a physician or health care practitioner, including MRI, MRA, MRS MRT, PET, SPEC, and CT scan. Precertification required for non-orthopedic CT and MRI, and PET. For other precertification requirements, see the *Utilization Management* (Prior Authorization) section.

The Plan covers technical and professional fees associated with:

- diagnostic and curative services, including radiation therapy, and
- pre-admission testing: Outpatient radiology tests 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.

Refer to the *Preventive Care/Wellness Services* section of this document for information regarding benefits for screening radiology services and other preventive radiology testing.

Benefit Description	In-Network	Out-of-Network
Reconstructive Services and Breast Reconstruction after Mastectomy	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Reconstruction Services and Breast Reconstruction after Mastectomy

This Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA) Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. For any covered individual who is receiving mastectomy-related benefits, coverage will be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- External prostheses that are needed before or during reconstruction; and
- Treatment of physical complications of all stages of the mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery). Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy as mandated by the Women's Health and Cancer Rights Act.

Prophylactic surgery is covered under certain circumstances:

- Must be prior authorized by the UM company.
- Women diagnosed with breast cancer at 45 years of age or younger; or
- Women who are at increased risk for specific mutation(s) due to ethnic background (e.g., Ashkenazi Jewish descent) and who have one or more relatives with breast cancer or ovarian cancer at any age; or
- Women who carry or have a first-degree relative who carries a genetic mutation in the TP53 or PTEN genes (Li-Fraumeni syndrome, Cowden syndrome (CS) and Bannayan–Riley–Ruvalcaba syndrome); or
- Women who possess BRCA 1 or BRCA 2 mutations confirmed by molecular susceptibility testing for breast and or ovarian cancer: or
- Women who received radiation treatment to the chest between ages 10 and 30 years, such as for Hodgkin disease; or
- Women with a first- or second-degree male relative with breast cancer or with a BRCA 1 or BRCA 2 mutation; or
- Women with multiple primary or bilateral breast cancers in a first or second-degree blood relative; or
- Women with multiple primary or bilateral breast cancers; or
- Women with one or more cases of ovarian cancer AND one or more first or second-degree blood relatives on the same side of the family with breast cancer.
- Women with three or more affected first or second-degree blood relatives on the same side of the family, irrespective of age at diagnosis.
- Reconstructive surgery if such procedures are intended to improve bodily function or to correct deformity from disease, infection, trauma, congenital anomaly, or results from a covered therapeutic procedure.

Benefit Description	In-Network	Out-of-Network
Reconstructive Services and Breast Reconstruction after Mastectomy	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Reconstruction Services and Breast Reconstruction after Mastectomy

No coverage is provided for prophylactic surgery or treatment as defined in the *Key Terms and Definitions* and *Exclusions* sections. See also the *Exclusions* sections related to cosmetic services including reconstructive surgery.

Benefit Description	In-Network	Out-of-Network
Rehabilitation Services (Cardiac)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Rehabilitation Services (Cardiac)

- Cardiac rehabilitation is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.)
- Cardiac rehabilitation programs must be ordered by a physician.

See also the definition of cardiac rehabilitation in the *Key Terms and Definitions* section.

Benefit Description	In-Network	Out-of-Network
Rehabilitation Services (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

Explanations and Limitations

Rehabilitation Services (Physical, Occupational, and Speech Therapy)

- Rehabilitation services are covered only when ordered by a physician.
- Inpatient rehabilitation admission requires prior authorization.
- Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year.
- 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.
- Short term active, progressive rehabilitation services for occupational, physical, or speech therapy must be performed by a licensed or duly qualified therapist.

Benefit Description	In-Network	Out-of-Network
Rehabilitation Services (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

Explanations and Limitations

Rehabilitation Services (Physical, Occupational, and Speech Therapy)

- 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.
- Maintenance Rehabilitation and coma stimulation services are not covered (see specific exclusions relating to rehabilitation therapies in the *Exclusions* section).
- 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 condition of the oral cavity, throat, or nasal complex (other than a frenectomy), an injury, or sickness that is other than a learning or mental disorder.

See the see the *Utilization Management* section for prior authorization requirements.

Benefit Description	In-Network	Out-of-Network
Second Physician Opinion Includes only one office visit per opinion	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Second Physician Opinion

For your second opinion, you may choose any In-Network, Board-certified specialist who is not an associate of the attending physician.

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).
- Skilled nursing facility (SNF) confinement or subacute care facility confinement payable up to 60 days per Plan Year for all confinements related to the same cause.

Benefit Description	In-Network	Out-of-Network
Enteral Formula and Special Food Product Inherited Metabolic Disease	Plan pays 80% after Plan Year Deductible; Maximum benefit $2,500 per Plan Year for Enteral Formula	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; Maximum benefit $2,500 per Plan Year for Enteral Formula

Explanations and Limitations

Special Food Product and Enteral Formula for Inherited Metabolic Disease

- Special Food Product: $2,500 maximum benefit per Plan Year for Special Food Products which are prescribed or ordered by a physician as medically necessary for the treatment of a person with an inherited metabolic disease. Inherited metabolic disease means a disease caused by an inherited abnormality of the body chemistry of a person.
- Special Food Product means a food product that is specifically 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. See Special Food Product in the *Key Terms and Definitions* section of this document.
- Enteral formulas for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by 1) deficient metabolism, or 2) malabsorption originating from congenital defects or 3) defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat.

Documentation to substantiate the presence of an inherited metabolic disease, including the documentation that the product purchased is a Special Food Product or Enteral Formula may be required before the Plan will reimburse for the cost associated with Special Food Products or Enteral Formulas.

Benefit Description	In-Network	Out-of-Network
2nd.MD (Second Opinion Service)	Plan Pays 100%, not subject to Deductible	Not Covered
Telemedicine **Doctor on Demand (DoD) only**		Not Covered
Medical Visit	$49, after Deductible	Not Covered
Psychology Visit (25-minute visit)	$79 , after Deductible	Not Covered
Psychology Visit (50-minute visit)	$129, after Deductible	Not Covered
Psychiatry Visit (initial 45-minute visit)	$229, after Deductible	Not Covered

Psychiatry Visit (15-minute follow-up visit)	$99, after Deductible	Not Covered
Telehealth (other telemedicine providers)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Telemedicine and Telehealth

- Doctor on Demand telemedicine services provided by this Plan 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. All specialists are board certified, leaders in research, and pioneers in medicine. To learn more visit www.2nd.MD/PEBP or call 1-866-841-2575.

Benefit Description	Center of Excellence	Non-Center of Excellence
Transplant Services (Organ, and Tissue)	Plan pays 80% after Plan Year Deductible up to the benefit maximum	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Transplants (Organ and Tissue)

- Coverage is provided only for eligible services directly 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.
- Coverage is provided for the donor when the receiver is a participant under this Plan. Coverage is provided for organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor (transport within the U. S. or Canada only). 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.
- 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.
- Transplantation-related services require precertification (see the *Utilization Management* section of this document for details). Coverage is provided only for eligible services directly 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.
- See the *Exclusions* section related to experimental and investigational services and transplants.
- 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.

Benefit Description	Center of Excellence	Non-Center of Excellence
Transplant Services (Organ, and Tissue)	Plan pays 80% after Plan Year Deductible up to the benefit maximum	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Transplants (Organ and Tissue)

- This Plan provides for reimbursement of certain costs associated with travel and hotel accommodations 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 *Travel Expenses* section.
- Expenses incurred for travel and hotel accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.
- PEBP does not provide advance payment for travel expenses related to organ or tissue transplants.

Benefit Description	
Travel Expenses	Subject to IRS Limitations under Publication 502 and Code 213(d) Subject to Deductible and Out-of-Pocket Maximum

Explanations and Limitations
Travel Expenses

This Plan allows for the reimbursement of certain travel and hotel accommodation expenses permitted under IRS Regulation 213(d) and IRS Publication 502 for qualified medical expenses for the member and one additional person (travel companion) when the expenses are associated with the following services, have been prior authorized by the UM company, and when the member resides 50 or more miles from the provider location:

- Organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence.
- Elective surgeries performed as exclusive hospitals/ambulatory facilities and
- Outpatient infusion services performed at exclusive outpatient infusion centers.

Travel expenses are covered when incurred in conjunction with the member's:

- Transplant or bariatric surgery (does not include pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon. Travel expenses incurred on or after one year are not eligible for reimbursement.
- 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 (including pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon; and
- Travel expenses related to an organ or tissue transplant, or bariatric surgery scheduled or performed at a facility or other provider type that is not a Center of Excellence as determined by the Plan Administrator or its designee will not be covered. Travel expenses related to an inpatient or outpatient surgery that is not determined to be a preferred hospital/ambulatory surgical facility by the UM company will not be covered. There are no exceptions.

Benefit Description	
Travel Expenses	Subject to IRS Limitations under Publication 502 and Code 213(d) Subject to Deductible and Out-of-Pocket Maximum

Explanations and Limitations

Travel Expenses

- If the travel companion has their own separate PEBP CDHP plan, travel expense reimbursement will not apply to the companion.
- PEBP does not provide advance payment for travel expenses.
- This Plan incorporates the travel expense reimbursement guidelines established in IRS Regulation 213(d) and IRS Publication 502
- The least expensive method of transportation must be used.
- Standard mileage reimbursement for the use of a personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center is based on the mileage from the member's residence to and from the facility (based on an objective source such as Google Maps).
- The Plan Administrator or its designee has full authority to approve or deny all or part of the travel expenses. The reduction and/or denial of travel expenses cannot be appealed.
- Travel expenses subject to Deductible and Out-of-Pocket Maximum.

Excluded travel expenses :
The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved):
•Alcoholic beverages.
•Car maintenance.
•Vehicle insurance.
•Flight insurance.
•Cards, stationery, stamps.
•Clothing.
•Dry cleaning.
•Entertainment (cable televisions, books, magazines, movie rentals).
•Flowers.
•Household products.
•Household utilities, including cell phone charges, house cleaner, baby-sitter, or day care services.
•Kennel fees.
•Laundry services.
•Meals (insomuch as it is excluded under the IRS Publication 502 and Regulations under 213(d).
•Security deposits.
•Toiletries.
•Travel expenses related to a facility or provider that is not a certified Center of Excellence, exclusive hospital/ambulatory surgical facility, or outpatient infusion facility; and
•Travel expenses incurred on or after one year following surgery are not eligible for reimbursement.
Travel expenses are subject to the annual cost sharing requirements.
Pre-approval for travel expenses:

Benefit Description	
Travel Expenses	Subject to IRS Limitations under Publication 502 and Code 213(d) Subject to Deductible and Out-of-Pocket Maximum

Explanations and Limitations
Travel Expenses

- Travel expenses must be pre-approved by PEBP or its designee:
  - If the member is unable to obtain pre-approval because the organ or tissue transplant required immediate travel, the member may submit travel costs to PEBP or its designee after the transplant surgery.
  - Pre-approval will provide an estimation of your travel reimbursement. A Travel Pre-Authorization form is available at www.pebp.state.nv.us.

Submitting Travel Reimbursement form and receipts:

- Requests for travel expense reimbursement must be submitted to PEBP using the Travel Reimbursement form available at www.pebp.state.nv.us.
- Travel Reimbursement forms and receipts must be submitted within 12 months of the date of the surgery/procedure.
  - The form must be completed, including the start and end times, destination, and purpose of trip.
  - Must include original itemized receipts identifying the name(s) of the person(s) incurring the expense.

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

Reimbursement will be based on actual expenses incurred and the actual number of days and travel times and may differ from the pre-approval estimation.

Benefit Description	In-Network	Out-of-Network
Vision Screening Exam	$25 Copay; $95 maximum Plan benefit per Plan Year, amounts exceeding $95 are not payable under this Plan. Not subject to Deductible.	You pay $25 Copay; $95 maximum Plan benefit per Plan Year; amounts greater than $95 is not payable under this Plan. Not subject to Deductible.

Explanations and Limitations
Vision Screening Exam*

- One annual preventive vision screening exam including refractive error testing per Plan Year.
- Hardware such as but not limited to contact lenses, lenses and frames are not covered.
- *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.
- PEBP does not maintain a network specific to vision care; however, the PPO network does have a list of some vision providers. PEBP will reimburse providers selected from the In-Network provider search up to $95 once each Plan Year participant responsible for $25 copay at time of service.

Schedule of Prescription Drug Benefits

Benefits for prescription drugs are provided through the prescription drug plan administered by the Pharmacy Benefit Manager, ExpressScripts ("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 requirements), *Exclusions*, *Key Terms and Definitions* and other sections that may apply to a specific benefit.

Express-Scripts offers helpful tools that allow participants to manage their prescriptions. Go to www.express-scripts.com or download the free mobile app and have your identification card available to register. The "Price a Medication" menu option under "Prescriptions" is used to determine estimated Out-of-Pocket cost. From this menu option, a prescription savings program called *My Rx Choices* is available to view side-by-side medication comparisons showing potential savings with lower-cost alternatives along with any applicable coverage alerts such as "prior authorization required". See the P*articipant Contact Guide* section or go to the PEBP website at *www.pebp.state.nv.us.*

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		
Preferred/Formulary Generic Drugs	Plan pays 80% after Plan Year Deductible	Not Covered
Preferred/Formulary Brand Drugs	Plan pays 80% after Plan Year Deductible	Not Covered
Non-Preferred/Non-Formulary Brand Drugs	You pay 100% of the cost of the medication; Deductible and Out-of-Pocket Maximum credit is not applied	Not Covered
Specialty Pharmaceutical Drug (Accredo Specialty Pharmacy)	Plan pays 80% after Plan Year Deductible	Not Covered
Preventive Medications (Limited only to those preventive drugs identified by the pharmacy benefit manager)	You pay 20%, not subject to Plan year Deductible	Not Covered

Benefit Description	In-Network	Out-of-Network

Prescription Drug Benefits

Explanations and Limitations
Prescription Drug Benefit

This Plan does not coordinate prescription drug plan benefits.

Some over the counter (OTC) drugs and prescription drugs are eligible to be covered under the Plan's *Preventive Care/Wellness Services* benefit in accordance with the Affordable Care Act; whereby, the Plan will waive the Copays and Deductibles and products are paid at 100%. Examples include aspirin, folic acid, smoking cessation products and female oral contraceptives. Please contact Express Scripts for more information.

Certain OTC female contraception products are covered when presented with a prescription from your physician to your pharmacy. These types of products include the female condom, sponges, and spermicides. Refer to the *Women's Preventive Care/Wellness Services* section for more information or call Express Scripts, whose contact information is in the *Participant Contact Guide*.

Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. Contact the Pharmacy Benefit Manager listed in the *Participant Contact Guide* or visit www.express-scripts.com to check vaccine coverage and locate your nearest In-Network pharmacy. Contact the pharmacy to verify their current vaccination schedule and vaccine availability.

Coverage is also provided for, but not limited to:

- Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (whooping cough)
- Prenatal & pediatric prescription vitamins
- Prescription female oral contraceptives
- Insulin and insulin injecting devices
- Orally Administered Chemotherapy: The Copayment 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 NRS 695G.167, the cost will not exceed $100 per prescription for a 30-day supply. For more information, see *Key Terms and Definitions* section.
- Chronic medication synchronization (for details see *Key Terms and Definitions* section)
- Topical Ophthalmic Products (for details see *Key Terms and Definitions* section)

Preventive Drug Benefit Program

The Preventive Drug Benefit Program provides participants access to certain preventive drugs without having to meet a Deductible and will instead only be subject to Coinsurance. 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 are limited to those preventive drugs identified by Express Scripts. Preventive drugs 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 Description	In-Network	Out-of-Network

Prescription Drug Benefits

benefit can be found by logging on to www.pebp.state.nv.us or by contacting Express Scripts located in the *Participant Contact Guide* section.

Prescription Retail Drugs

Certain drugs fall into a category called specialty drugs. Specialty drugs are available only through the Specialty Pharmacy listed the *Participant Contact Guide* section, and prescriptions are limited to a 30-day supply. Plan participants are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. Contact Express Scripts to determine if your prescription is considered specialty.

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:

- Limited access.
- Complicated treatment regimens.
- Compliance issues.
- Special storage requirements; or
- Manufacturer reporting requirements.

This Plan's Pharmacy Benefit Manager maintains a list of special drugs classified as special pharmaceuticals. For information regarding special pharmaceuticals, contact the Pharmacy Benefit Manager listed in the *Participant Contact Guide*.

30-Day Retail Program - Express Advantage Network Program

Use an Express Advantage Network (EAN) retail pharmacy to fill short-term medications (up to a 30-day supply) to maximize your pharmacy benefits. You may still use a non-EAN Express Script preferred (network) pharmacy to fill your short-term medications Network, but you may be subject to additional deductibles or coinsurance for your medication.

To find a preferred pharmacy near you, register or log in to express-scripts.com/findapharmacy or call Express Scripts' Member Services at 855-889-7708.

There are three ways to transfer a prescription to a preferred pharmacy:

1. Take your prescription bottle to your new pharmacy and they will contact your current pharmacy to transfer your prescription.
2. Call your new pharmacy and ask them to contact your current (non-EAN) pharmacy for your prescription.
3. Ask your doctor to call your new pharmacy with your prescription information.

Smart90 Retail and Home Delivery Program

The Smart90 program is a feature of your prescription plan, managed by Express Scripts. With this program, you have two ways to get up to a 90-day supply of your long-term medications (those you take regularly for ongoing conditions). You can fill your long-term prescriptions through home delivery from the Express Scripts Home Delivery Pharmacy or at a retail pharmacy in the Smart90 network.

You will need to move your long-term medications to both a 90-day supply and to either a participating retail pharmacy or Express Scripts Home Delivery Pharmacy. If, after your second 30-day supply courtesy fill of your long-term medication, you do not make the switch you will pay a higher cost for your prescription medication and will not receive credit toward your Deductible or Out-of-Pocket Maximum.

Smart90 Retail Pharmacy

To locate a participating Smart90 Retail Pharmacy or an Express Advantage Network Pharmacy, log in to the E-PEBP Portal located at www.pebp.state.nv.us and select *Express Scripts*. You can also get pharmacy information by calling Express Scripts' Member Services at 855-889-7708. You can transfer your medications easily in-store, by phone or online.

Express Scripts Home Delivery

You may use home delivery through the Express Scripts Home Delivery Pharmacy to receive a 90-day supply of your maintenance medications and have them mailed to you with free standard shipping. Not all drugs are available via mail order. Check with Express Scripts for further information on the availability of your prescription medication. Enrolling in home delivery is easy! First, log in to express-scripts.com.

If you are enrolling a new prescription in home delivery:

- **Contact your doctor** and ask them to e-prescribe a 90-day prescription directly to Express Scripts
- OR **send a request** by selecting "Forms" or "Forms & Cards" from the "Benefits" menu, print and mail-order form and follow the mailing instructions
- OR **call Express Scripts'** Member Services at 855-889-77058 and they will contact your doctor for you if you are enrolling a current prescription:

Transfer retail prescriptions to home delivery by clicking "Add to Cart" for eligible prescriptions and check out. You can also refill and renew prescriptions. Express Scripts will contact your doctor and take care of the rest.

Check Order Status to track the shipping of your prescriptions. Please allow up to 14 days. Please keep in mind, longer delivery times may be due to additional correspondence need with prescribers, medication availability and/or delivery times from the shipping vendor.

Generics Preferred Program

When your doctor prescribes a brand-name drug and a generic substitute is available, you will automatically receive the generic drug unless:

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		

Your doctor writes "dispense as written" (DAW) on the prescription; or
You request the brand-name drug at the time you fill your prescription.

If you choose generic medicines, you get safe medicines at lower cost. Your copayment for the generic drug will be less than the copayment for the brand-name drug.

If a generic is available, but you or your doctor request the brand-name drug, you will pay the applicable brand copayment, plus the full difference in cost between the brand-name drug and the generic equivalent. This difference in cost is referred to as the ancillary fee. The ancillary fee is in addition to the copayment, so the cost could exceed the copayment maximum.

Specialty Drug Program

Specialty drugs are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, etc. Certain drugs fall into a category called specialty drugs. Specialty drugs and prescriptions are generally limited to a 30-day supply. Specialty drugs are available only through the Accredo, the Plan's Specialty Pharmacy (see the *Participant Contact Guide*). Through Accredo, patients receive an enhanced level of individual service such as one-on-one clinical support, a resource to help manage possible side effects and (for certain conditions) Accredo nurses to help administer your medication. Plan participants are encouraged to register with the Accredo Specialty Pharmacy before filling their first prescription for a specialty drug. Check with Express Scripts to determine if your prescription is considered specialty.

Copayment assistance (manufacturer-funded patient assistance) for specialty drugs will not apply toward your Deductible and Out-of-Pocket Maximum.

SaveonSP Program

As part of your prescription drug plan, Nevada Public Employees' Benefits Program has partnered with an Express Scripts' copay assistance program, SaveonSP, to help save money on certain specialty medications. Through the SaveonSP Program, manufacturer-funded assistance is maximized where the cost of the Program drug(s) is reimbursed by the manufacturer at no cost to the participant.

The medications included in the SaveonSP Program are classified as Non-Essential Health Benefits under the Affordable Care Act. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) 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 *Non-Essential Benefit Specialty Drug List*, are eligible to participate in the program.

- Select medications on the *Non-Essential Benefit Specialty Drug List* will be free of charge ($0) to members who participate.
- Prescriptions must be filled through Accredo Specialty Pharmacy.

Benefit Description	In-Network	Out-of-Network

Prescription Drug Benefits

- The medications and associated copays included in this program are subject to the Pharmacy Benefit Manager's clinical rules.
- If the medication you are taking is on the SaveonSP *Non-Essential Benefit Specialty Drug List* and you wish to participate, call SaveonSP at 1-800-683-1074.

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

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 Home Delivery pharmacy and include blood glucose monitors, test strips, insulin, syringes, alcohol pads, and lancets. For more information contact Express Scripts' Member Services at 855-889-7708.

Extended Absence Benefit

If you are going to be away from your home for an extended period, either in the country or outside of the country, you 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 in advance by the participant to the prescription drug Plan Administrator listed in the *Participant Contact Guide*. A maximum of two (2) early refills are allowed every 180 days. You may be required to obtain a new written prescription from your physician and any necessary prior authorizations.

Out-of-Country Emergency Medication Purchases

This Plan may cover emergency prescription drugs purchased if you reside in the United States and travel to a foreign country. You will need to pay for the drug at the time of purchase and later submit for reimbursement from the Pharmacy Benefit Manager. Prescription drug purchases made outside of the United States are subject to Plan provisions, limitations and exclusions, clinical review, and determination of medical necessity. The review will also include regulations determined by the FDA. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the United States.

If your purchase is eligible for reimbursement, you must use the Direct Claim Form available from the prescription drug Plan Administrator. Direct Claim Forms may be requested from the prescription drug plan or obtained by logging in to www.express-scripts.com. In addition to the Direct Claim Form, you are required to provide:

Benefit Description	In-Network	Out-of-Network
Prescription Drug Benefits		

- A legitimate copy of the written prescription completed by your physician.
- Proof of payment from you to the provider of service (typically your credit card invoice).
- Prescription and receipt must be translated to English and include the American equivalent National Drug Code for the prescription purchased.
- Reimbursement request must be converted to United States dollars.

Any foreign purchases of prescription medications will be subject to Plan limitations such as:

- Benefits and coverage
- Deductibles
- Coinsurance
- Dispensing maximums
- Annual benefit maximums
- Medical Necessity
- Usual and Customary (U&C) or prescription drug pharmacy benefit manager contracted allowable
- FDA approval
- Plan prior authorization requirements

Contact the Express Scripts before traveling or moving to another country to discuss any criteria that may apply to a prescription drug reimbursement request.

Out-of-Network Pharmacy Benefit

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.

Other Limitations:

- This Plan does not coordinate prescription drug plan benefits with other prescription drug plans. It is the participant's responsibility to use the appropriate primary and secondary (if applicable) prescription plan.
- See exclusions related to medications in the *Exclusions* section of this document.
- The formulary is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

Benefit Limitations and Exclusions

This Plan 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 Medical 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.*

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

The Plan never pays benefits equal to all the medical expenses you may incur. You are always responsible for paying for certain expenses for medical services and supplies yourself. 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 Medical Benefits*; and
- Certain wellness or preventive services that are paid by this Plan at 100% do not accumulate towards the out-of-pocket maximum.

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 Medical 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.

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 Medical Benefits* sections.

Exclusions Under the Medical Plan

The following is a list of services and supplies or expenses not covered by this Plan. The 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 pay toward services that are not covered or otherwise excluded will not count toward your 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.

Alternative/Complimentary Health Care Exclusions: Expenses for chelation therapy (except as may be medically necessary for treatment of acute arsenic, gold, mercury, or lead poisoning) and for diseases due to clearly demonstrated excess of copper or iron. Expenses for prayer, religious healing, or spiritual healing, except services provided by a Christian Science Practitioner. Expenses for naturopathic, Naprapathy services or treatment/supplies. Expenses for homeopathic treatments/supplies that are not FDA approved.

Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.

Bariatric and Overweight Surgery: The Plan's individual lifetime maximum is one (1) bariatric surgery while covered under any current or previous PEBP 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. PEBP or its designee will determine the In-Network Center of Excellence facility.

Behavioral Health Care Exclusions

- Expenses for hypnosis and hypnotherapy.
- Expenses for behavioral health care services related to: adoption counseling; court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws); custody counseling; dance, 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, couples and or sex counseling; intellectual disability (mental retardation); pregnancy counseling; vocational disabilities, and 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.

Chronic Medication Synchronization: *(NRS 695G.1665)* Provision concerning coverage for prescription drugs irregularly dispensed for the synchronization.

1. A managed care organization that offers or issues a health care plan which provides coverage for prescription drugs:
   a) Must authorize coverage for and may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for synchronizing the insured's chronic medications:
      1. The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the insured; and
      2. The insured requests less than a 30-day supply.
   b) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the managed care organization.
   c) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).
2. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery, or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.
3. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.
4. As used in this section:
   (a) "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.
   (b) "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.

(c) "Unit-of-use packaging" means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

Complications of a non-covered service: 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: 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.

Contraception or its Therapeutic Equivalent

From 2017 Legislative Session - AB 249 (NRS 695G.1715)

1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:
   (a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent, which is lawfully prescribed or ordered, and which has been approved by the Food and Drug Administration.
   (b) Any type of device for contraception or its therapeutic equivalent, which is lawfully prescribed or ordered, and which has been approved by the Food and Drug Administration.
   (c) Insertion or removal of a device for contraception.
   (d) Education and counseling relating to contraception.
   (e) Management of side effects relating to contraception; and
   (f) Voluntary sterilization for men and women.
2. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the managed care organization.
3. A managed care organization that offers or issues a health care plan shall not:
   (a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit included in the health care plan pursuant to subsection 1.
   (b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefits.
   (c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefits.
   (d) Penalize a provider of health care who provides any such benefits to an insured, including, without limitation, reducing the reimbursement of the provider of health care.
   (e) Offer or pay any type of material inducement, bonus, or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefits to an insured; or
   (f) Impose any other restrictions or delays on the access of an insured to any such benefits, including, without limitation, a program of step therapy or prior authorization.
4. Coverage pursuant to this section for a covered spouse or the covered dependent of an insured must be the same as for the insured.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery, or renewed on or after January 1, 2019, has the legal effect of including the coverage required

by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

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

Concierge membership fees: 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.

Continued Medical Treatment: Required provision concerning coverage for continued medical treatment. (*NRS 695G.164*)

1. The provisions of this section apply to a health care plan offered or issued by a managed care organization if an insured covered by the health care plan receives health care through a defined set of providers of health care who are under contract with the managed care organization.
2. Except as otherwise provided in this section, if an insured who is covered by a health care plan described in subsection 1 is receiving medical treatment for a medical condition from a provider of health care whose contract with the managed care organization is terminated during the medical treatment, the health care plan must provide that:
3. The insured may continue to obtain medical treatment for the medical condition from the provider of health care pursuant to this section, if:
    a. The insured is actively undergoing a medically necessary course of treatment; and
    b. The provider of health care and the insured agree that the continuity of care is desirable.
4. The provider of health care is entitled to receive reimbursement from the managed care organization for the medical treatment the provider of health care provides to the insured pursuant to this section, if the provider of health care agrees:
    a. To provide medical treatment under the terms of the contract between the provider of health care and the managed care organization with regard to the insured, including, without limitation, the rates of payment for providing medical service, as those terms existed before the termination of the contract between the provider of health care and the managed care organization; and
    b. Not to seek payment from the insured for any medical service provided by the provider of health care that the provider of health care could not have received from the insured were the provider of health care still under contract with the managed care organization.
    1. The coverage required by subsection 2 must be provided until the later of:

(a) The 120th day after the date the contract is terminated; or
(b) If the medical condition is pregnancy, the 45th day after:
i. The date of delivery; or
ii. If the pregnancy does not end in delivery, the date of the end of the pregnancy.

5. The requirements of this section do not apply to a provider of health care if:
6. The provider of health care was under contract with the managed care organization and the managed care organization terminated that contract because of the medical incompetence or professional misconduct of the provider of health care; and
(b) The managed care organization did not enter into another contract with the provider of health care after the contract was terminated pursuant to paragraph (a).
7. An evidence of coverage for a health care plan subject to the provisions of this chapter that is delivered, issued for delivery, or renewed on or after October 1, 2003, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal thereof that conflicts with this section is void.
8. The Commissioner shall adopt regulations to carry out the provisions of this section.
(Added to NRS by 2003, 3370)

Controlled Substance or Intoxicated: (NRS 695G.405) Prohibited from denying coverage solely because insured was intoxicated or under the influence of controlled substance; exceptions.

1. Except as otherwise provided in subsection 2, a managed care organization shall not:
(a) Deny a claim under a health care plan solely because the claim involves an injury sustained by an insured because of being intoxicated or under the influence of a controlled substance.
(b) Cancel participation under a health care plan solely because an insured has made a claim involving an injury sustained by the insured because of being intoxicated or under the influence of a controlled substance.
(c) Refuse participation under a health care plan to an eligible applicant solely because the applicant has made a claim involving an injury sustained by the applicant because of being intoxicated or under the influence of a controlled substance.
2. The provisions of subsection 1 do not prohibit a managed care organization from enforcing a provision included in a health care plan to:
(a) Deny a claim which involves an injury to which a contributing cause was the insured's commission of or attempt to commit a felony.
(b) Cancel participation under a health care plan solely because of such a claim; or
(c) Refuse participation under a health care plan to an eligible applicant solely because of such a claim.

3. The provisions of this section do not apply to a managed care organization under a health care plan that provides coverage for long-term care or disability income.

Corrective Appliance, Orthotic Device Expenses, and Appliances: Any items that are not 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 s*ection), including, but not limited to, personal comfort items like air purifiers, humidifiers, electric heating units, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, 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 and surgery or any drugs used for cosmetic purposes, including but not limited to health and beauty aids.

Complications resulting from Cosmetic Services or Surgery are not covered.

There is no coverage for travel costs.

This Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA) Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. For any covered individual who is receiving mastectomy-related benefits, coverage will be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- External prostheses (breast forms that fit into your bra) that are need before or during reconstruction; and Treatment of physical complications of all stages of the mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery).

Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy as mandated by the Women's Health and Cancer Rights Act.

Prophylactic surgery is covered under certain circumstances:

- Must be prior authorized by the UM company.

- Women diagnosed with breast cancer at 45 years of age or younger; or
- Women who are at increased risk for specific mutation(s) due to ethnic background (e.g., Ashkenazi Jewish descent) and who have one or more relatives with breast cancer or ovarian cancer at any age; or
- Women who carry or have a first-degree relative who carries a genetic mutation in the TP53 or PTEN genes (Li-Fraumeni syndrome and Cowden and Bannayan-Riley-Ruvalcaba syndromes); or
- Women who possess BRCA 1 or BRCA 2 mutations confirmed by molecular susceptibility testing for breast and or ovarian cancer: or
- Women who received radiation treatment to the chest between ages 10 and 30 years, such as for Hodgkin disease; or
- Women with a first- or second-degree male relative with breast cancer or with a BRCA 1 or BRCA 2 mutation; or
- Women with multiple primary or bilateral breast cancers in a first or second-degree blood relative; or
- Women with multiple primary or bilateral breast cancers; or
- Women with one or more cases of ovarian cancer AND one or more first or second-degree blood relatives on the same side of the family with breast cancer.
- Women with three or more affected first or second-degree blood relatives on the same side of the family, irrespective of age at diagnosis.
- Reconstructive surgery if such procedures are intended to improve bodily function or to correct deformity from disease, infection, trauma, congenital anomaly, or results from a covered therapeutic procedure.

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.

*Breast augmentation/augmentation mammoplasty excluded, except when the patient undergoing surgeries for gender dysphoria has received 12 continuous months of hormonal (estrogen) therapy and the breast tissue growth failed to result a Tanner Stage 5 on the puberty scale, as determined by the provider, or the recipient has a medical contraindication to hormone therapy. The Plan Administrator will determine authorization and consent to care based on medical necessity.

Costs of Reports, Bills, etc.: 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.

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.

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:

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 Medical 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 Medical 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. 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 www.pebp.state.nv.us.

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.
- 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 Medical Benefits* section or elsewhere in this document under the section titled *Obesity and Overweight Care Management Program*;
- Naturopathic, Naprapathy, or homeopathic treatments/substances.
- Weight control or anorexiants, except those anorexiants 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 and Overweight 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 Medical 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.
- 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 Medical Benefits*.
- Non-prescription male contraceptives, e.g., condoms.
- Dental products such as topical fluoride preparations and products for periodontal disease.
- 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 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 Medical 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: 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' 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.

Expenses for Which a Third-Party Is Responsible: Expenses for services or supplies for which a third-party is required to pay because of the negligence or other tortious or wrongful act of that third-party (see the provisions relating to third-party liability in the *Subrogation and Third-Party Recovery* section for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third-party is required to pay for those services or supplies).

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 or its designee to be experimental and/or investigational services as follows:

- If outcome data from randomized controlled clinical trials, recommendations from consensus panels, national medical associations, or other technology evaluation bodies and from authoritative, peer-reviewed US medical or scientific literature:
- Is insufficient to show that the procedure or treatment is safe, effective, or superior to existing therapy; or
- Does not conclusively demonstrate that the service or therapy improves the net health outcomes for total an appropriate population for whom the service might be rendered or proposed over the current diagnostic or therapeutic interventions, even if the service, drug, biological, or treatment may be recognized as a treatment or service for another condition, screening, or illness.
- If the procedure or treatment has not been deemed consistent with accepted medical practice by the National Institutes of Health, the Food and Drug Administration, or Medicare.
- When the drug, biologic, device, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the Food and Drug Administration or any other state or federal regulatory agency, and such final approval has not been granted for that indication, condition, or disease.
- When a nationally recognized medical society states in writing that the procedure or treatment is experimental; or
- When the written protocols used by a facility performing the procedure or treatment state that it is experimental. Clinical trials may still be covered even if the procedure or treatment is otherwise experimental or investigational. Refer to the *Schedule of Medical Benefits* and *Key Terms and Definitions* sections.

Fertility and Infertility Treatment:
Except as otherwise specified in the Schedule of Medical Benefits section, all other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) except services directly related to artificial insemination services up to the maximum benefit limit 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.

Gender Dysphoria and/or Gender Services: Certain procedures associated with gender dysphoria treatment and/or gender related surgery found to be non-medically necessary in the Treatment for Gender Dysphoria section above are not covered.

- No more than one genital surgery in the individual's lifetime covered under any current or previous PEBP health plan.
- There is no coverage for travel costs.
- A surgery to reverse a surgery to treat gender dysphoria will not be covered.

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, unless otherwise specified in this Plan's Schedule of Medical Benefits.

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.

Growth Hormone: Coverage for off-labeled growth hormone.

Gym Fees: 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 listed above.

Hearing Care: Special education and associated costs in conjunction with sign language education for a patient or family members.

Home Birth/Delivery: 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 under a home health care program for services that are provided by an immediate relative or someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a physician.
- 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.
- In-home services provided by certified nurse aids or home health aides.
- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the Summary of Medical Benefits and Schedule of Medical 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.

Human Papillomavirus Vaccine: (*NRS 695G.171*) Required provision concerning coverage for human papillomavirus vaccine.

1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.
2. A health care plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.
3. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery, or renewed on or after July 1, 2007,

has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal thereof which conflicts with subsection 1 is void.

4. For the purposes of this section, "human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

Illegal Act: 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. 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.

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.

Internet/Virtual Office Visit: 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. **Note**: This Plan has an exclusive in-network provider agreement with Doctor on Demand for telemedicine services for this Plan.

Maternity/Family Planning:

- 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.
- 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.

Medically Necessary Emergency Services: Required provision concerning coverage for medically necessary emergency services; prohibitions.

- Each managed care organization shall provide coverage for medically necessary emergency services provided at any hospital.
- A managed care organization shall not require precertification for medically necessary emergency services.
    - As used in this section, "medically necessary emergency services" means health care services that are provided to an insured by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:
        (a) Serious jeopardy to the health of an insured.
        (b) Serious jeopardy to the health of an unborn child.
        (c) Serious impairment of a bodily function; or
        (d) Serious dysfunction of any bodily organ or part.
- A health care plan subject to the provisions of this section that is delivered, issued for delivery, or renewed on or after October 1, 1999, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which conflicts with this section is void. (*NRS 695G.170*)

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.).

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, except for covered services provided by a behavioral health practitioner, midwife or nurse midwife, nurse practitioner, physician assistant, chiropractor, dentist, homeopath, podiatrist, or certain preventive/wellness screening services.

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,

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 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.

Ophthalmic Products: *(NRS 695G.172)* Required provision concerning coverage for early refills of topical ophthalmic products.

1. A managed care organization which offers or issues a health care plan that provides coverage for prescription drugs shall not deny coverage for a topical ophthalmic product which is otherwise approved for coverage by the managed care organization when the insured, pursuant to NRS 639.2395, receives a refill of the product:
   (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.
2. The provisions of this section do not affect any deductibles, copayments or coinsurance authorized or required pursuant to the health care plan.
3. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2016, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void. As used in this section, "topical ophthalmic product" means a liquid prescription drug which is applied directly to the eye from a bottle or by means of a drop

Orally Administered Chemotherapy: This Plan complies with *NRS 695G.167*; Required provision concerning coverage for orally administered chemotherapy.
A managed care organization that offers or issues a health care plan which provides coverage for the treatment of cancer using chemotherapy shall not:

1. Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.
   a) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

b) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. An evidence of coverage for a health care plan subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery, or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.
3. Nothing in this section shall be construed as requiring a managed care organization to provide coverage for the treatment of cancer using chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

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.

Partial Hospitalization Service: 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.

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 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 Medical Benefits* section. For additional information, please contact this Plan's UM company or Claims Administrator.

Prophylactic drugs are excluded.

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.

Article 3 **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.

Article 4 **POS 23 Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness and injury is provided.

Article 5 **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.

Prostate Screening: Required provision concerning coverage for prostate cancer screening.

1. A health care plan issued by a managed care organization that provides coverage for the treatment of prostate cancer must provide coverage for prostate cancer screening in accordance with:
    a) The guidelines concerning prostate cancer screening which are published by the American Cancer Society; or
    b) Other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations, and which include current or prevailing supporting scientific data.

2. A health care plan issued by a managed care organization that provides coverage for the treatment of prostate cancer must not require an insured to obtain prior authorization for any service provided pursuant to subsection.
   Any evidence of coverage for a health care plan issued by a managed care organization that provides coverage for the treatment of prostate cancer which is delivered, issued for delivery, or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with subsection 1 is void.

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, stammering and conditions of psychoneurotic origin.
- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living.
- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment of mental retardation, Down syndrome, or autism (unless specified otherwise within the *Summary of Medical Benefits and Schedule of Medical Benefits* sections) 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.

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 Medical 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.

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.

Telehealth: *(NRS 695G.162)* Required provision concerning coverage for services provided through telehealth**.**

1. A health care plan issued by a managed care organization for group coverage must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.
   A managed care organization shall not:
   (a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1.
   (b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1.
   (c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or
   (d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.
2. A health care plan of a managed care organization must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. Such a health care plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.
3. The provisions of this section do not require a managed care organization to:
   (a) Ensure that covered services are available to an insured through telehealth at an originating site.
   (b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or
   (c) Enter into a contract with any provider of health care or cover any service if the managed care organization is not otherwise required by law to do so.
4. Evidence of coverage that is delivered, issued for delivery, or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which conflicts with this section is void.
5. As used in this section:
   (a) "Distant site" has the meaning ascribed to it in *NRS 629.515*.

(b) "Originating site" has the meaning ascribed to it in *NRS 629.515*.
(c) "Provider of health care" has the meaning ascribed to it in *NRS 439.820*.
(d) "Telehealth" has the meaning ascribed to it in *NRS 629.515*.

Topical Ophthalmic Products: *(NRS 695G.172)* Required provision concerning coverage for early refills of topical ophthalmic products.

1. A managed care organization which offers or issues a health care plan that provides coverage for prescription drugs shall not deny coverage for a topical ophthalmic product which is otherwise approved for coverage by the managed care organization when the insured, pursuant to NRS 639.2395, receives a refill of the product:
   (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.
2. The provisions of this section do not affect any deductibles, copayments or coinsurance authorized or required pursuant to the health care plan.
3. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery, or renewed on or after January 1, 2016, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal which conflicts with this section is void.
4. As used in this section, "topical ophthalmic product" means a liquid prescription drug which is applied directly to the eye from a bottle or by means of a dropper.

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 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 Medical Benefits and Schedule of Medical Benefits*.

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 Medical Benefits* and *Schedule of Medical Benefits.* Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Expenses for weight loss surgery performed without a precertification 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 anorexia, bulimia, or acute starvation. 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 Premier Plan).

Other Benefit Exclusions

- Stress reduction therapy or cognitive behavior therapy for sleep disorders.
- Sleep therapy (except for central or obstructive apnea when medically necessary and when a precertification has been received from the UM company), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.
- Charges that result from appetite control, food addictions, eating disorders (except documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by us and present significant symptomatic medical problems) or any treatment of obesity, unless otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits.*
- Except as otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*, drugs, medicines, procedures, services, and supplies to correct or enhance erectile

function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.

- 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.
- 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 Medical Benefits and Schedule of Medical Benefits.*

Medical Claims Administration

How Medical Benefits are Paid

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 directly. 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 are responsible for paying your share of these charges.

If services are provided through the PPO network, the PPO health care provider may submit the proof of claim directly to PEBP's third-party claims administrator; however, you will be responsible for the payment to the PPO health care provider for any applicable Deductible, Coinsurance, or copayments.

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 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 Medical 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.

See also, NAC 287.610.

Most providers send their bills directly to the PEBP's claims administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party claims administrator 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 what documents or medical information is necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains all the following information:

- A description of the services or supplies provided including appropriate procedure codes.
- Details of the charges for those services or supplies.
- Appropriate diagnosis code.
- 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 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 that medical, pharmacy or dental expenses you 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 or is missing one or more of the following components. This is not an all-inclusive list:

- Itemized bill to include but not be limited to: 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.
- Emergency room notes.
- 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). This Plan will deny payment for such medical devices until a copy of the invoice is provided to this Plan's Claims Administrator.

Claims are processed by the third-party claims administrator in the order they are received. If a claim is held or "soft denied" that means the third-party claims administrator is holding the claim to receive additional information, either from the participant, the provider or to get clarification on benefits to be paid. A claim that is held or soft denied will be paid or processed when the

requested additional information is received. Claims filed while another claim(s) is held or soft denied may be paid or processed even though they were received later.

It is your responsibility to maintain copies of the EOB 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.

Where to Send the Claim Form

Send the completed claim form, the bill you received (retain a copy for your records) and any other required information to the Claims Administrator at the address listed in the *Participant Contact Guide* in this document.

Appeals

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.

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.

Medical and Dental 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.

Level 1 Claim Appeal

NAC 287.670

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 will review your 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 your request for appeal, it will be requested promptly.

The third-party administrator will issue a decision of your Level 1 Claim Appeal in writing within 20 days after receipt of your request for appeal. If the decision upholds the denial of benefits in whole or in part, the notification to you will explain the reasons for the decision, with reference to the applicable provisions of the Plan upon which the denial is based. The notification will explain the steps necessary if you wish to proceed to a Level 2 Appeal if you are not satisfied with the response at Level 1.

Level 2 Claim Appeal

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 form*s are available at www.pebp.state.nv.us or by request by contacting PEBP Customer Service at 775-684-7000 or 800-326-5496. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal **must** include a copy of:

- Any document submitted with your Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use all resources available to assure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. 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.

External Claim Review

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 www.pebp.state.nv.us. The OCHA will assign an independent external review organization within five 5 days after receiving the request. 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
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

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 NRS 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.

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

If you have a denied precertification 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 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 the 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 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.

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 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 www.pebp.state.nv.us.

The request must be submitted to:

Office for Consumer Health Assistance
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

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 www.pebp.state.nv.us.

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, 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 www.pebp.state.nv.us.

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
3320 W. Sahara Avenue, Suite 100
Las Vegas NV 89102
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: *http://dhhs.nv.gov/Programs/CHA/*

Prescription Drug Review and Appeals

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 administrative coverage review requests.

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 clinical review 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 1-855-889-7708 or the prescriber may submit a completed Initial Coverage Review form obtained online at www.express-scripts.com/services/physicians/. (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

Administrative Coverage Review

The initial 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 review may be requested and conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent 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.

If the necessary information is provided to Express Scripts 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' 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 sever 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.

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, physician, panel of clinicians, trained prior authorization staff member, or an independent third-party prescription drug utilization management company.

Level 1 Appeal Decisions and Notifications

Express Scripts will render Level 1 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 20 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 benefit determination. Standard Post-Service: NAC 287.670

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 must request by mail or fax to the appropriate 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 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 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. Standard Post-Service: NAC 287.680

External Reviews

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, all internal appeal rights must be exhausted prior to requesting an external review. 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.

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 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 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, 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, the IRO will notify the claimant 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. 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 could seriously jeopardize the life or health or the ability for the patient 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 is eligible for urgent processing, 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 written notice of its decision.

Coordination of Benefits

Which Benefits are Subject to Coordination?

When you or your covered dependents also have medical, dental or vision coverage from some other source, benefits are determined using coordination of benefits (COB). In many of those cases, one plan serves as the primary plan or program and pays benefits or provides services first. In these cases, the other plan serves as the secondary plan or program and pays some or all the difference between the total cost of those services and payment by the primary plan or program. Benefits paid from two different plans can occur if you or a covered dependent is covered by this Plan and is also covered by:

- Any primary payer besides this Plan.
- Any other group health care plan or individual policy.
- Any other coverage or policy covering the participant or covered dependent.
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company.
- Medicare.
- Other government programs, such as: Medicaid, Tricare/CHAMPUS, a program of the U.S. Department of Veterans Affairs, or any coverage provided by a federal, state, or local government or agency; or
- Workers' Compensation.

NOTE: 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 you have additional prescription drug coverage that is primary.

This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source (as described above), would allow you to recover more than 100% of allowable expenses you incur. In some instances, you may recover less than 100% of those allowable expenses from the duplicate sources of coverage. It is possible that you will incur out of pocket expenses, even with 2 (two) payment sources.

When and How Coordination of Benefits (COB) Applies

Many individuals have family members who are covered by more than one medical or dental plan or policy. If this is the case with your family, you must let the Plan Administrator, or its designee know about all your coverages when you submit a claim.

Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan or policy, (called the secondary plan) may then pay 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.

If the CDHP is secondary coverage, the participant will be required to pay their copayments and/or Coinsurance as applicable.

For the purposes of this *Coordination of Benefits* 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.

"Allowable expense" means a health care service or expense, including Deductibles, Coinsurance, or copayments, that is covered in full or in part by any of the plans covering the person, except as described below, or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

Examples of expenses that are not allowable under this Plan:

- The difference between the cost of a semi-private room in the hospital and a private room.
- When both plans use usual and customary (U&C) fees, any amount in excess of the highest of the U&C fee for a specific benefit.
- When both plans use negotiated fees, any amount in excess of the highest negotiated fee is not an allowable expense (except for Medicare negotiated fees, which will always take precedence); and
- When one plan uses U&C fees and another plan uses negotiated fees, the secondary plan's payment arrangement is not the allowable expense.
- When one plan uses Maximum Allowable Charge and another plan uses negotiated fees, any amount more than the highest negotiated fee is not an allowable expense (except for Medicare negotiated fees, which will always take precedence).
- When one plan uses Maximum Allowable Charge and another plan uses Usual and Customary fees, any amount more than the highest Maximum Allowable Charge fee for a specific benefit

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

Plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any plan that does not use these same rules always pays its benefits first.

When two plans cover the same person, the following 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 following 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.

These rules are:

Rule 1: Non-Dependent/Dependent

The plan that covers a person other than as a dependent, for example 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 because 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 (that is, as a retired employee) pays second.

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.

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 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.

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.

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 paid or provided before the Plan had actual knowledge of the specific terms of that court decree.

Rule 3: Active/Laid-Off or Retired Employee

The plan that covers a person, as an active employee (that is, an employee who is neither laid-off nor retired) or as an active employee's dependent pays first; the plan that covers the same person as a laid-off/retired employee or as a laid-off or 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.

If a person is covered as a laid-off or 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 rather than by this rule.

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.

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.

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 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.

Administration of COB

To administer Coordination of Benefits (COB), the Plan reserves the right to:

- Exchange information with other plans involved in paying claims.
- Require that you or your health care provider furnish any necessary information.
- Reimburse any plan that made payments this Plan should have made; or
- Recover any overpayment from your hospital, physician, dentist, other health care provider, other insurance company, you or your dependent.

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 considered benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

This Plan follows the customary coordination of benefits 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 is secondary, it will pay secondary medical benefits 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 an HMO, 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 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 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 all rights the participant may have against the other plan, and the 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. Refer to the *Enrollment and Eligibility Master Plan Document (MPD)* for more information regarding enrollment in the Medicare Exchange.

Entitlement to Medicare Coverage (Retirees and their Covered Dependents)

When retirees and/or their covered dependent reaches Medicare eligible age, the Plan will require the individual to enroll in premium-free Medicare Part A (if eligible) and purchase Medicare Part B. This Plan also requires retirees and/or their covered dependent under age 65 years who are entitled to Social Security Disability Income Benefits and are also entitled to Medicare coverage after a waiting period to enroll in Medicare Parts A and B. See the PEBP *Enrollment & Eligibility MPD* available at www.pebp.state.nv.us for more information.

Retirees Ineligible for Premium-Free Medicare Part A

The Plan will allow retirees and their covered dependents to retain coverage under this Plan when they are ineligible for premium-free Medicare Part A. The Plan will generally pay as primary for services that would have been covered by Part A. However, when eligible, the retiree and/or his covered dependent must enroll in Medicare Part B coverage. For retirees and/or his or her covered dependents who are eligible for Medicare Part B, this Plan will always be secondary to Medicare part B (except as specified below regarding Medicare and ESRD) whether not you have enrolled. This Plan will assume that Medicare will pay 80% of Medicare Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

Coverage under Medicare and This Plan when You Have End-Stage Renal Disease (ESRD)

If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan will remain as the primary payor for the first 30 months of your or your dependent's entitlement to Medicare. However, if this Plan is currently paying benefits as secondary to Medicare for you or your dependent, this Plan will remain secondary upon your or your dependent's eligibility or entitlement to Medicare.

If you are retired, under age 65 years and are receiving Medicare ESRD benefits, you will not be required to transition to PEBP's Medicare Exchange program. When you reach age 65 years you will be transitioned to the Medicare Exchange in accordance with PEBP's eligibility requirements as stated in the *Enrollment and Eligibility MPD*.

How Much This Plan Pays When It Is Secondary to Medicare

When you are retired and covered by Medicare Parts A and B, this Plan is secondary to Medicare. This Plan pays as secondary 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 a retiree or a retiree's covered dependent is enrolled in Medicare Part B, this Plan will pay as secondary to Part B.

If a Part B eligible retiree or the dependent of a retiree is not enrolled in Part B coverage, this Plan will estimate the Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only pay the remaining 20% of Part B expenses.

Note: A Medicare participant has the right to enter a Medicare private contract with certain health care practitioners. Under Medicare private contracts, the participant agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that practitioner. If a PEBP Medicare participant enters such a contract, this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to the private contract.

Coordination with Other Government Programs

Medicaid

If you are covered by both this Plan and Medicaid, this Plan is primary and pays first and Medicaid is secondary.

Medicare

If you are age 65 or older, entitled to benefits under Medicare, and work for an employer that did not employ 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding Plan Year, then Medicare is the primary payer for you and your spouse. The benefits of this Plan will then be the secondary form of coverage.

If you or your spouse is age 65 or older, entitled to benefits under Medicare, and works for an employer that employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding Plan Year, the following rules apply:

- This Plan is primary payer for any person aged 65 or older who is an active employee or the spouse of an active employee of any age.

Tricare

If a participant is covered by both this Plan and Tricare (the program that provides health care services to active or retired armed services personnel and their eligible dependents), this Plan will pay first, and Tricare will pay 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 receives services in a U.S. Department of Veterans Affairs Hospital or facility because of a military service-related illness or injury, Benefits are not payable by the Plan. If a participant receives services in a U.S. Department of Veterans Affairs hospital or facility because 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 Plan's Maximum Allowable Charge, only to the extent those services are medically necessary and are not excluded by the Plan.

Worker's Compensation

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 are incurred, this Plan will pay benefits, subject to its

right to recover those payments when it is determined that they are covered under a Workers' Compensation or occupational disease law. However, before such payment will be made, you and/or your covered dependent must execute a subrogation and reimbursement agreement that is acceptable to the Plan Administrator or its designee.

Disability

If you are under age 65, have current employment status with an employer with fewer than 100 employees, and become disabled and entitled to benefits under Medicare due to such disability, then Medicare will be primary for you and this Plan will be the secondary form of coverage. If you are under age 65, have current employment status with an employer with at least 100 employees, and you become disabled and entitled to benefits under Medicare due to such disability (other than ESRD, as discussed above) this policy will be primary for you and Medicare will be the secondary form of coverage.

Subrogation and Third-Party Recovery

Subrogation 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.

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 www.pebp.state.nv.us for more information regarding third-party liability and subrogation.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) **901 S. Stewart Street, Suite 1001** **Carson City, NV 89701** **Customer Service:** **(775) 684-7000, (702) 486-3100, or (800) 326-5496** **Fax: (775) 684-7028** **www.pebp.state.nv.us**	**Plan Administrator** • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR **Claims Submission** **P O Box 30541** **Salt Lake City, UT 84130-0541** **EDI #39026** **Appeal of Claims** **P O Box 30546** **Salt Lake City, UT 84130-0546** **Customer Service: (888) 763-8232** **www.UMR.com** **Diabetes Care Management form submission** **UMR** **27 Corporate Hill Drive** **Little Rock, AR 77205 Fax: 800-458-0701** **Email: diabetes@HealthscopeBenefits.com**	**Third-party Claims Administrator/Third-party Administrator/PPO Network/Disease Management Administrator for Diabetes** • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Disease Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Utilization Management Company **Sierra Health-Care Options, Inc** **PO BOX 15645** **Las Vegas, NV 89144-5648** **Customer Service : 888-323-1461** **Fax : 800-282-8845**	• Pre Certification/Prior Authorization • Utilization Management • Case Management • Transplants
Express Scripts Pharmacy Benefit Administrator **Customer Service and Prior Authorization** **(855) 889-7708**	Pharmacy Benefit Manager for Prescription Drugs information • Retail network pharmacies

www.Express-Scripts.com **Express Scripts Home Delivery/Accredo Specialty Drug Services** **PO Box 66566** **St. Louis, MO 63166-6566** **Customer Service: (855) 889-7708** **Express Scripts Benefit Coverage Review Department** **PO Box 66587, St. Louis, MO 63166-6587** **Phone: 800-946-3979** **Administrative Coverage Review and Appeals** **SaveonSP** **1-800-683-1074**	• Prior authorization • Customer service • Formulary, forms, online ordering • Price a Medication tool • Home delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies **Express Scripts Clinical Appeals Department** PO Box 66588 St. Louis, MO 63166-6588 Phone: 800-753-2851 Fax: 877-852-4070 • Clinical Reviews **MCMC LLC Attn: Express Scripts Appeal Program** 300 Crown Colony Dr. Suite 203 Quincy, MA 02169-0929 Phone: 617-375-7700 ext. 28253 Fax: 617-375-7683 External Review Requests
Diversified Dental Services **5470 Kietzke Lane, Ste 300** **Reno, NV 89511** **ProviderRelations@ddsppo.com** **1-866-270-8326** **diversifieddental.com**	PPO Dental Network • Statewide PPO Dental Providers • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
HSA Bank HRA Claim Submission **PO Box 2744** **Fargo, ND 58108-2744** **hsaforms@hsabank.com** **Fax: 855-764-5689** **www.hsabank.com** **Customer Service:** **833-228-9364** **askus@hsabank.com** **myaccounts.hsabank.com**	• HSA and HRA Claims Administrator

United Healthcare **Group Number: 370074** **Customer Service: 1-888-763-8232** **UnitedHealthcare Specialty Benefits** **P.O. Box 7149** **Portland, ME 04112-7149**	• Basic Life Insurance for eligible active and retirees
The Standard Insurance Company **900 SW Fifth AvenuePortland, OR 97204** **(888) 288-1270** ***https://www.standard.com/mybenefits/nevada/***	• Voluntary (Supplemental) Life Insurance • Long-Term Disability • Voluntary Short-Term Disability • Generali Travel Assistance • Beneficiary Designations
Office for Consumer Health Assistance **3320 W. Sahara Avenue, Suite 100** **Las Vegas, NV 89102** **Customer Service:** **(702) 486-3587 or (888) 333-1597** ***http://dhhs.nv.gov/Programs/CHA/Contact_GovCHA/***	• Consumer Health Assistance • Concerns and problems related to coverage • Provider billing issues • External review information

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: NRS 695G.0–2 - 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 setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

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; therefore, whether or not it is made.

Ambulance: A vehicle, helicopter, airplane, 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 anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
- It provides at least one operating room and at least one post-anesthesia recovery room.
- 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.

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.

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 (AHCRQ),

(d) the Centers for Medicare and Medicaid Services (CMS),

(e) a cooperative group or center of the NIH, CDC, AHCRQ, 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 Disorders and related terms [NRS 695G.1645 effective January 1, 2019]**:**

- "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.
- "Autism Spectrum Disorder" has the meaning ascribed to it in NRS 427A.875 [autism spectrum disorder means 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].
- "Behavioral therapy" means 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, registered behavior technician or state certified behavior interventionist.
- "Evidenced-based research" means research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to Autism Spectrum Disorders.
- Habilitative or Rehabilitative" means counseling, guidance and professional services and treatment programs, including, without limitations, applied behavior analysis, that are necessary to develop, maintain and restore to the maximum extent practicable, the functioning of a person.
- "Licensed Assistant Behavior Analyst" means a person who holds current certification as a Board-Certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services and who provides

behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

- Licensed Behavior Analyst" means a person who holds current certification as a Board-Certified Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and is licensed as a behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services.
- "Prescription Care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medication.
- "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- "Registered Behavior Technician" has the meaning ascribed to it in NRS 437.050.
- "Screening for Autism Spectrum Disorders" means medically necessary assessments, evaluations, or tests to screen and diagnose whether a person has an autism spectrum disorder.
- "State Certified Behavior Interventionist" has the meaning ascribed to it in NRS 437.055.
- "Therapeutic care" means services provided by licensed or certified speech-language-pathologists, occupational therapists, and physical therapists.
- "Treatment plan" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

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: This provider 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). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

- Behavior modification program supervised by a qualified professional.
- Consultation with a dietician or nutritionist.
- Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit.

A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen.

- Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise Therapist or other qualified professional.
- Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
- Reduced-calorie diet program supervised by dietician or nutritionist.

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 PEBP.

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 *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 and 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: All inpatient 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, 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, or a state or federal holiday.

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. Such individuals are payable by this Plan, including 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.

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: NRS 695G.1665 - Provision concerning coverage for prescription drugs irregularly dispensed for the synchronization.

2. A managed care organization that offers or issues a health care plan which provides coverage for prescription drugs:
   d) Must authorize coverage for and may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for synchronizing the insured's chronic medications:
      1. The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the insured; and
      2. The insured requests less than a 30-day supply.
   e) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the managed care organization.
   f) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).

2. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery, or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or renewal which conflicts with this section is void.

4. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.

4. As used in this section:
   (a) "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.
   (b) "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.

(c) "Unit-of-use packaging" means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

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.

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 health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility.

Contraceptives or its Therapeutic Equivalent
From 2017 Legislative Session SB233 (NRS 639.28075, NRS 639.2396, NRS 689A.0418, NRS 689B.0378, NRS 695G.1715, where applicable)

- Pursuant to a valid prescription or order for a drug to be used for contraception or its therapeutic equivalent which has been approved by the FDA a pharmacist shall:
    - The first time dispensing the drug or therapeutic equivalent to the patient, dispense up to a 3-month supply of the drug or therapeutic equivalent.
    - The second time dispensing the drug or therapeutic equivalent to the patient, dispense up to a 9-month supply of the drug or therapeutic equivalent, or any amount which covers the remainder of the plan year if the patient is covered by a health care plan, whichever is less.
    - For a refill in a plan year following the initial dispensing of a drug or therapeutic equivalent pursuant to paragraphs (a) and (b), dispense up to a 12-month supply of the drug or therapeutic equivalent or any amount which covers the remainder of the plan year if the patient is covered by a health care plan, whichever is less.
- The provisions of paragraphs (b) and (c) of subsection 1 only apply if:
    - The drug for contraception or the therapeutic equivalent of such drug is the same drug or therapeutic equivalent which was previously prescribed or ordered pursuant to paragraph (a) of subsection 1; and
    - The patient is covered by the same health care plan.
- If a prescription or order for a drug for contraception or its therapeutic equivalent limits the dispensing of the drug or therapeutic equivalent to a quantity which is less than the amount otherwise authorized to be dispenses pursuant to subsection 1, the pharmacist must dispense the drug or therapeutic equivalent in accordance with the quantity specified in the prescription or order.
- Therapeutic equivalent means a drug which:
    - Contains and identical amount of the same ingredients in the same dosage and method of administration as another drug.
    - Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and
    - Meets any other criteria required by the FDA for classification as a therapeutic equivalent.
- A pharmacist may, in his or her professional judgment and pursuant to a valid prescription that specifies an initial amount of less than a 90-day supply or a drug (other than a controlled substance) followed by periodic refills of the initial amount of the drug, dispense not more than a 90-day supply of the drug if: (a) The patient has used an initial 30-day supply of the drug or the drug has previously been prescribed to the patient in a 90-day supply; (b) The total number of dosage units that are dispensed does not exceed the total number of dosage units, including refills, that are authorized on the prescription by the prescriber.

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. (See also the *Coordination of Benefits* section).

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.

Coronavirus Aid, Relief, and Economic Security Act (CARES Act); Families First Coronavirus Response Act (HR 6201) ("CARES Act").

This Plan shall comply with the CARES Act to the extent it applies. The Plan shall cover COVID-19 diagnostic testing and certain COVID-19 testing related items and services without cost sharing (deductibles, coinsurance, copayments), prior authorization, or other medical management requirements. This coverage includes the COVID-19 diagnostic test and COVID-19 diagnostic testing-related visit to order or administer the test. A testing related visit may occur in a physician's office, via telehealth, in an urgent care center or emergency room. In-network and Out-of-Network costing sharing will not apply. To the extent it applies, this Plan will cover qualifying items, services, or immunizations intended to prevent or mitigate COVID-19 (qualifying coronavirus preventive services) without imposing cost sharing. To be covered, the services must be either

(i) an evidenced-based item or service that has a "A" or "B" rating in the current recommendations from the United States Preventive Services Task Force, or
(ii) an immunization with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Expansion of Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), and Health Reimbursement Arrangements (HRAs):

Effective January 1, 2020, individuals may use HSAs, FSAs, and HRAs to purchase over-the-counter medicines without a prescription, and to purchase menstrual care products. To the extent it applies, this Plan shall allow early prescription refills to ensure members have sufficient supply of medication on hand. The refill shall stay consistent with the standards' supply previously filled by the member as allowed by the Plan (e.g., 30- or 90-days' supply). To the extent it applies, the Plan shall allow HSA members to continue to contribute to their 2019 HSAs to July 15, 2020 in accordance with IRS Notice IR-2020-58) This Act is effective March 18, 2020 to apply retroactively.

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 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.

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 www.pebp.state.nv.us) and are not covered under the medical expense coverage of this Plan unless the medical Plan specifically indicates otherwise in the *Schedule of Medical 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 child of a participant under the age of 26 years, including:

- Natural child,
- 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
- Child under age 19 years for whom you have legal guardianship under a court order; or
- Over age of 26 years if the adult child is deemed permanently disabled, has maintained continuous medical coverage, is incapable of self-sustaining employment and depends chiefly on the participant or the participant's spouse or domestic partner for support and maintenance, and claimed on the participant's previous year's tax return as a dependent. (NAC 287.312)

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 mental retardation, cerebral palsy, epilepsy, neurological disorder, or psychosis.

Domestic Partner: As defined by NRS 122A.030.

Drug: See the definition for prescription drug.

Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and 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; and the charges for them are usual and customary and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule; and coverage for the services or supplies is not excluded (as provided in the *Exclusions* section); and the Plan Year maximum benefits for those services or supplies has not been reached.

Emergency: See the definition for Medical Emergency.

Emergency Care: Medical and health services provided for a medical condition that manifests itself 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:

- Placing the health or survival of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

This Plan does not require precertification for medically necessary emergency services provided at any hospital in accordance with NRS 695G.170. For information, refer to the separate PEBP Health and Welfare Wrap Document available at www.pebp.state.nv.us.

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.

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: Enteral Formulas is subject to NRS 689B.0353.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Experimental and/or Investigational Services: NRS 695G.173 Required provision concerning coverage for treatment received as part of clinical trial or study.

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 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."
- Nevada Statutes mandate the following criteria be met in cases of Cancer and Chronic Fatigue Syndrome:
    1. A policy of health insurance must provide coverage for medical treatment in a clinical study or trial if:
        a. Treatment is for either Phase I, II, III, IV cancer or Phase II, III, IV Chronic Fatigue Syndrome.
        b. Study is approved by:
            i. Agency of National Institute of Health.
            ii. A cooperative group (see bill for exact definition).
            iii. FDA for new investigational drug
            iv. US Dept. of Veteran Affairs.
            v. US Dept. of Defense.
        c. Health care provider and facility have authority to provide the care for Phase I cancer.
        d. Health care provider and facility have experience to provide the care for Phase II, III, IV cancer or chronic fatigue syndrome.
        e. No other treatment considered a more appropriate alternative.
        f. Reasonable expectation based on clinical data that treatment will be at least as effective as other treatments.
        g. Study is conducted in Nevada.
        h. Participant signs a statement of consent that he has been informed of:
            i. The procedure to be undertaken.
            ii. Alternative methods of treatment.
            iii. Associated risks of treatment.
    2. Coverage for medical treatment is limited to:
        a. A drug or device approved for sale by the FDA.
        b. Reasonably necessary required services provided in treatment or as a result of complications to the extent that they would have otherwise been covered for Phase II, III, IV cancer or chronic fatigue syndrome.
        c. The cost of any routine health care services that otherwise would have been covered for an insured for Phase I cancer.
        d. Initial consultation; and

e. Clinically appropriate monitoring.

3. Treatment not required to be covered if provided free by sponsor.
4. Coverage does not include:
    a. Portions customarily paid by other government or industry entities.
    b. A drug or device paid for by manufacturer or distributor.
    c. Excluded health care services.
    d. Services customarily provided free in study.
    e. Extraneous expenses related to study.
    f. Expenses for persons accompanying participant in study.
    g. Any item or service provided for data collection not directly related to study.
    h. Expenses for research management of study.

NOTE: To determine how to obtain a precertification of any procedure that might be deemed to be experimental and/or investigational, see the *precertification* in the *Utilization Management* section.

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-along 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/ Gender Identity Disorder/ Transsexualism/ Transgender/ Gender Nonconforming: Gender Dysphoria, as defined by the American Psychiatric Association, refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. Generally, it is a condition in which the person has the desire to live as a member of the opposite sex and progressively take steps to live in the opposite sex role full-time.

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 Medical 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.

Gestational Carrier: Gestational carrier means an adult woman who is not an intended parent and who enters into a gestational agreement to bear a child conceived using the gametes of other persons and not her own. NRS 126.580

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, 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:

- 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 very 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 life expectancy of 6 months or less. 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.
    c. 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.

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 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 Sound and Natural Teeth (ISNT): 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 (see also the definition of Sound and Natural Teeth).

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 www.pebp.state.nv.us. You may also call the number of 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.

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).

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 Emergency: The sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child, impairment of a bodily function or dysfunction of any bodily organ or part.

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:

- Is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- Is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American Medical and Dental standards; and
- Is determined by the Plan Administrator or its designee to meet all the following requirements:
- It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
- It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
- It is an appropriate service or supply given the patient's circumstances and condition; and

- It is a cost-efficient supply or level of service that can be safely provided to the patient; and
- It is safe and effective for the illness or injury for which it is used.

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 Emergency Services: NRS 695G.170 Required provision concerning coverage for medically necessary emergency services; prohibitions.

- Each managed care organization shall provide coverage for medically necessary emergency services provided at any hospital.
- A managed care organization shall not require precertification for medically necessary emergency services.
    - As used in this section, "medically necessary emergency services" means health care services that are provided to an insured by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:
      (a) Serious jeopardy to the health of an insured.

(b) Serious jeopardy to the health of an unborn child.
(c) Serious impairment of a bodily function; or
(d) Serious dysfunction of any bodily organ or part.

- A health care plan subject to the provisions of this section that is delivered, issued for delivery, or renewed on or after October 1, 1999, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which conflicts with this section is void.

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.

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.

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.

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 Medical Benefits* are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Non-Participating Provider: A health care provider who does not participate in the Plan's Preferred Provider Organization (PPO).

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.

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 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: 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 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. NAC 287.095

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.

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 amount of 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.

Positive Annual Open Enrollment Period: This process requires that each eligible employee or eligible retiree affirmatively make his or her benefit elections during the PEBP annual enrollment period. Even if you do not want to make any coverage changes, you must affirmatively make your elections, or you will be defaulted to self-coverage only under the PEBP base Plan.

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.

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 Physician (PCP): A physician in family practice, internal medicine, obstetrics and gynecology and pediatrics.

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 established in accordance with NRS 287.0402 to 287.049, inclusive.

Prophylactic Surgery: A surgical procedure performed for

1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or
2) 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).

Prostate Screening: NRS 695G.177 - Required provision concerning coverage for prostate cancer screening.

- A health care plan issued by a managed care organization that provides coverage for the treatment of prostate cancer must provide coverage for prostate cancer screening in accordance with:
  - The guidelines concerning prostate cancer screening which are published by the American Cancer Society; or

  - Other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.
- A health care plan issued by a managed care organization that provides coverage for the treatment of prostate cancer must not require an insured to obtain precertification for any service provided pursuant to subsection.
- Any evidence of coverage for a health care plan issued by a managed care organization that provides coverage for the treatment of prostate cancer which is delivered, issued for delivery, or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which conflicts with subsection 1 is void.

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. 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.

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
- 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.

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: The maximum amount the Plan will pay for a specific covered healthcare service as determined by the Plan Administrator.

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, and that is performed by a licensed therapist acting within the scope of his or her license. See the *Schedule of Medical 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

(a) The cancellation or discontinuance of coverage has only a prospective effect; or

(b) 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; or

(c) fraud.

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.

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.

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.

Sound and Natural Teeth: Sound and natural teeth (not dentures, bridges, pontics, or artificial teeth) that are free of active or chronic clinical decay; and have at least 50% bony support; and are functional in the arch; and have not been excessively weakened by previous dental procedures.

Special Food Product: [NRS 689B.0353] 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.

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, 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 to restore normal speech or to correct dysphagia or swallowing defects and disorders due to illness, injury, or surgical procedure. Speech therapy for functional purposes, including (but not limited to) a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays/disorders are excluded from coverage.

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 (opposite sex or same sex) as determined by the laws of the State of Nevada**.** 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: 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 Senate Bill 290 from the 2021 Legislative Session:

1. An insurer that offers or issues a policy of group health insurance which provides coverage of a prescription drug for the treatment of cancer or any symptom of cancer that is part of a step therapy protocol shall allow an insured who has been diagnosed with stage 3 or 4 cancer or the attending practitioner of the insured to apply for an exemption from the step therapy protocol. The application process for such an exemption must:

   (a) Allow the insured or attending practitioner, or a designated advocate for the insured or attending practitioner, to present to the insurer the clinical rationale for the exemption and any relevant medical information.

   (b) Clearly prescribe the information and supporting documentation that must be submitted with the application, the criteria that will be used to evaluate the

request and the conditions under which an expedited determination pursuant to subsection 4 is warranted.

(c) Require the review of each application by at least one physician, registered nurse or pharmacist.

2. The information and supporting documentation required pursuant to paragraph (b) of subsection 1:

(a) May include, without limitation:

(1) The medical history or other health records of the insured demonstrating that the insured has:

(I) Tried other drugs included in the pharmacological class of drugs for which the exemption is requested without success; or

(II) Taken the requested drug for a clinically appropriate amount of time to establish stability in relation to the cancer and the guidelines of the prescribing practitioner; and

(2) Any other relevant clinical information.

(b) Must not include any information or supporting documentation that is not necessary to make a determination about the application.

3. Except as otherwise provided in subsection 4, an insurer that receives an application for an exemption pursuant to subsection 1 shall:

(a) Make a determination concerning the application if the application is complete or request additional information or documentation necessary to complete the application not later than 72 hours after receiving the application; and

(b) If it requests additional information or documentation, make a determination concerning the application not later than 72 hours after receiving the requested information or documentation.

4. If, in the opinion of the attending practitioner, a step therapy protocol may seriously jeopardize the life or health of the insured, an insurer that receives an application for an exemption pursuant to subsection 1 must make a determination concerning the application as expeditiously as necessary to avoid serious jeopardy to the life or health of the insured.

5. An insurer shall disclose to the insured or attending practitioner who submits an application for an exemption from a step therapy protocol pursuant to subsection 1 the qualifications of each person who will review the application.

6. An insurer must grant an exemption from a step therapy protocol in response to an application submitted pursuant to subsection 1 if:

(a) Any treatment otherwise required under the step therapy or any drug in the same pharmacological class or having the same mechanism of action as the drug for which the exemption is requested has not been effective at treating the cancer or symptom of the insured when prescribed in accordance with clinical indications, clinical guidelines or other peer-reviewed evidence;

(b) Delay of effective treatment would have severe or irreversible consequences for the insured and the treatment otherwise required under the step therapy is

not reasonably expected to be effective based on the physical or mental characteristics of the insured and the known characteristics of the treatment;

(c) Each treatment otherwise required under the step therapy:

(1) Is contraindicated for the insured or has caused or is likely, based on peer-reviewed clinical evidence, to cause an adverse reaction or other physical harm to the insured; or

(2) Has prevented or is likely to prevent the insured from performing the responsibilities of his or her occupation or engaging in activities of daily living, as defined in 42 C.F.R. § 441.505;

(d) The condition of the insured is stable while being treated with the prescription drug for which the exemption is requested and the insured has previously received approval for coverage of that drug; or

(e) Any other condition for which such an exemption is required by regulation of the Commissioner is met.

7. If an insurer approves an application for an exemption from a step therapy protocol pursuant to this section, the insurer must cover the prescription drug to which the exemption applies in accordance with the terms of the applicable policy of group health insurance. The insurer may initially limit the coverage to a 1-week supply of the drug for which the exemption is granted. If the attending practitioner determines after 1 week that the drug is effective at treating the cancer or symptom for which it was prescribed, the insurer must continue to cover the drug for as long as it is necessary to treat the insured for the cancer or symptom. The insurer may conduct a review not more frequently than once each quarter to determine, in accordance with available medical evidence, whether the drug remains necessary to treat the insured for the cancer or symptom. The insurer shall provide a report of the review to the insured.

8. An insurer shall post in an easily accessible location on an Internet website maintained by the insurer a form for requesting an exemption pursuant to this section.

9. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2022, has the legal effect of including the coverage required by this section, and any provision of the policy that conflicts with this section is void.

10. As used in this section, "attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the cancer or any symptom of such cancer of an insured.

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:

1. 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
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
5. 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
6. 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 standard telephone, facsimile, or electronic mail. NRS 629.515

NRS 695G.162 Required provision concerning coverage for services provided through telehealth**.**

- A health care plan issued by a managed care organization for group coverage must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.
- A managed care organization shall not:
  (a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1.
  (b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1.
  (c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or
  (d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.
- A health care plan of a managed care organization must not require an insured to obtain precertification for any service provided through telehealth that is not required for the service when provided in person. Such a health care plan may require prior authorization for a service provided through telehealth if such precertification would be required if the service were provided in person or by other means.
- The provisions of this section do not require a managed care organization to:
  (a) Ensure that covered services are available to an insured through telehealth at an originating site.
  (b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or
  (c) Enter into a contract with any provider of health care or cover any service if the managed care organization is not otherwise required by law to do so.

5. Evidence of coverage that is delivered, issued for delivery, or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which conflicts with this section is void.
6. As used in this section:
   (a) "Distant site" has the meaning ascribed to it in NRS 629.515.
   (b) "Originating site" has the meaning ascribed to it in NRS 629.515.
   (c) "Provider of health care" has the meaning ascribed to it in NRS 439.820.
   (d) "Telehealth" has the meaning ascribed to it in NRS 629.515.

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. Examples include Doctor on Demand. The program provides telephone and online video consultations with a physician and serves patients of all ages.

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.

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.

Topical Ophthalmic Products: NRS 695G.172 -Required provision concerning coverage for early refills of topical ophthalmic products.

1. A managed care organization which offers or issues a health care plan that provides coverage for prescription drugs shall not deny coverage for a topical ophthalmic product which is otherwise approved for coverage by the managed care organization when the insured, pursuant to NRS 639.2395, receives a refill of the product:
   (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.
2. The provisions of this section do not affect any Deductibles, copayments or Coinsurance authorized or required pursuant to the health care plan.

3. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery, or renewed on or after January 1, 2016, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal which conflicts with this section is void.
4. As used in this section, "topical ophthalmic product" means a liquid prescription drug which is applied directly to the eye from a bottle or by means of a dropper.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that 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 Medical 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.

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, or 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, that 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.

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 Medical 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.