LOW DEDUCTIBLE PPO PLAN
MASTER PLAN DOCUMENT

PLAN YEAR 2025

(EFFECTIVE JULY 1, 2024 – JUNE 30, 2025)

775-684-7000

702-486-3100

1-800-326-5496

https://pebp.nv.gov

Public Employees' Benefits Program
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Amendment Log

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

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), Exclusive Provider Organization (EPO) 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.

PEBP participants choosing this Plan should examine this document, the PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document (MPD), the Active Employee Health and Welfare Wrap Plan Document, the Retiree Health and Welfare Wrap Plan Document, the Section 125 Health and Welfare Benefits Plan Document, the Health Reimbursement Arrangement (HRA) Summary Plan Description (SPD), and the PEBP Enrollment and Eligibility Master Plan Document. These documents are available at https://pebp.nv.gov/ 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 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 Low Deductible PPO Plan (also referred to as the LD PPO Plan). The Low Deductible PPO 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 LD PPO Plan 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.

An independent Third-Party Claims Administrator pays the claims for the medical, dental and vision benefits. An independent Pharmacy Benefit Manager pays the claims for prescription drug benefits.

The Plan and this document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code (NAC) 287 and all other applicable provisions of Nevada Law. Additionally, PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA).

The Plan described in this document is effective **July 1, 2024**, and unless stated differently, replaces other PPO Plan documents/summary plan descriptions previously provided to you.

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

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. Members should keep informed of this document as the Plan is amended from time to time. 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 PEBP.

Suggestions for Using this Document:

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

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

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 https://pebp.nv.gov/.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan Master Plan Document and Summary of Benefits and Coverage for Individual and Family
- 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

- EPO Plan Master Plan Document and EPO Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description
- Health Reimbursement Arrangement Master Plan Document

Participant Rights

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.
- 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.

Summary of the LD PPO Components

Highlights of the Plan

The Low Deductible PPO Plan is a PEBP administered preferred provider organization (PPO) plan which provides both In-Network and Out-of-Network benefits. As a member, you receive coverage for many medically necessary services and supplies, subject to any Plan *Benefit Limitations 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 Out-of-Network benefits.
- Reimbursement for *Eligible Medical Expenses* described in this document (and as determined by the Plan Administrator) for participants residing permanently, part time, or while traveling outside of the United States. Refer to the *Out-of-Country Medical, Prescription Drug, and Vision Purchases* section for more information.
- Coverage for eligible preventive care services at 100% when using In-Network providers. Refer to the *Schedule of Benefits* 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 *https://pebp.nv.gov/*.

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)	$0	$4,000	$500	$10,600
Family	Family: $0 Individual family member: None	Family: $8,000 Individual family Member: $4,000	Family: $1,000 Individual family member: $500	$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 covered family members. The In-Network Family Deductible includes an "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), including amounts exceeding the Plan's reference-based pricing for hip and knee replacement, preauthorization penalties, and other out of pocket costs.

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 **$0**. 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 **$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 **$0** and includes a **$0** 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 **$0** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **$0** "Individual Family Member" Deductible (under no circumstances will one single family member be required to pay more than **$0** toward the **$0** Family Deductible). The **$0** 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 **$1,000** and includes a **$500** "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 **$1,000** Family Deductible is met; or the Plan will pay benefits for one single family member who has met the **$500** "Individual Family Member" Deductible (under no circumstances will one single family member be required to pay more than **$500** toward the **$1,000** Out-of-Network Family Deductible). The **$1,000** 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, except where prohibited by law.

Copayments

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

Out-of-Pocket Maximums

In-Network Out-of-Pocket Maximums

The In-Network Out-of-Pocket Maximum (OOPM) is the maximum amount you will pay for In-Network eligible medical and prescription drug expenses during the Plan Year. Member cost share (Deductible, copayments, and/or Coinsurance for Eligible Medical Expenses accumulate toward your OOPM. The OOPM for:

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

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

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

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

Out-of-Network Out-of-Pocket Maximum

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

- Individual (covered as self-only) is **$10,600.**

- Family coverage (participant plus one or more covered dependents) is **$21,200**. (The Family coverage tier does not include an embedded Individual Family Member OOPM.)

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

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

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

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

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

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

Description of In-Network and Out-of-Network

Provider Network

PEBP leases a network of preferred providers (PPO) through a contract with a vendor who maintains such a network. For more information, see the Participant Contact Guide 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 contracted PPO Network is responsible for credentialing providers by confirming public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

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

The provider network is subject to change. It is possible that you might not be able to obtain specific services from an In-Network provider. Or you might find that an In-Network 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.

Pursuant to NRS 695G.164, if a member is receiving medical treatment from a provider whose In-Network status changes during the course of treatment, the member may continue to receive treatment with that provider at In-Network rates under certain circumstances. See more detailed explanation in PPO Network Health Care Provider Services section.

In-Network Provider Benefits

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

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

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

Out-of-Network Provider Benefits

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

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

Other Providers

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

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

Out-of-Network Benefit Exceptions

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

If you are traveling outside your network and you need non-emergency 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.

Emergency Care

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

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

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

Other Exceptions

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

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

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

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

- Participant travels to an area not serviced by an In-Network provider within 50 miles.
- If a participant travels to an area serviced by an In-Network provider, the participant must use an In-Network provider to receive benefits at the In-Network benefit level.
- If there is a specialty not available inside the participant's eligible PPO network, benefits may be paid as In-Network.

Preferred Provider Organizations (PPO Network)

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

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

Service Area

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

Directories of Network Providers

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

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

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

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

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 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 the Plan's Maximum Allowable Charge, costs that do not exceed the Plan's reference based pricing for services performed at exclusive facilities; (as those terms are defined in the *Key Terms and Definitions* section of this document);
- Not services or supplies that are excluded from coverage (as provided in the Benefit Limitations and Exclusions section).
- Charges for services or supplies that do not exceed the Plan Year maximum benefits as shown in the Schedule of Benefits.

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 Copayments, Deductibles, or Coinsurance toward the amounts you incur that are eligible medical expenses. However, you are only required to pay copayments and coinsurance for eligible medical expenses up to the Plan year individual or family out-of-pocket maximum.

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

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

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

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 be more than the usual and customary charges.
- Determined to be more than the 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, excluded benefits as listed in the *Benefit Limitations and Exclusions* section, 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 Deductible or Out-of-Pocket Maximum.
- Preventive Care/Wellness benefits 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

Copayment, Deductible, and or Coinsurance requirements as outlined in this document and are described in more detail in the *Schedule of Benefits*.

With exception of services subject to the No Surprises Act, Out-of-network providers may bill you 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 90th day after:
  - The date of delivery; or
  - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Out-of-Country Medical, Prescription and Vision Purchases

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, providers in 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, determination of medical necessity, and the Plan's Maximum Allowable Charge. The review may include application of pertinent Food and Drug Administration (FDA) regulations. Out-of-country medication purchases are only eligible for reimbursement while traveling outside of the United States.

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
  - Usual and Customary or this 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 third-party 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 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 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 Reimbursement Arrangement (HRA)

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

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.*

PEBP will be funding an HRA for active employees enrolled in a qualifying PEBP plan for Plan Year 2025. **This is a one-time event.**

Funds in the HRA account may be used to pay for qualified medical expenses as defined by the IRS (see IRS Publication 502), other than premiums, including payment of Copay, Deductibles, Coinsurance, and other Out-of-Pocket qualifying healthcare expenses not covered by this Plan.

The HRA may only be used to pay or reimburse qualified Out-of-Pocket health care expenses incurred by the following individuals enrolled in this Plan (or other non-HRA group health coverage providing minimum value):

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

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

Any funds remaining in the 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 as long as the member maintains the same Plan.

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

Unlike a Flexible Spending Account (FSA), participants cannot be reimbursed from funds that are not yet available in the HRA. Any reimbursement from the HRA will be the lesser of the available HRA balance or the claim amount paid to the provider.

HRA funds are not portable between different plan types; participants cannot use HRA funds if they are no longer covered by the initial Plan with an HRA. If a participant terminates their coverage, the remaining balance in the HRA account will revert to PEBP, unless the qualified beneficiary elects COBRA. Participants enrolled with an HRA who change plans during the Open Enrollment period or during a Qualifying Life Event to a plan with an HSA and retirees who transition coverage to the Medicare Exchange will forfeit any remaining funds in the HRA account.

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

- They are eligible to enroll in and continue coverage under a PEBP plan; or
- Continue coverage under COBRA.
    - If a participant elects COBRA coverage, the HRA account will remain in place until COBRA coverage is terminated.

In the case of a retroactive coverage termination, any funds used from the 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 HRA balance and who transition to the Medicare Exchange will forfeit any remaining funds in the HRA on the last day of coverage under this Plan.

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

Timely Filing of HRA Claims

In accordance with NAC 287.610, claim requests must be submitted to the third-party claims 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 HRA-eligible coverage ends, 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 in accordance with NAC 287.610. HRA funds may not be used to pay premiums.

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

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

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 plans.

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

Utilization Management

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

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

PEBP, the third-party claim administrator, 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 care and services as specified in this Plan's *Summary of Benefits* and *Schedule of Benefits*. These include medical, mental health, behavioral health, 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 (sometimes referred to as a continued stay review) is the ongoing assessment of health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or skilled nursing or sub-acute facility. When you are receiving medical services in a hospital or other 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 is medically necessary. The UM company will also help coordinate your medical care with other healthcare benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services, 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, expenses incurred after the notification will be your responsibility. If your hospital stay is determined not to be medically necessary, no benefits will be paid on any related hospital, medical or surgical expense. You may also appeal the determination (refer to the *Appealing a Utilization Management determination* section).

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 treatments that would have been authorized under the utilization management program.

Case Management

Case management is a voluntary process administered by the UM company. Its 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 quality, 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. Case management is available for individuals diagnosed with sickle cell and its variants (NRS 695G.174,) among other conditions. Case management is also available for a disability resulting from a mental health or substance use disorder diagnosis.

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 https://pebp.nv.gov/.

Precertification (Prior Authorization) Process

Precertification or prior authorization review is a procedure administered by the UM company to assure health care services meet or exceed accepted standards of care. In certain cases, as set forth below, 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, benefits may be reduced, even if the service is medically necessary.** The UM company uses nationally recognized guidelines and criteria as standard measurement tools to determine whether benefits are approved and/or pre-certified.

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. 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)

Inpatient Admissions

- Acute inpatient or observation
- Long-Term Acute Care
- Rehabilitation

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

Outpatient and Physician – Surgery

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

However, when services are not performed at an In-Network, contracted ASC, procedures will require prior authorization. This is commonly referred to as Site of Service. Examples of services that require prior authorization include, but are not limited to:

- Back Surgeries and hardware related to surgery
- Total and remaining Hip and Knee Surgeries
- Biopsies (excluding skin, colonoscopy and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Oophorectomy, unilateral and bilateral
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Surgeries to treat Gender Dysphoria
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery
- Sleep apnea related surgeries, limited to:
  - Radiofrequency ablation (Coblation, Somnoplasty)
  - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic) and reconstruction surgery
- Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Varicose vein surgery/sclerotherapy

- Any procedure deemed to be Experimental and/or Investigational (provider must indicate on the pre-certification request that the service/procedure is Experimental and/or Investigational and/or part of a clinical trial)
- Intraoperative Neuro Monitoring

Prophylactic surgery

Outpatient and Physician – Diagnostic Services

- CT, PET, SPEC, and MRI
- Capsule endoscopy
- Genetic Testing, including:
  - BRCA
  - Biomarker testing for the diagnosis, treatment, appropriate management, and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.

Requests for precertification for biomarker testing will be responded to within 72 hours after receipt, or within 24 hours if the provider indicates the request is urgent.

Outpatient and Physician – Continuing Care Services

- Applied Behavior Analysis (ABA) Therapy for Medical, Mental Health, and Substance Use Disorder
- Electroconvulsive Therapy (ECT)
- Chemotherapy
  - Oral Chemotherapy to be reviewed by Pharmacy Benefit Manager
- Radiation Therapy
- Oncology and transplant related injections, infusions, and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric Oxygen
- Home Health Care
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Durable Medical Equipment exceeding $1,000
  - Prior authorization is based on overall cost to the plan and/or purchase price, not the amount billed for monthly rental. DME rental to purchase in accordance with Medicare guidelines.
- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables and infusions excluding services reviewed by the PBM
- Intensive Outpatient programs, including partial hospitalization programs
- Sickle Cell Disease
- Vein Therapy

- Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a combined visit limit of 90 visits between the types of therapy per Plan Year.
    - Visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder.

Services Not Requiring Precertification (Prior Authorization)

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

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

The UM company 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. 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 Utilization Management Determination* section).

Centers of Excellence Benefit (Voluntary)

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

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

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

For details of how this benefit works, covered expenses, and limitations and disclosures, please see the Centers of Excellence Wrap Plan Document online at https://pebp.nv.gov/.

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

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).

2nd.MD

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

Hospital Admission

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

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 determines 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

Emergency and Urgent Hospital Admissions includes 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

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

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 Maximum Allowable Charge. Amounts exceeding this Plan's established cost threshold will not apply to your annual Deductible or Out-of-Pocket Maximum.

Air Ambulance Services

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

See the Utilization Management section for air ambulance precertification requirements.

Air/Flight Schedule Inter-Facility Transfer

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 if the transport is deemed medically necessary. The following conditions apply:

- Services via any form of air/flight for inter-facility transfers must be pre-certified before transport of the participant to another hospital or facility, and the participant is in a hospital or other health care facility under the care or supervision of a licensed health care provider; and
- Inaccessibility to ground ambulance transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

Emergency Air Ambulance

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

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

See *Air Ambulance Services* and the *No Surprises Act* for details on plan benefits and coverage.

Gender Dysphoria

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

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

- Notification to the participant that the precertification process begins with the initial contact to the UM company.
- Advising participants of providers who specialize in this type of treatment.

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

Health Care Services and Supplies Review

A participating provider, including 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 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.

Summary of Benefits

To determine the benefit limitations for any health care service or supply, review the Summary and Schedule of Benefits listed below.

To determine precertification requirements, refer to the *Utilization Management* section.

Copay applies to Primary Care Physician (PCP) and Specialist office visits for evaluation and management services only; imaging, surgery, and other services provided during a PCP or Specialist office visit are subject to the Plan Year Deductible and Coinsurance.

Benefit Description	In-Network	Out-of-Network
Physician Office Visits		
Primary Care Physician (PCP) Office Visit	$30 Copay	Plan pays 50% after Deductible
Specialist Services (including Allergy Services)	$50 Copay	Plan pays 50% after Deductible
No referral is required for these visits. Imaging, surgery, and other services provided in an office setting subject to Deductible and Coinsurance.		

Benefit Description	In-Network	Out-of-Network
ACA Wellness/Preventive Office Visits and Preventive Screenings The Plan covers recommended preventive care services without participant cost-sharing when services are received by In-Network providers. For more details see *Preventive Services* in the *Summary of Benefits*.		
Primary Care Wellness Visit	$0 Copay	Not Covered
Obstetrics and Gynecology ACA Services	$0 Copay	Not Covered
Prenatal and Postnatal Office Visit	$0 Copay	Not Covered
No referral is required for these visits. Imaging, surgery, and other services provided in an office setting subject to Deductible and Coinsurance		

Benefit Description	In-Network	Out-of-Network
Wellness/Preventive Office Visits and Preventive Screenings		
Mammography screening	$0 Copay	Not Covered
Limit: One 2D or 3D mammogram screening per Plan Year for women aged 40 years and older.		
Papanicolaou (Pap) test	$0 Copay	Not Covered
Prostate Specific Antigen (PSA) screening	$0 Copay	Not Covered
Colorectal screening	$0 Copay	Not Covered
Colorectal Screening: Starting at age 45 in accordance with the American Cancer Society's screening guidelines.		
Counseling for sexually transmitted infections (STI), HIV counseling and testing	$0 Copay	Not Covered
Breastfeeding support, supplies, and counseling	$0 Copay	Not Covered
*Contact the third-party claims administrator for the purchase of covered breast pumps. Rental for heavy duty electrical (hospital grade) covered only when medically necessary and only during the newborn's inpatient hospital stay***.**		
Screening for interpersonal and domestic violence	$0 Copay	Not Covered
Contraceptives/In-office counseling	$0 Copay	Not Covered
FDA approved injections, implants, and contraceptive devices not covered under the pharmacy benefits.		
Screening for Gestational Diabetes	$0 Copay	Not Covered
Real Appeal	$0 Copay	Not Covered
High-risk Human Papillomavirus (HPV) testing	$0 Copay	Not Covered
For more information, refer to the Preventive Services in the Schedule of Benefits section. An office visit copay may apply if services provided during the visit include additional services that are not preventive services.		

Benefit Description	In-Network	Out-of-Network
Hospital Facility Services		
Inpatient Hospital Admission	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Inpatient Delivery Postpartum/Newborn Care Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Outpatient Observation	$500 Copay	Plan pays 50% after Deductible
Outpatient Observation period lasting more than 23 hours will be considered and paid as an inpatient confinement.		
Outpatient Surgery	$500 Copay	Plan pays 50% after Deductible
Other services, related to and during the outpatient surgery on that date, are not subject to the deductible and coinsurance.		
Skilled Nursing Facility Limit: 100 days per Plan Year	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Rehabilitation, Habilitation Facility **	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Hospital facility services require precertification. In emergencies in which a member is admitted to hospital for an inpatient stay, the UM company must be notified with 24 hours, the next business day following the admission. ***See the Utilization Management section for precertification requirements, including emergency hospital admissions.*** ****Rehabilitation, Habilitation Facility services are limited to 60 days per Plan Year; however, visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder.***		

Benefit Description	In-Network	Out-of-Network
Urgent Care and Emergency Services		
Urgent Care Services*	$80 Copay	$80 Copay, subject to the Plan's Maximum Allowable Charge
Emergency Room Services**	$750 Copay	$750 Copay *

When using Out-of-Network urgent care services, you are responsible for paying this Plan's copayment amount, plus any amounts exceeding the Plan's Maximum Allowable Charge. See Key Terms and Definitions for more information.
***Emergency Room services: If admitted to the hospital, the ER Copay is waived and the Inpatient Hospital Copay applies.*

Urgent and Emergency Services		
Ambulance (ground/water)	Plan pays 80% after Deductible	Plan pays 80% after Deductible, subject to the Maximum Allowable Charge
Ambulance (air)	Plan pays 80% after Deductible	Plan Pays 80% after Deductible

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

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

The Out-of-Network Ground Ambulance Provider Bills	**$2,000**
The Plan Pays 80% of $1,000 × 140%	**$1,120**
The Out-of-Network Provider May Bill You For	**$ 880**

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

See the Utilization Management section for air ambulance precertification requirements.

Benefit Description	In-Network	Out-of-Network
Outpatient Specialty Imaging and Diagnostic Testing		
Computer Tomography (CT) Scan	Plan pays 80% after Deductible	Plan pays 50% after Deductible

Positron Emission Tomography (PET) Scan	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Magnetic Resonance Imaging (MRI/MRA)	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Nuclear Medicine	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Angiogram and Myelogram	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Outpatient Specialty Imaging and Diagnostic testing: When performed Out-of-Network, you are responsible for the Plan's cost-share and any amount exceeding the Plan's Maximum Allowable Charge. See the Utilization Management section for precertification requirements.		

Benefit Description	In-Network	Out-of-Network
Non-Specialty Imaging and Diagnostic Testing (Including X-rays and Ultrasounds; except Specialty Imaging and Diagnostic Testing)		
Services provided in a Primary Care Physician Office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Services provided in a Specialty Care Physician's Office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Services provided in a hospital outpatient setting	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Diagnostic Mammography	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Non-Specialty Imaging and Diagnostic testing: When performed Out-of-Network, you are responsible for the Plan's cost-share and amounts exceeding the Plan's Maximum Allowable Charge.		

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		
General Laboratory Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Routine/Preventive Lab Testing*	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Routine and Preventive Lab Services **** Routine/preventive lab services must be performed at a freestanding, non-hospital-based lab facility.*** • Medically necessary routine labs when ordered by a physician as part of comprehensive medical care. • Preventive laboratory services such as basic metabolic panel, lipid panel, etc. • Routine/preventive lab tests performed at an outpatient hospital or hospital-based free-standing lab facility/draw station are not covered.		
Pre-admission Lab Testing Services**	Plan pays 80% after Deductible	Plan pays 50% after Deductible

Pre-Admission Lab Testing Services		
***Pre-admission lab testing performed on an outpatient basis at a hospital-based lab or free-standing hospital-based lab draw station within 7 days prior to a scheduled hospital admission or outpatient surgery. Testing must be related to the sickness or injury for which admission or surgery is planned.*		
Outpatient Rehabilitation and Habilitative Therapy Services Outpatient Speech, Occupational, and Physical Therapy		
Speech Therapy	$50 Copay per Visit	Plan pays 50% after Deductible
Occupational Therapy	$50 Copay per Visit	Plan pays 50% after Deductible
Physical Therapy	$50 Copay per Visit	Plan pays 50% after Deductible
Outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) is subject to copay for each therapy type. *Precertification required; speech, occupational, and physical therapy visits are limited to a combined 90 visits based on distinct visit-types per Plan Year. Visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder..*		

Benefit Description	In-Network	Out-of-Network
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and Pulmonary rehabilitation	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Dialysis	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Wound Therapy	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Chemotherapy Treatment	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Radiation therapy (Outpatient hospital/facility, or physician's office)	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Infusion Therapy (home/outpatient, including specialty drugs)	Plan pays 70% after Deductible	Plan pays 50% after Deductible
See the Utilization Management section for precertification requirements.		

Benefit Description	In-Network	Out-of-Network
Hinge Health		
Digital Musculoskeletal (MSK) Care	**$0 copay; not subject to deductible**	Not Covered

Benefit Description	In-Network	Out-of-Network
Surgical Services		
Performed in a Primary Care Physician's office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Performed in a Specialty Care Physician's office	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Performed in same-day surgery facility or Ambulatory Surgery Center (ASC)	$500 Copay	Plan pays 50% after Deductible
See the Utilization Management section for surgical services requiring precertification.		

Benefit Description	In-Network	Out-of-Network
Medical Supplies, Equipment, and Prosthetics		
Durable Medical Equipment	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Durable Medical Equipment (DME): Limited to one purchase, repair, or replacement of a specific item of DME every 3 years. DME rental to purchase in accordance with Medicare guidelines. The purchase or rental of DME, including oxygen related equipment in excess of $1,000 requires precertification.		
Orthopedic and prosthetic devices	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Orthopedic and prosthetic devices: Limited to a single purchase of a type of prosthetic device, including repair and replacement, every 3 years. Orthopedic and prosthetic devices in excess of $1,000 require precertification.		
Hearing Aids	$50 Copay per Device	$50 Copay per Device

Hearing Aids: Coverage for medically necessary, FDA approved air conduction hearing aids. Subject to a $50 Copay per device, Maximum benefit $1,500 per device, per each ear, every 3 years.		
Special Food Product	Plan pays 80% after Deductible	Plan pays 50% after Deductible
*See **Enteral Formulas and Special Food Products** in the Schedule of Benefits.*		
Enteral Formula	Plan pays 80% after Deductible	Plan pays 50% after Deductible
*Enteral Formula for the treatment of inherited metabolic disease. See **Enteral Formulas and Special Food Products** in the Schedule of Benefits.*		

Mental/Behavioral Health Treatment		
Inpatient/Residential Rehabilitation	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Intensive Outpatient Treatment Program	Plan pays 100% after Deductible	Plan pays 50% after Deductible
Partial Hospitalization Program	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Applied Behavioral Therapy	Plan pays 100% after Deductible	Plan pays 50% after Deductible
Outpatient treatment	Plan pays 100% after Deductible	Plan pays 50% after Deductible
Psychological testing	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Refer to the Utilization Management section for precertification requirements.		

Benefit Description	In-Network	Out-of-Network
Other Medical Services – Doctor on Demand, Telehealth, 2nd.MD		
	Doctor on Demand Telemedicine Visit	
Medical Visit	$10 Copay per Visit	Not Covered
Psychology Visit (25-minutes)	$20 Copay per Visit	Not Covered
Psychologist Visit (50 -minutes)	$30 Copay per Visit	Not Covered

Psychiatrist Visit (45 minutes/initial visit)	$30 Copay per Visit	Not Covered
Psychiatry Visit (15-minute follow-up visit)	$20 Copay per Visit	Not Covered
Telehealth Visit		
Primary Care Visit	$30 Copay per Visit	Plan pays 50% after Deductible
Specialist Care Visit	$50 Copay per Visit	Plan pays 50% after Deductible
2nd.MD (Second Opinion Services)		
2nd.MD (Second Opinion Services)	$0 Copay per Visit	Not Covered

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Chiropractic (Spinal manipulation services)	$50 Copay per Visit	Plan pays 50% after Deductible
Chiropractic and spinal manipulation services: Limited to 20 office visits per Plan Year.		
Acupuncture, Acupressure services	$50 Copay per Visit	Plan pays 50% after Deductible
Acupuncture and acupressure services: Limited to 20 visits (combined) per Plan Year, 100 visits (combined) per lifetime.		

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Home Health Care	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Home Health Care: Limited to 60 visits per Plan year; may provide for private duty nursing in the home; requires precertification. Additional visits are subject to preauthorization by the UM company.		

Office-based infertility services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Temporomandibular Joint (TMJ) Disorder Services*		
Office-based services (excluding surgical services)	**Specialist Visit:** $50 Copay **Other office-based services:** Plan pays 80% after Deductible	Plan pays 50% after Deductible
TMJ Surgical Services (including surgical services)	**Outpatient Surgery:** $500 Copay **Inpatient:** Plan pays 80% after Deductible	Plan pays 50% after Deductible
TMJ disorder and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Limited to two (2) surgeries in a lifetime.		

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Hospice	Plan pays 80% after Deductible	Plan pays 50% after Deductible
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. For outpatient bereavement counseling services, see Hospice Services in the Schedule of Benefits. Precertification is required for both inpatient and outpatient hospice services exceeding six (6) months. *For a description of the hospice care benefits, see Hospice Services in the Schedule of Benefits.*		

Benefit Description	In-Network	Out-of-Network
Obesity Care Management (OCM) Program (Disease Management Program)		

Weight Loss Medication	*Preferred -Retail 30-Day Supply	Home Delivery 90-Day Supply*	
Preferred/Formulary Generic	$0 Copay	$0 Copay	Not Covered
Preferred/Formulary Brand	$20 Copay	$40 Copay	Not Covered
Non-Preferred/Non-Formulary Brand	$75 Copay	$150 Copay	Not Covered

*__Preferred Retail Network__ *Pharmacies: Copayments apply if you fill your prescription at a* __Preferred Retail Network__ *retail pharmacy. If you fill your prescription at a non-*__Preferred Retail Network__ *retail pharmacy, you will pay an additional $10 per prescription. If you currently use a non-*__Preferred Retail Network__ *pharmacy and you want to avoid the $10 upcharge, call a* __Preferred Retail Network__ *pharmacy to transfer your prescription. See the Schedule of Pharmacy Benefits for instructions on how to find a* __Preferred Retail Network__ *pharmacy. Certain weight loss medications may not be available in 90-day supply. Contact Express Scripts for information about your prescribed medication.*

* Retail 90-day Supply is three (3) times the copay for the 30-day supply

Benefit Description	In-Network	Out-of-Network
Obesity Care Management (OCM) Program (Disease Management Program)		
Office Visit (OCM weight loss provider)	$0 Copay	Not Covered
Laboratory test	$0 Copay	Not Covered
Outpatient laboratory test services as determined by your weight loss provider (and as covered under this Plan). Outpatient laboratory tests must be performed at an in-network, free-standing, non-hospital-based lab facility such as Lab Corp or Quest. See Outpatient Laboratory Services for more information.		
Nutritional Counseling Services	$0 Copay	Not Covered
Nutritional Counseling Services are covered for enrolled OCM participants who are actively engaged in the program. Nutritional counseling services must be provided by a registered dietician or nutritionist. The frequency of the nutritional counseling services will be determined by the third-party claims administrator and will be based on medical necessity and engagement in the OCM program.		
OCM benefits subject to requirements/compliance with the OCM program as indicated in the Schedule of Benefits Section.		

Benefit Description	In-Network	Out-of-Network
Vision Care Services		
Vision Screening Exam (preventative)	$10 Copay	$10 Copay
Limited to one, preventative exam per Plan Year, per covered individual. The maximum benefit this Plan will pay per Plan Year, per covered individual is $100.		
Prescription eyewear	$10 Copay	$10 Copay
Single vision, bifocal and trifocal lenses, and prescription contact lenses. *Eyeglasses, or contact lenses in lieu of eyeglasses, limited to $100 every 24 months.*		

Prescription Drug Benefits			
In-Network Pharmacy Benefits			
	Preferred Retail Network **Pharmacies*** (30-Day Supply)	**Smart90 Retail Pharmacies** (90-Day Supply)	**Home Delivery Express Scripts Pharmacy** (90-Day Supply)
Preferred Formulary Generic	$10 Copay	$20 Copay	$20 Copay
Preferred Formulary Brand	$40 Copay	$80 Copay	$80 Copay
Non-Preferred/Non-Formulary Brand	$75 Copay	$150 Copay	$150 Copay
Specialty Drugs			
Specialty Drugs Accredo Specialty Mail Order Pharmacy	N/A	N/A	You pay 30% after Deductible for drugs on the SaveOnSP program. OR Copay limit of $100 min and $250 max applies (30-Day Supply)

Preferred Retail Network** *Pharmacies: Copayments apply if you fill your prescription at a* **Preferred Retail Network** *retail pharmacy. If you fill your prescription at a non-Preferred Retail Network** *retail pharmacy, you will pay an additional $10 per prescription. If you currently use a non-***Preferred Retail Network** *pharmacy and you want to avoid the $10 upcharge, call a* **Preferred Retail Network** *pharmacy to transfer your prescription.*

Prescription drugs are not covered when purchased from Out-of-Network pharmacies.

See the Schedule of Benefits in this document for important information related to pharmacy benefits, including how to find a **Preferred Retail Network** *and Smart90 pharmacy.*

Schedule of Benefits

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

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

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

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

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

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

Acupuncture and Acupressure Services

Acupuncture and acupressure are covered under this Plan if performed by a licensed health care provider acting within the scope of that license. Acupuncture and acupressure services must be provided by In-Network and are limited to 20 visits per Plan Year, maximum 100 visits per lifetime.

Maintenance services are not a covered benefit.

Alcohol and Substance Abuse Services (inpatient and outpatient)

Medically necessary inpatient and outpatient alcohol and substance abuse services will be provided under the same terms as medical and surgical benefits, with no additional financial or treatment limitations. Substance abuse care benefits are for acute medical detoxification and for substance abuse rehabilitation and counseling.

Inpatient and outpatient programs for alcohol and substance abuse treatment require precertification. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require precertification.

Allergy Testing and Treatment

Coverage is provided for medically necessary allergy testing, preparation of serum, serum, and administration of injections. For allergy treatment only, the participant will be responsible for the lesser of the primary care or specialist office visit copay or the cost of the serum/injection.

Ambulance Services

Ambulance services are covered if the services are medically necessary, and they are:

- Provided in an emergency; or
- Provided in a non-emergency setting when prior authorized by the UM company.

Autism Spectrum Disorders

This Plan provides coverage for autism spectrum disorder per NRS 695G.1645 including coverage of screening for and diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders for covered dependents individuals.

Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

Bariatric/Weight Loss Surgery

Covered services include medically necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese *with* associated illnesses. These services may have a reduced benefit unless you receive precertification.

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 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 bariatric surgery services providers are in-network and facility chosen to provide services are in-network.

There is no payment if services are provided at an out-of-network facility or out-of-network surgeon, or other ancillary providers are used.

Participants are limited to one obesity related surgical procedure of any type in an individual's lifetime while covered under this Plan or any PEBP self-funded Plan. For example, a participant cannot have lap band surgery and subsequently seek benefits for gastric bypass. The first service related to surgical weight loss will be considered payable under this Plan, any others will not. If a participant had coverage under a different plan (any other plan other than a PEBP self-funded Plan) previously and subsequently had a bariatric surgery, they are still eligible to have one bariatric procedure paid for under the Plan, provided that precertification criteria are met.

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

It is the responsibility of the participant to ensure that their providers and facilities chosen to provide these services are in-network for benefits to be paid. Participants can verify the network status of any provider (including a facility) by calling the Claims Administrator located in the *Participant Contact Guide*.

Participants must receive treatment in a Bariatric Surgery Center of Excellence which 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.

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 be considered part of the Plan's mandatory precertification requirements. For the Plan to consider your bariatric surgery a covered benefit under this Plan; you will have to begin the precertification process again with the appropriate providers.

Services, pre- and post-surgery must be at an in-network facility, with in-network providers AND be at a certified Center of Excellence for bariatric weight loss.

Precertification/Pre-Surgery Criteria for Weight Loss Surgery
The participant or their physician must contact the UM company to begin the process toward surgical intervention for obesity. The initial contact will include:

- Notifying the participant that the precertification process begins with the initial contact to UM company.
- Notifying the participant that precertification requests presented to the UM company before the clinical criteria listed below has been completed will be denied. A precertification request may be reconsidered upon completion of the clinical criteria.
- Informing 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 wellness/preventive services and how to proceed with meeting the clinical indications listed below; and
- Advising participants of Centers of Excellence in bariatric surgery provider in their geographic area.

Clinical Criteria for Weight Loss Surgeries is managed by the UM Company.

Surgical or invasive treatments for obesity or morbid obesity including but not limited to bariatric weight/loss services, reversals, and treatments to resolve complications are generally excluded.

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

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

Blood Services for Surgery

Medically necessary blood and related supplies provided during a surgical or other procedure that requires blood replacement are covered services.

Chemotherapy

Chemotherapy and other drug therapies that are medically necessary to treat cancers and other diseases and conditions are covered services. Covered when ordered by a physician; chemotherapy must be pre-certified by the UM company.

See prescription benefits for orally administered chemotherapy drugs:

Patients undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year (excluding sales tax).

Chiropractic Services

(Spinal Manipulation (non-surgical))

Coverage is provided for up to 20 visits per Plan Year for medically necessary spinal manipulations and adjustments.

Maintenance services are not a covered benefit.

Clinical Trials

A clinical trial is the process for testing new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases.

Coverage for certain treatment received as part of a clinical trial or study for treatment of cancer or chronic fatigue syndrome will be provided subject to the requirements and limitations set forth in NRS 695G.173.

Diabetic Services for Type 1, Type 2, and Gestational Diabetes

Coverage is provided for the medically necessary management and treatment of diabetes, including infusion pumps and related supplies, medication, equipment, supplies, and appliances for the treatment of diabetes.

Coverage is provided for the medically necessary self-management of diabetes for training and education provided after you are diagnosed with diabetes for the care and management of diabetes, including, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.

Durable Medical Equipment (DME)

Coverage is provided for the purchase, rental, repair, or maintenance of durable medical equipment prescribed by a provider for a medically necessary condition other than kidney dialysis. **DME is limited to one purchase, repair, or replacement of a specific item of DME every 3 years.** Rental of DME will be subject to Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME of more than $1,000 requires precertification from the UM company.

To help determine what durable medical equipment is covered, see the definition of "Durable Medical Equipment" in the Key Terms and Definitions section, below.

Coverage will be based on an amount equal to the generally accepted cost of durable medical equipment that provides the medically necessary level of care at the lowest cost.

Items not covered under this benefit include, but are not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, and any other primarily non-medical equipment, except as otherwise covered and described within this *Schedule of Benefits* and the *Benefit Limitations and Exclusions* sections.

Also excluded are exercising equipment, vibratory or negative gravity equipment, swimming or therapy pools, spas, and whirlpools (even if recommended by your medical provider to treat a medical condition).

Enteral Formulas and Special Food Products

Enteral Formulas and Special Food Products are covered in accordance with NRS 689B.0353.

There is a $2,500 maximum benefit per Plan Year for Special Food Products for the treatment of a person with inherited metabolic diseases or for Medically Necessary treatment of a mental health diagnosis. The maximum will not apply to Medically Necessary treatment of a mental health disorder.

Inherited metabolic diseases is characterized under NRS 689B.0353 as the following:

- deficient metabolism, or
- malabsorption originating from congenital defects, or
- defects arising shortly after birth,

for amino acid, organic acid, carbohydrate or fat.

Family Planning, Fertility, Infertility, Sexual Dysfunction Services and Male Contraception

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.

Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility for a covered individual (limited to one diagnostic evaluation for infertility every Plan Year, and up to three (3) per lifetime, and up to six (6) artificial inseminations per lifetime. See exclusions in the Benefit Limitations and Exclusions. These limits and exclusions apply to both office-based and non-office-based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in the Summary of Medical Benefits

Contact the Utilization Management company for prior authorization for procedures related to sexual dysfunction.

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.

Medically necessary services for subscriber, spouse, and/or domestic partner to diagnose problems of infertility are covered for one workup per Plan Year up to three (3) evaluations per lifetime. For infertility services that are not covered under this Plan, see the *Benefit Limitations and Exclusions* section.

Gender Dysphoria

This Plan provides benefits to individuals seeking medically necessary services for the treatment of gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders from Providers acting within the scope of their license.

Procedures, services, and supplies related to surgery and sex hormones associated with gender affirmation/confirmation should be reviewed by the UM Company for medical necessity. Determinations of medical necessity shall include recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

This plan does not discriminate on the basis of gender identity or expression. Claim or coverage appeal shall include a consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment. The plan does not provide coverage for cosmetic benefits.

Cosmetic Surgery means:

- Means a surgical procedure that:
  - Does not meaningfully promote the proper function of the body
  - Does not prevent or treat illness or disease; and

  - Is primarily directed at improving the appearance of a person.
- This Includes, without limitation, cosmetic surgery directed at preserving beauty.

Genetic Counseling/Testing

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

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

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

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

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

- The results will directly impact clinical decision-making and/or clinical outcome for the individual.
- The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and
- One of the following conditions is met:
  - The participant demonstrates signs/symptoms of a genetically linked heritable disease, or
  - The participant or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

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

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

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

Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing is not covered.

Hearing Aids

When air conduction hearing aids are medically necessary: Each air conduction hearing aid is subject to a $50 copay (per device, per each ear), with maximum plan benefit of $1,500 per device every three (3) 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 deductibles to receive credit towards the Out-of-Pocket Maximum.

Over the Counter hearing aids are excluded from the Plan.

Hinge Health Digital Musculoskeletal (MSK) Care

Hinge Health's Digital MSK Program is offered through the Pharmacy Benefit Manager and is designed to help members with Musculoskeletal Care using digital technology. The program offers qualifying participants virtual physical therapy focusing on prevention, acute injury, chronic and surgical care programs via digital physical therapy plus additional physical and behavioral support through a full clinical-care team. Members will also have access to other

services, such as pelvic floor therapy, advanced wearable technology for electrical nerve stimulation and pain relief, expert medical opinion consultation, health education, etc.

Members will complete a screener to assess which Digital MSK ClinicTM programs is right for them. The questionnaire screener leverages data analytics combined with a dedicated clinical care team review to match each member's personal needs with the right program tools and resources. This program is managed by Express Scripts and is provided at no cost to members.

Home Health Care

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

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

Excluded from coverage as home health care are:

- Personal care, custodial care, domiciliary care, or homemaker services.
- In-home services provided by a licensed provider acting within the scope of their license.
- Over-the-counter medical equipment, over-the-counter supplies, or any prescription drugs, except to the extent that they are covered elsewhere in this *Schedule of Benefits*.

Hospice Services

The following hospice care services are covered for members with a terminally ill, limited life expectancy of six months. Additional days would have to be preauthorized by the UM Company.

- Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week
- Outpatient bereavement counseling of the participant and his or her immediate family (limited to 6 visits for family members combined if they are not otherwise eligible for mental health benefits under their specific plan). Counseling must be provided by:
  - A psychiatrist.
  - A psychologist; or
  - A licensed, master's level clinician.

- Respite care providing nursing care for a maximum of 8 inpatient respite care days per Plan Year and 37 hours per Plan Year for outpatient respite care services. Inpatient respite care will be provided only when the UM company determines that home respite care is not appropriate or practical.

Hospital, Skilled Nursing Care, and Services in an Outpatient Surgical Center

Inpatient Care

Medically necessary inpatient hospital care is covered. Services include, but are not limited to:

- Services for medical conditions treated in an acute care hospital inpatient environment.
- Semi-private room and board (private room when medically necessary).
- General nursing care facilities, services, and supplies on an inpatient basis.
- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility. For related covered services refer to Other Services and Supplies in the *Schedule of Benefits* section.
- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Maternity and newborn care for up to 48 hours of inpatient care for a mother and her newborn child following a vaginal delivery and up to 96 hours of inpatient care for a mother and her newborn child following a cesarean delivery. The time periods will commence at the time of the delivery. Any decision to shorten the length of inpatient stay to less than those time-periods will be made by the attending physician after conferring with the mother.
- Inpatient, short-term rehabilitative services, limited to treatment of conditions that are subject to significant clinical improvement over a continuous 30-day period from the date inpatient therapy commences in a distinct rehabilitation unit of a hospital, skilled nursing facility, or other facility approved by us (limited to 100 days per Plan Year).
- Inpatient alcohol and substance abuse rehabilitation services in a hospital, residential treatment facility, or day treatment program; and
- Inpatient mental health services.

Inpatient services to treat mental illness conditions are subject to medical necessity. Provider visits received during a covered admission are also covered. Benefits are provided for medically necessary inpatient care, outpatient care, partial hospitalization, and provider office services for the diagnosis, crisis intervention and treatment of severe mental illness conditions and substance abuse conditions as noted in the *Schedule of Benefits*.

Inpatient services must be provided by a licensed hospital, psychiatric hospital, alcoholism treatment center, or residential treatment center.

The member should contact the UM company to determine medical necessity, appropriate treatment levels and appropriate settings. Inpatient services are subject to precertification notification guidelines to avoid potential penalties related to non-notification of services.

If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times in the UM section, above, the UM Company must receive notification as soon as reasonably possible after the admission or you may be subject to reduced benefits as provided in this Plan.

Medically necessary care at a skilled nursing facility (limited to 100 days per Plan Year) for non-custodial care is covered. A skilled nursing facility is a facility that is duly licensed by the state and/or federal government and that provides inpatient skilled nursing care, rehabilitation services, or other related health services that are not custodial or convenience in nature. Skilled nursing care includes medically necessary services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse. This Plan does not cover skilled nursing care that is not covered by CMS. Prior care in a hospital is not required before being eligible for coverage for care in a skilled nursing facility.

Medical Prescription Coupon Program

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

Outpatient Care

Medically necessary outpatient hospital or outpatient surgical center care is covered. Services furnished in a hospital or outpatient surgical center premises are covered, including use of a bed and periodic monitoring by a hospital's nursing or other staff that are medically necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital. If a hospital intends to keep a patient in observation status for more than 48 hours, observation status will become an inpatient admission for administration of benefits.

Coverage for the following benefits is dependent upon the benefits described in the *Schedule of Benefits* for this Plan. Mental health and substance abuse outpatient services include, but are not limited to:

- Services for medical conditions treated in an acute care hospital outpatient environment.
- Semi-private room and board (private room when medically necessary) if patient is in observation status.
- General nursing care facilities, services, and supplies on an outpatient basis.

- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility.
- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Outpatient, short-term rehabilitative services.
- Outpatient alcohol and substance abuse rehabilitation services in a hospital, hospital residential treatment facility, or day treatment program; and
- Outpatient mental health services.

Medically necessary short-term outpatient habilitative and rehabilitative services are covered for:

- Short-term speech, physical, and occupational habilitative and rehabilitative therapy for acute conditions that are subject to significant clinical improvement over a 90-day period, as determined by the UM company, from the date outpatient therapy commences or to maintain function in an individual. Precertification required for habilitative and rehabilitative therapy exceeding a combined visit limit of 90 visits per Plan Year (visit limits will not apply to Medically Necessary treatment of mental health or substance use disorder): and
- Services for cardiac rehabilitation and pulmonary rehabilitation (limited to 60 visits/sessions per Plan Year for each type of therapy).

Medically necessary services such as radiation therapy and chemotherapy (including chemotherapy drugs), are covered to the extent that such services are delivered in the most appropriate clinical manner and setting as part of a treatment plan.

Services that are not covered under this benefit include:

- Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution.
- Private duty nursing and private rooms in an inpatient setting.
- Personal, beautification, or comfort items for use while in a hospital or skilled nursing facility; and
- Services related to psychosocial rehabilitation or care received as a custodial inpatient.

Lab and Diagnostic Services

Coverage is provided for medically necessary laboratory and diagnostic procedures, services, and materials, including:

- Diagnostic x-rays.
- Fluoroscopy.
- Electrocardiograms; and
- Laboratory tests.

Coverage is also provided for other laboratory and diagnostic screenings as well as provider services related to interpreting such tests.

Outpatient laboratory services are covered for pre-admission testing, urgent care, or emergency room. Pre-admission testing must be performed within 7 days of a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

Outpatient laboratory services for routine/preventive lab testing must be performed at a non-hospital-based, freestanding laboratory such as Lab Corp or Quest.

If a freestanding, non-hospital-based laboratory facility is not available within 50 miles of your residence, you may use an in-network outpatient hospital facility or hospital-based lab draw station.

Routine lab services from independent labs may not be paid as wellness unless the TPA system finds a corresponding wellness office visit within a reasonable number of days prior or after lab date to validate wellness diagnosis.

Mastectomy and Reconstructive Surgery

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. Subject to the terms and conditions of this *Schedule of Benefits*, any covered individual who is receiving mastectomy or other breast cancer related treatment 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 structure.
- External prostheses (breast forms that fit into your bra) that are need before or during reconstruction; and Treatment of physical complications for stages of mastectomy, including lymphedemas (fluid build-up in the arm and chest on the side of the surgery).

If reconstructive surgery occurs within three years after a mastectomy, the amount of the benefits for that surgery will equal the amounts provided for in the Plan at the time of the mastectomy. If the surgery occurs more than three years after the mastectomy, the benefits provided are subject to the terms, conditions, and exclusions contained in the Plan at the time of reconstructive surgery.

- Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy.

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.

Maternity and Newborn Services

Medically necessary maternity services for pregnant participants are covered, including prenatal and postpartum care, related delivery room and ancillary services and newborn care. Newborn care includes care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of newborn to and from the nearest facility staffed and equipped to treat the newborn's condition. Newborn care is subject to the eligibility requirements as defined in the *Schedule of Benefits*.

Notwithstanding anything in this *Schedule of Benefits* to the contrary, participant does not need precertification from the UM company to obtain access to obstetrical or gynecological care from a professional in this Plan's network who specializes in obstetrics or gynecology. The provider, however, may be required to comply with certain procedures, including obtaining precertification for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating providers who specialize in obstetrics or gynecology, refer to the Low Deductible PPO Plan network at *https://pebp.nv.gov/*.

Notwithstanding anything in this *Schedule of Benefits* to the contrary, in the case of a person who has a child enrolled in coverage, this Plan will permit such person to designate any pediatrician as a primary care physician if such pediatrician is a participating provider.

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). Individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.

Services that are not covered include:

- Amniocentesis to the extent that it is performed to determine the sex of the child.
- Non-newborn circumcisions after eight weeks of age unless medically necessary and provided a precertification.

Medical Care

Medically necessary medical care and services, performed by a physician or other professional on an inpatient and outpatient basis, are covered, including:

- Office visits and consultations.
- Hospital and skilled nursing facility services.
- Ambulatory surgical center services.
- Home health care services.
- Surgery; and
- Other professional services.

Note: 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 Surgery/Surgeries definition 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. See Certified Surgical Assistant in the *Key Terms and Definitions* section.

Mental Health Services

Medically necessary mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other qualified mental health care professional are covered according to the limits provided in the *Schedule of Benefits* sections.

Outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require precertification. This Plan provides mental health benefits in accordance with the MHPAEA.

No Surprises Act

The federal No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from a Out-of-network provider at an in-network facility. Beneficiaries receiving these services will only be responsible for paying their in-network cost sharing and cannot be balance billed by the provider or facility for emergency services.

Emergency Services

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities;
- Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO provider or a PPO emergency facility;
- By calculating the cost-sharing requirement for out-of-network Emergency Services consistent with the federal No Surprises Act; and

- By counting any cost-sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost-sharing payments were made with respect to Emergency Services furnished by a PPO provider or a PPO emergency facility.

Post Stabilization Services

Emergency Services furnished by an out-of-network Provider or out-of-network emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; and
- The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is an Out-of-network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any IN-NETWORK providers at the facility who are able to treat you, and that you may elect to be referred to one of the participating providers listed; and
- The participant or beneficiary gives informed consent to continued treatment by the nonparticipating provider, acknowledging that the participant or beneficiary understands that continued treatment by the nonparticipating provider may result in greater cost to the participant or beneficiary.

Non-Emergency Items or Services from a Out-of-network Provider at a IN-NETWORK Facility

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Out-of-network provider at a IN-NETWORK facility, the items or services are covered by the plan:

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a IN-NETWORK provider,
- By calculating the cost-sharing requirements consistent with the federal No Surprises Act.
- By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a IN-NETWORK provider,
- Non-emergency items or services performed by a Out-of-network provider at a IN-NETWORK facility will be covered based your out-of-network coverage if:

  - At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Out-of-network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any IN-NETWORK providers at the facility who are able to treat you, and that you may elect to be referred to one of the IN-NETWORK providers listed; and
  - The participant or dependent gives informed consent to continued treatment by the Out-of-network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Out-of-network provider may result in greater cost to the participant or beneficiary.

- The notice and consent exception does not apply to Ancillary services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-network provider satisfied the notice and consent criteria, and therefore these services will be covered:

  - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a IN-NETWORK provider,
  - With cost-sharing requirements calculated consistent with the federal No Surprises Act, and
  - With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by an in-network provider.

Your cost sharing amount for Non-emergency Services at IN-NETWORK Facilities by Out-of-network Providers will be based on the lessor of billed charges from the provider or the Qualifying Payment Amount.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from a out-of-network provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from a Out-of-network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a IN-NETWORK provider.
- In general, you cannot be balanced billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a IN-NETWORK provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your Network (IN-NETWORK) deductible and Network (IN-NETWORK)

out-of-pocket maximum in the same manner as those received from a IN-NETWORK provider.

Payments to out-of-network Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services. Non-Emergency Services at IN-NETWORK Facilities by Out-of-network Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Out-of-network provider. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

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

The Plan will pay a total plan payment directly to the out-of-network provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

External Review

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a out-of-network provider at a IN-NETWORK facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review. Please see the External Review procedures in the SPD for further information.

Continuity of Coverage

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

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

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

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

Incorrect IN-NETWORK Provider Information

A list of IN-NETWORK providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

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

Continued Coverage Following Termination of a Provider Contract

For serious health conditions not covered by the No Surprises Act, if a participant is receiving a medically necessary course of treatment from an in-network provider and that provider leaves the network (except for termination due to medical incompetence or professional misconduct), and the participant and the provider agree that a disruption to the participant's current care may not be in the best interest or if continuity of care is not possible immediately with another in-network provider, this Plan will pay that provider at the same level they were being paid while contracted with this Plan's network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- Such treatment is no longer medically necessary or no later than the 120th day after the date the contract is terminated; or
- If the medical condition is pregnancy, the 90th day after:
  - The date of delivery; or
  - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Obesity Care Management Program

The Obesity Care Management (OCM) Program is open to participants who have been diagnosed as obese by their physician and who meet the criteria set out in this section.

Participants who opt-in to the OCM Program may be eligible for enhanced benefits. These benefits include:

- Services provided by an in-network provider certified by the American Board of Bariatric Medicine (ABBM) and specializes in weight loss services or if there is no certified provider within 50 miles of a participant's residence, services may be provided by any in-network provider.
- Laboratory tests provided by an in-network free-standing, non-hospital-based outpatient laboratory facility such as Lab Corp or Quest.
- Nutritional counseling services, when provided in-network, frequency is determined by the Claims Administrator and is based on medical necessity.

Weight Loss Medications:

- 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. Long-term weight loss medications are excluded.
- This Plan does not coordinate prescription drug plan benefits.

Medications purchased at non-participating pharmacies are not covered under this Plan.

Gym memberships, exercise equipment, and bariatric restrictive weight loss surgery are not included in the OCM benefits. Refer to the *Summary of Medical Benefits* section for more information.

For enrollment information, please contact the Claims Administrator as listed in this document under the *Participant Contact Guide*. When you enroll in the program, your effective date will typically be the 1st of the month following your enrollment in the program. The effective date will be determined by PEBP.

The information described in this section provides a summary of the Program's functions. For more detailed information, please contact the Claims Administrator.

The Obesity Care Management Program is optional and considered an "opt-in" Program. To be eligible for the enhanced wellness benefits, participants must meet certain criteria and adhere to certain participation requirements.

Once you have met your final weight loss goal as determined by your weight loss provider at the onset of your participation in a medically supervised weight loss program, benefits under the Obesity Care Management Program will end. This Plan does not provide benefits for ongoing maintenance care. If you choose to receive ongoing maintenance care, you will be responsible for the cost of receiving the services.

The Claims Administrator provides an Obesity Care Management Participant Program navigation guide available through the PEBP Member Portal, see the *Participant Contact Guide* for more information.

The Obesity Care Management Program is administrated by the Claims Administrator.

Engagement in the Program
You must remain actively engaged in a medically supervised weight loss program.

Monitoring Engagement
The Claims Administrator will assist your weight loss provider with completing monthly progress reports. The initial report should include your weight and BMI or waist circumferences, and a description of your treatment plan to include weekly weight loss goals, final weight loss goal,

exercise regimen, diet, and nutrition instructions. Subsequent monthly reports should provide information regarding your weight loss progress and adherence to the treatment plan. Submission of these reports will be a requirement for payment under the enhanced wellness benefits. If your monthly weight loss reports are not received by the Claims Administrator, your benefits under this program will end, and your coverage will return to the standard LD PPO Plan benefits where other Plan limitations will apply. The effective date of the return to the standard Low Deductible PPO Plan benefits will be the first day of the month following the non-compliance notification received from the Claims Administrator.

How to Enroll in the Obesity Care Management Program

- Contact the Claims Administrator for a list of in-network weight loss providers. This information is located on the Claims Administrator's website by logging into the E-PEBP Portal.
- Make an appointment with an in-network weight loss provider. The Claims Administrator can also help you identify which in-network provider may best meet your needs, based on geography or other specialized needs you may have.
- When you make an appointment with your in-network weight loss provider, before you go, be sure to take an Obesity Care Management Program Enrollment form with you. This form is located on the Claims Administrator's website under forms.
- Have your in-network weight loss provider complete the enrollment form and submit (by mail or fax) the completed form to the Claims Administrator. Their name, address and fax number are provided on the enrollment form.
- The 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 Claims Administrator will enroll you in the program. The Claims Administrator will notify PEBP and the Pharmacy Benefit Manager of your enrollment. If you do not meet the criteria for weight loss benefits, the Claims Administrator will notify you of the denial of benefits.
- Engagement in the Program.

Benefits under the Obesity Care Management Program

The following benefits are included, many at no cost to you, when provided under this program subject to the limits in the *Summary of Medical Benefits* section:

- Office Visits.
- Laboratory tests.
- Nutritional counseling.
- Meal replacement therapy; and
- Certain medications under the prescription drug component of the Plan.

Oral Surgery, Dental Services, and Temporomandibular Joint Disorder

Medically necessary oral surgery procedures are covered (inpatient or outpatient) related to the following:

- Accidental injury to the jaw bones or surrounding tissues when the injury occurs, and the repair must commence within 90 days after the accidental Injury, regardless of date enrolled in the plan. Services that commence after 90 days are not covered unless determined to be medically appropriate.
- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
- Non-dental surgical procedures and hospitalization required for newly born and children placed for adoption or newly adopted to treat congenital defects, such as cleft lip and cleft palate.
- Repair and restoration of teeth from injuries that arise from non-gustatory trauma.
- Extraction of teeth when related to radiation therapy or in advance of an organ transplant (other than a corneal transplant).
- Medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including treatment of fractures.
- Under certain circumstances (listed below) 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 beneficiary when services are rendered in a hospital or outpatient surgical facility, when enrolled individual is being referred because, in the opinion of the dentist, the individual:
        - 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. Refer to the dental benefits described in the PEBP Self-funded PPO Dental Plan Master Plan Document available at *https://pebp.nv.gov/*.

Temporomandibular Joint Disorder (TMJ) and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. TMJ surgeries are covered under the medical benefits based on medical necessity and are limited to an annual maximum of one surgery and a lifetime maximum of two (2) surgeries.

Precertification is required for dental general anesthesia in a hospital or outpatient surgical facility. Dental anesthesiology services are covered only for procedures performed by a qualified specialist in pediatric dentistry, a dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

Only the services and supplies described above are covered, even if the condition is due to a genetic, congenital, or acquired characteristic. Exclusions include:

- Except as described above as an inclusion, 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 as set forth above;
- 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 above.
- Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and near 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 are not limited to cosmetic restorations, veneers, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

Orthopedic Devices and Prosthetic Devices

Coverage for orthopedic devices is limited to medically necessary braces for problems requiring complete immobilization or for support, or if the braces are custom fitted or have rigid bar or flat steel supports and stays, splints, devices for congenital disorders, post, and pre-operative devices.

One medically necessary prosthetic device, approved by the Centers for Medicare & Medicaid Services (CMS), is covered for each missing or non-functioning body part or organ every three years. Coverage is limited to:

- Devices that are required to substitute for the missing or non-functioning body part or organ.
- Adjustment of initial prosthetic device; and

- The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.
- Repair and replacement of prosthetic devices is not covered except in limited situations involving mastectomy reconstructive surgery.

Orthopedic shoes, foot orthotics or other supportive devices of the feet are excluded, except when such devices are:

- An integral part of a covered leg brace and its expense is included as part of the cost of the brace:
- For diabetes mellitus and for foot deformity, history of pre-ulcerative calluses, history of previous ulceration, peripheral neuropathy with evidence of callus formation, poor circulation or previous amputation of the foot or part of the foot:
- For rehabilitation prescribed as part of post-surgical or post-traumatic casting care; or
- Prosthetic shoes for members with a partial foot.

Ostomy Care Supplies

Coverage is provided for medically necessary care and supplies after colon, ileum, or bladder surgery to assist in carrying on normal activities with a minimum of inconvenience.

Outpatient Rehabilitative and Habilitative Therapy Services

Coverage is provided for medically necessary physical, speech, occupational, cardiac, and pulmonary therapy habilitative and rehabilitation services that are performed by a physician or by a therapy provider licensed in accordance with state regulations for that therapy discipline.

Coverage for these services is available for acute conditions arising from illness or injury, as well as chronic or developmental conditions up to the benefit limits as defined in the benefit Plan.

- Outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) and is subject to cost-share for each therapy type.
- Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year (limit not applied to therapy treating a behavioral health condition).
- There is no limit for Cardiac Rehabilitation services.

PEBP also offers participants access to Hinge Health Digital Musculoskeletal (MSK) Care program for virtual therapy focusing on prevention, acute injury, chronic and surgical care programs. See Hinge Health, above, for more information.

Partial Hospitalization Services

Partial hospitalization services are covered for mental illness and substance abuse according to the benefits listed in the *Schedule of Benefits*. The same services covered for inpatient services are also covered for partial hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One partial treatment day is defined as no less than

three and no more than 12 hours of therapy per day. Partial day treatment is covered only when the member receives care through a day treatment program.

Podiatry Services

Podiatry services are covered for the medically necessary treatment of acute conditions of the foot such as infections, inflammation, or injury and other foot care that is disease related.

The following services are not covered:

- 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 routine foot care.

Preventive Services

Notwithstanding anything to the contrary in this *Summary of Medical Benefits*, the following preventive services will be covered without any participant cost-sharing if such services are provided by a participating provider:

- Periodic physical examinations and routine immunizations.
- 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.
- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics.
- Colorectal cancer screening starting at age 45 years in accordance with:
  - The guidelines published by the American Cancer Society; or
  - Other guidelines or reports concerning such screening that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data.
- Immunizations, including COVID-19, influenza, pneumococcal, Haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, measles, diphtheria, human papillomavirus (HPV), pertussis (whooping cough), poliovirus, rotavirus, varicella (chickenpox), shingles (herpes zoster) and tetanus, if such immunizations have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (Note: Immunizations related to foreign travel or employment are excluded.);
- Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.
- Evidence-based items or services that have an “A” or “B” Recommendation by the United States Preventive Services Task Force (USPSTF) and Section 2713(a)(5) of

the Public Health Service Act and Section 9(h)(v) (229) of the 2015 Consolidated Appropriations Act.

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services guidelines including the American Academy of Pediatrics Bright Futures guidelines; and
- With respect to women, such additional preventive care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Human Papillomavirus testing and vaccination pursuant to NRS 695G.171.

Women's Preventive Services

This Plan covers FDA approved contraceptive methods, including contraceptive injection or the insertion of a device at a hospital immediately after an insured gives birth, sterilization procedures, and patient education and counseling for women with reproductive capacity. The FDA requires the services to be "prescribed" by a physician even for over-the-counter methods. This Plan complies with the coverage requirements for contraception and related health services set forth in NRS 695G.1715.

Colorectal Cancer Screening

Colorectal screening tests are covered at 100% when provided in-network for adults aged 45 years and older who are at average risk of 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. For more information regarding colorectal screening guidelines, contact the Claim's Administrator.

Screening Mammograms

Preventative mammograms are covered at 100% for women aged 40 years and older under the Affordable Care Act and USPSTF, or beginning at age 35 for members with a high-risk of breast cancer, when performed in-network.

Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions

Healthy Diet/Physical Activity Counseling and Obesity Screening/Counseling for adults aged 18 years and older are covered under the Wellness/Preventive Care Benefit when the Participant or covered dependent is referred by a primary care practitioner; for those who are obese; and have additional cardiovascular disease (CVD) risk factors. This wellness/preventive benefit is limited to twelve (12) Health Diet/Physical Activity Counseling or Obesity Screening/Counseling sessions according to recommendations from the USPSTF. Additional visits are subject to a specialist visit copay, deductible, or coinsurance where applicable.

Prostate Cancer Screening

Limited to 1 preventative per plan year and offered in accordance with NRS 695G.177, which includes reference to the American Cancer Society guidelines.

Smoking/Tobacco Cessation

- Prescription and over-the-counter smoking/tobacco cessation products are covered under the prescription drug program. Over-the-counter smoking cessation products must be accompanied by a prescription written by a physician.
  - Some examples of cessation products eligible to be paid at 100% include Chantix (by prescription only), nicotine gum, nicotine patches, and nicotine lozenges.
  - Some limitations on quantity may apply and are at the discretion of the Pharmacy Benefit Manager and your physician.
- Benefits for over-the-counter products are limited to those that are FDA approved and 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 https://pebp.nv.gov/).
- 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:

Preventive Services for Adults and Families*: Visit the U.S. Preventive Task Force at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-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 for infants, children, and teens: *Visit the U.S. Department of Health & Human Services at https://www.hhs.gov/vaccines/index.html*

Vaccines & Immunizations: *Visit the Centers for Disease Control and Prevention at https://www.cdc.gov/vaccines/index.html*

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

Preventive care services identified through the above links are recommended services. It is up to the participant and their physician or provider of care to determine which services to provide.

The Plan Administrator has the authority to determine which services and quantity limits will be covered at the 100% wellness benefit; unless otherwise mandated by the Affordable Care Act or mandated in accordance with applicable Nevada Revised Statutes.

Radiation Therapy

Medically necessary professional services related to radiation therapy are covered.

See the *Utilization Management* (Prior Authorization) section for precertification requirements.

Real Appeal

Nevada Public Employees' Benefits Program has partnered with UMR's Real Appeal program. Real Appeal provides eligible members a benefit for virtual weight loss and weight management coaching sessions. Sessions are covered under the preventive care benefit resulting in no cost-sharing to members. Real Appeal supports members eighteen (18) years of age and older.

This support includes, but not limited to, one-on-one coaching and online group sessions with supporting video content delivered by a virtual coach.

A qualified enrolled member will receive:

- Access to a coaches who will guide you through the program and develop a custom plan that fits your needs, preferences, and goals.
- 24/7 access to digital tools and dashboards.
- A Real Appeal kit containing health weight management tools that may include fitness guides, recipes, digital food and weight scales
- Support from online group classes with a coach and other members who share what's helped them achieve success.

For more information, contact the Plan's third-party claims administrator listed in the Participant Contact Guide.

Skin Lesions

Coverage is provided for medically necessary removal of skin lesions and related pathological analysis of such lesions. Coverage is provided for the removal of port wine lesions.

Transplant Services

Medically necessary organ transplants at an approved Center of Excellence are covered when you are the organ recipient in the following cases:

- Bone marrow.
- Cornea.
- Heart.
- Heart and lung.

- Intestinal and liver.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Pancreas and kidney; and
- Stem cell.

Centers of Excellence are facilities that meet vigorous credentialing requirements for the specific type of organ transplant. A facility that is designated as a Center of Excellence for one type of organ transplant may not be designated as a Center of Excellence for another type of organ transplant. Designation as a Center of Excellence is at the UM company's sole discretion.

Organ transplants are only covered where the organ donor's suitability meets the OPTN/UNOS (Organ Procurement and Transplantation Network/United Network for Organ Sharing) donor evaluation and guideline criteria, when applicable.

Coverage for related transplant services is limited to:

- Tests necessary to identify an organ donor.
- The reasonable expense of acquiring the donor organ.
- Transportation of the donor organ (but not the donor), and life support where such support is for the sole purpose of removing the donor organ.
- Storage costs of an organ, but only as part of an authorized treatment protocol; and
- Follow-up care.

The following services are excluded from coverage:

- Services provided at a facility that has not been designated as an approved Center of Excellence.
- Services provided to an organ donor unless otherwise specified elsewhere in this document.
- Services provided in connection with purchasing or selling organs.
- Transplants utilizing any animal organs.
- Any transportation of the donor (as opposed to transportation of the donor organ only) is excluded, except as otherwise covered under the *Travel Expense* section for transplant services.
- Any expenses associated with an organ transplant where an alternative remedy is available are excluded.
- Artificial heart implantation is excluded.
- Services for which government funding or other insurance coverage is available are excluded.
- Tissue transplants (whether natural or artificial replacement materials or devices are used) or oral implants, including the treatment for complications arising from

tissue or organ transplants or replacement are excluded, except as described above.

2nd.MD Opinion

2nd.MD provides eligible members with direct access to elite specialists across the county for expert second opinions. Specialists answer questions about disease, cancer, chronic conditions, surgery or procedure, medications, and treatment plans. Specialists are board certified, leaders in research, and pioneers in medicine. To learn more visit *www.2nd.MD/PEBP* or call 1-866-841-2575.

Telemedicine or Telehealth (Doctor on Demand)

Telemedicine (virtual medicine) is available through Doctor on Demand. Participants can register with Doctor on Demand and connect face-to-face with a board-certified doctor, therapist or licensed psychologist on a smartphone, tablet, or computer through live video. Some of the medical and behavioral health conditions that may be treated include cold and flu, bronchitis, sinus issues, urinary tract infection, anxiety, depression, etc. Doctor on Demand providers can also prescribe medications (except controlled substances). For more information, visit https://pebp.nv.gov/ or the *Summary of Medical Benefits*.

Services available include:

- Medical visit
- Psychologist visit
- Psychiatry visit

You may receive services from a provider who is in a different location using information and audio-visual communication technology. Telemedicine does not include communication through telephone, facsimile, or email.

Doctor on Demand physicians do not prescribe DEA controlled substances and may elect not to treat or prescribe other medications based on what is clinically appropriate. In a true medical emergency, such as chest pains, shortness of breath or broken bones, dial 911 or seek immediate medical attention as appropriate.

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

Transplants (Organ and Tissue)

Organ, bone marrow and tissue transplant coverage are provided only for eligible services related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.

This Plan will provide coverage for the donor when the recipient 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 related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his/her Plan will pay first and benefits under this Plan will be reduced by the amount payable under the donor's Plan.

Transplantation-related services require precertification (see the *Utilization Management* section of this document for details).

See the specific exclusions related to experimental and investigational services and transplants in the *Benefit Limitations and Exclusions* section.

This Plan provides for reimbursement of certain costs associated with travel and lodging accommodations for the patient and one additional person when the travels are associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to *Transplant Services* section for additional information. Expenses incurred for travel and lodging accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.

This Plan does not provide advance payment for travel expenses related to organ or tissue transplants.

See the specific exclusions related to experimental and investigational services and transplants in the *Benefit Limitations and Exclusions* section.

This Plan provides for reimbursement of certain costs associated with travel and lodging accommodations for the patient and one additional person when the travels are associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to *Schedule of Benefits* section for additional information. Expenses incurred for travel and lodging accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.

This Plan does not provide advance payment for travel expenses related to organ or tissue transplants.

Use of Centers of Excellence for Transplant and Gastric (Bariatric) Procedures

This Plan requires participants to use an in-network Center of Excellence for transplant and bariatric weight/loss surgery. An appropriate Center of Excellence facility will be identified by the Plan's UM company and third-party Claims Administrator.

Travel

This Plan allows for the reimbursement of certain travel and lodging accommodation expenses consistent with Section 213(d) of the Internal Revenue Code and IRS Publication 502 for qualified medical expenses for the member and one additional person (travel companion).

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

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

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

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

PEBP does not provide advance payment for travel expenses.

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

Pre-approval for Travel Expenses

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

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

Submitting Travel Reimbursement

- Requests for travel expense reimbursement must be submitted to PEBP using the Travel Reimbursement form available at pebp.nv.gov.

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

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

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

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

Eligible Travel Expenses

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

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

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

Excluded Travel Expenses

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

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

Vision Care Services

Vision Screening Exam (preventative)

One annual preventive vision screening exam including refractive error testing per Plan Year.

PEBP does not maintain a network specific to vision care; however, the PPO network does have a list of some vision providers.

Prescription eyewear

Single vision, bifocal and trifocal lenses, and prescription contact lenses.

Eyeglasses, or contact lenses in lieu of eyeglasses, limited to $100 every 24 months.

Schedule of Prescription Drug Benefits

Benefits for prescription drugs are provided through the prescription drug plan administered by the Pharmacy Benefit Manager, Express Scripts ("ESI"). Coverage is provided only for those pharmaceuticals (drugs and medicines) 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.

Some over the counter (OTC) drugs and prescription drugs are eligible to be covered under the Plan's Preventive Care Services benefit in accordance with the Affordable Care Act; whereby, the Plan will waive the Copay and Deductible 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* 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.

Coverage is also provided for, but not limited to:

- COVID-19 vaccinations and medications.
- Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (tetanus, diphtheria, and pertussis -whooping cough)
- Prenatal & pediatric prescription vitamins
- Prescription female oral contraceptives
- Insulin, diabetic supplies (such as lancets, syringes, test strips), insulin pumps, and insulin pump supplies
    - Insulin pumps and supplies are covered under the pharmacy benefit's base day and quantity limits, subject to copayments, deductibles, or coinsurance.
- Orally Administered Chemotherapy (NRS 695G.167): 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 more information, see *Key Terms and Definitions* section.
- Prescription drugs irregularly dispensed for purposes of synchronization of chronic medication pursuant to the provisions of NRS 695G.1665Topical Ophthalmic Products See also NRS 695G.172. Refills of topical ophthalmic products will be covered when medically necessary, including when requested: (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.

- Medically necessary prescription drugs to treat sickle cell disease and its variants pursuant to the provisions of NRS 695G.174.
- Human Papillomavirus testing and vaccination under NRS 695G.171.
- The Plan provides benefits for substance use disorder including coverage for all drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.
- The Plan provides prescription benefits for psychiatric conditions for drugs that are approved by the Food and Drug Administration or the use of a drug to treat a psychiatric condition that is supported by medical or scientific evidence when prescribed by a Provider acting within the scope of their license. These prescription drugs are not subject to medical management techniques, such as step therapy.

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

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 can be found by logging on to https://pebp.nv.gov/ or by contacting Express Scripts located in the *Participant Contact Guide* section.

The plan adheres to NRS 695G.1715 regarding contraception and related health services.

Specialty Prescription Drugs

Specialty drugs are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, etc. Specialty drugs and prescriptions are limited to a 30-day supply. Specialty drugs must be filled through Accredo, an Express Scripts Specialty Pharmacy (see the *Participant Contact Guide)*. 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.
- Treat complex medical conditions.
- 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 Express Scripts listed in the *Participant Contact Guide*.

For Specialty Drugs part of the SaveOnSP program, the coinsurance applies. For Specialty Drugs not part of the SaveOnSP program, the respective coinsurance applies with a copay limitation of $100 minimum and a maximum of $250.

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

Preferred Retail Pharmacy Network

For short-term prescriptions, such as antibiotics, use a Preferred Retail Pharmacy (for lower copays) or a Non-Preferred Retail Pharmacy (where you will pay $10 extra for each short-term prescription). 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.

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 a Preferred Retail Network Pharmacy, log in to the E-PEBP Portal located at https://pebp.nv.gov/ 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** through Express Scripts' website 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. After we receive your prescription from your doctor, you will receive your medication within 7 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:

- 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.

Example:

Brand name medicine cost:	**$120**
Generic medicine cost:	$50
Difference:	$70
Plan Non-Preferred Brand Copayment:	$75
Total cost:	**$145**
If you chose the generic drug, you would pay:	$10

SaveonSP Program

As part of your prescription drug plan, PEBP 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 available to help assisting members with 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 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.
- 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.
- The SaveonSP Program drug list can be found at *www.saveonsp.com/pebp*

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 copay outlined in the SaveonSP Program Drug List and that cost will not apply toward your Deductible or Out-of-Pocket Maximum.

Diabetes Care Value

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

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 pharmacy benefit manager 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 Express Scripts. Prescription drug purchases made outside of the United States are subject to Plan provisions, *Benefit Limitations and Exclusions,*, clinical review, and determination of medical necessity. The review may include application of pertinent Food and Drug Administration (FDA) regulations. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the United States.

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:

- A legitimate, legible 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.

The claim will be processed based on the American equivalent National Drug Code and charged based upon that drug copay tier. If an American equivalent National Drug Code does not exist, the claim will be denied.

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

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 *Benefit Limitations and 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 *Summary of Medical Benefits* and *Schedule of Benefits* sections. This list is not all-inclusive; if you have questions about a service or supply, contact the Claims Administrator listed in the *Participant Contact Guide*.

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

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

- 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 LD network contract rate, services listed in the *Benefit Limitations and Exclusions* section.
- Charges in excess of the usual and customary charge determined by the Plan Administrator.
- Any additional amounts you must pay because you failed to comply with the utilization management requirements described in the *Utilization Management* section.
- Benefits exceeding those services or supplies subject to maximum individual or lifetime limit(s) for certain eligible medical expenses as listed in the *Schedule of Benefits*; and
- Certain wellness or preventive services that are paid by this Plan at 100% do not accumulate towards the out-of-pocket maximum.

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 *Summary of Benefits* and *Schedule of Benefits* sections for the maximum individual or lifetime limit(s) and any Plan Year limit applicable to certain covered expenses. Plan Year limits are met by days, hours, visits, or dollar limits paid under 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 *Summary of Medical Benefits* and *Schedule of Benefits* sections.

Exclusions Under the 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: Termination of pregnancy is excluded, other than medically indicated abortions that are medically necessary to save the life of the mother and complications of such abortions.

This plan provides abortion benefits in accordance with NRS 422.250.

Alternative/Complimentary Health Care: Expenses for chelation therapy, except as may be medically necessary for treatment of mental health, acute arsenic, gold, mercury, or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron. Expenses for prayer, religious or spiritual healing or counseling. Expenses for homeopathic treatments/supplies that are not FDA approved. See the *Summary of Medical Benefits* and *Schedule of Benefits* for benefit limitations and copayments and cost-sharing.

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 out-of-network ancillary provider are used, unless covered under the No Surprises Act. PEBP or its designee will determine the in-network Center of Excellence facility.

Behavioral (Mental) Health Services

- Expenses for behavioral health care services related to:
    - adoption counseling;
    - non medically necessary court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws);
    - custody counseling;
    - dance/poetry/art therapy,
    - developmental disabilities;
    - dyslexia,
    - learning disorders;
        -
    - family planning counseling;

  - marriage and/or couples counseling (the exclusion for marriage/couples counseling will not limit individual mental health counseling for an otherwise covered mental health condition);
  - intellectual disability;
  - pregnancy counseling;
  - vocational disabilities, and
  - 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 disorder.

Complications of a non-covered service: Expenses for care, services or treatment required because of complications from treatment or medications are 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.

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

Corrective Appliance, Orthotic Device Expenses, and Appliances:
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)

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

- air purifiers,
- humidifiers,
- electric heating units,
- swimming pools,
- spas,
- saunas,
- escalators,
- lifts,
- motorized modes of transportation determined to be not medically necessary,

- pillows,
- orthopedic mattresses,
- water beds, and
- air conditioners are excluded.

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

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

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

Cosmetic Services and Surgery: The Plan excludes expenses for cosmetic services and surgery or any drugs used for cosmetic purposes, including but not limited to health and beauty aids unless explicitly noted in the Covered Services section.

Complications resulting from Cosmetic Services or Surgery are not covered.

*Breast augmentation/augmentation mammoplasty excluded, except as otherwise covered and described above.

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 Benefits*, services involving

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

Coverage for dental services as the result of an injury to 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 https://pebp.nv.gov/.

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

Orthodontia is a specific Plan exclusion.

Drugs, Medicines, Nutrition or Devices Exclusions:

- 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 of this document).
- Non-Prescription (non-legend or over the counter) drugs or medicines (except as preventive care medications required by the Affordable Care Act).
- Foods and nutritional/dietary supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs, and minerals (whether they can be purchased over the counter or require a prescription), except when provided during hospitalization; prenatal vitamins or minerals requiring a prescription.
- Special Food Product (as defined in the Key Terms and Definitions section), except for the benefit described as covered under Special Food Product in the Schedule of Benefits section or elsewhere in this document
- Naturopathic, Naprapathic, or homeopathic treatments/substances.
- Weight control or anorexiants (phentermine, Xenical, HCG, including the OTC weight loss products), except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy.
- Compounded prescriptions in which there is not at least one ingredient that is a Legend Drug requiring a prescription, as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, or other health care facility.
- Vaccinations, immunizations, inoculations, or preventive injections that are not covered under the *Summary of Benefits* section.
- Marijuana and any derivative, including CBD, THC, edibles, etc. are not a covered benefit under this Plan.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the *Prescription Drug Program*.
- Drugs to enhance athletic performance such as anabolic steroids (including off-labeled growth hormone). Coverage for human growth hormone or equivalent is excluded unless specifically covered and described in the *Summary of Benefits*.
- Non-prescription male contraceptives, e.g., condoms.
- Dental products such as topical fluoride preparations and products for periodontal disease, except as a preventive service required under the Affordable Care Act.
- Hair removal or hair growth products (*i.e.,* Propecia, Rogaine, Minoxidil, Vaniqa).
- Vitamin A derivatives (retinoids) for dermatologic use.
- Vitamin B-12 injections (except for treatment of Mental Health, pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (unless otherwise specified in the *Schedule of Benefits*).
- Anti-aging treatments (even if FDA-Approved for other clinical indications).

Durable Medical Equipment Exclusions:
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 benefit as described in this document.

Expenses Exceeding Usual and Customary Charges, Maximum Allowable Charge, Prevailing Rates and Plan 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 Plan contracted rate as defined in the *Key Terms and Definitions* section, except as required by independent dispute resolution under the No Surprises Act .

Expenses for Which a Third Party Is Responsible: See "Third-Party Liability" of the Health and Welfare Wrap document that can be found on https://pebp.nv.gov/ (NAC 287.755)**.**

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided either before the patient became covered under the medical program or after the date the patient's coverage ends, except under those conditions described in COBRA.

Experimental and/or Investigational Services: Unless mandated by law, expenses for any medical services, supplies, drugs, or medicines that are determined by the Plan Administrator, UM company, or its designee to be experimental and/or investigational services.

Fertility and Infertility Services: Except as otherwise specified in the *Schedule of Benefits* section, 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 corn, 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 surgery found not to be medically necessary in the Treatment for Gender Dysphoria section above are not covered. The Plan provides benefits to individuals seeking services for the treatment of gender dysphoria and gender incongruence.

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 Benefits*.

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.

Hearing Aids: Over the Counter hearing aids are excluded from the Plan.

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 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.
- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the *Summary of Benefits* and *Schedule of Benefits*.
- Expenses for any services provided substantially or primarily for the participant's convenience or the convenience of a caregiver.

Hospital Employee, Medical Students, Interns or Residents: Expenses for the services of an employee of a hospital, skilled nursing facility or other health care facility, when the facility is obligated to pay that employee.

Hypnosis and Hypnotherapy: (As defined by CMS) an artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility.

Illegal Act: Expenses incurred by any covered participant for injuries resulting from commission (or attempted commission by the covered participant) of an illegal act the Plan Administrator determines involved violence or the threat of violence to another person, or in which any weapon or explosive is used by the covered participant, unless such injury is the result of a physical or mental health condition or domestic violence. The Plan Administrator's determination that this exclusion applies shall not be affected by any prosecution, or acquittal of (or failure to prosecute) the covered participant in connection with the acts involved.

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 except as specifically provided.

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, and complications of such termination.
- Childbirth courses.
- Expenses related to delivery associated with the newborn of a pregnant dependent-child.
- 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 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 participant, 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 or other licensed provider acting within the scope of their license.

Non-Emergency Hospital admission: Care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.

Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses) of a health care provider, 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: 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.

Orthodontia: Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an accident or medical condition.

Personal Comfort Items: Expenses for patient convenience, including (but not limited to) care of family members while the participant 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), when the services, procedures, Prescription of Drugs, or Prophylactic surgery is prescribed or performed for:

- Avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results, in certain circumstances; or
- Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder. Participants should use the Plan's UM company to assist in the determination of a proposed surgery to determine if it is or is not covered under this Plan.

NOTE: Some prophylactic surgeries may be covered under this Plan if certain criteria are met. Please refer to the *Schedule of Benefits* section. For additional information, please contact this Plan's UM company or Claims Administrator.

Prophylactic drugs are excluded.

Rehabilitation Therapy (Inpatient or Outpatient):

- Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing, and related services.
- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or

unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
- Expenses for maintenance rehabilitation, as defined in the *Key Terms and Definitions* section.
- Expenses for speech therapy for functional purposes including (but not limited to) stuttering and stammering.
- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living or for Medically Necessary treatment of a mental health or substance use disorder diagnosis.
- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency.

Service Animals: Expenses for the purchase, training, or maintenance of any type of service animal, even if designated as medically necessary.

Smoking Cessation or Tobacco Withdrawal: Expenses for non-prescription (over the counter) tobacco/smoking cessation products such as nicotine gum or patches, unless prescribed by a physician. There are no benefits payable for the use of electronic cigarettes. Prescription smoking/tobacco cessation products are payable under the prescription drug benefit as described in the *Schedule of Benefits* section.

Stand-By Physicians or Health Care Practitioners: Expenses for any physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the physician or health care practitioner was available on a stand-by basis.

Taxes: Sales taxes, unless specifically covered in the Plan. See also CMS Publication 15-1, The Provider Reimbursement Manual – Part 1, Chapter 21, Section 2122.2.G.

Telephone Calls: Expenses for telephone calls between a physician or other health care provider and any patient, other health care provider, UM company or vendor; or any representative of this Plan for any purpose whatsoever.

Transplant (Organ and Tissue):
- Expenses for 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 complications thereof, except those transplant services as described under Transplants in the *Schedule of Benefits*.
- Expenses related to 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.

Urgent Care: Any urgent care services that are received out-of-network are excluded unless the urgent care service is received out-of-area as defined in the *Key Terms and Definitions*.

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 Benefits* and *Schedule of Benefits.*

War or Similar Event: Expenses incurred because of an injury or illness due to a participant's participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Weight Management and Physical Fitness:

- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs, and prescription drugs, except those services specified in the *Summary of Benefits* and *Schedule of Benefits*. Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Expenses for weight loss surgery performed without a precertification from the UM company will be denied.
- Expenses related to programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.
- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of an eating disorder (such as anorexia, bulimia, etc.). Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under any PEBP self-funded medical Plan (e.g., LD PPO Plan, CDHP, and EPO Plan).

Other Benefit Exclusions

- Stress reduction therapy or cognitive behavior therapy for sleep disorders.

  - The exclusion for cognitive therapy does not apply to Medically Necessary treatment of a mental health or substance use condition.
- Sleep therapy (except for central or obstructive apnea when medically necessary and when a precertification has been received from the UM company), behavioral training or therapy, milieu therapy (unless the care is otherwise medically necessary), biofeedback (unless included with psychotherapy), behavior modification, sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.
  - Charges that result from appetite control unless otherwise provided in the Summary of Benefits and Schedule of Benefits.
- Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (BEST), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.
- Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or Chiropractor's office, or at a retail location are excluded, unless otherwise specified in the *Summary of Benefits and Schedule of Benefits*.

Claims Administration

How Benefits are Paid

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 Claim

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 are 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 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 that they are received.

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, or rescission of coverage (retroactive cancellation).

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.

Claims 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.

You will be provided with:

- upon request and without charge, reasonable access to and copies of relevant documents, records, and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- a full and fair review that considers comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on

which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

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.

You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:

- information that is sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
- the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review (when external review is applicable);

- the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
- reference the specific Plan provision(s) on which the determination is based;
- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- an explanation of the Plan's appeal process and Level 2 appeal process and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol, or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and

- disclosure of the availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).

The notification 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 https://pebp.nv.gov/ or by request by contacting PEBP Customer Service. Furthermore, you are welcome to submit Level 2 Claim Appeals online through a form that can be found under the subheading "Filing an Appeal" under PEBP's contact us web page. A Level 2 Appeal must be submitted to PEBP within 35 days after you 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 resources available to ensure 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 https://pebp.nv.gov/. 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
7150 Pollock Dr
Las Vegas, NV 89119
Phone: (702) 486-3587, (888) 333-1597
Web:
https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/

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 https://pebp.nv.gov/.

The request must be submitted to:

Office for Consumer Health Assistance
7150 Pollock Dr
Las Vegas, NV 89119
Phone: (702) 486-3587, (888) 333-1597
Web:
https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/

Standard Request for External UM Review

A standard request for external UM review may be filed with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. A standard external review request form can be found on the PEBP website at https://pebp.nv.gov/.

A standard external review decision will be made within 45 days of OCHA's receipt of the request.

As with the expedited external review, a standard external review must be submitted to the Office for Consumer Health Assistance at the contact information listed above.

Experimental and/or Investigational Claim/UM External Review

If you received a denial for a service, durable medical equipment, procedure, or other therapy because the third-party administrator or the UM company determined it to be experimental and/or investigational, or subject to the No Surprises Act, or rescission of coverage, you may request an external review. To proceed with the experimental and/or investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.

A "Physician Certification of Experimental/Investigational /Denials" is located under "Forms" on the PEBP website at https://pebp.nv.gov/.

After this form is completed by the treating physician, it should be attached to the Request for External Review" form and submitted to the Office for Consumer Health Assistance at:

Office for Consumer Health Assistance
7150 Pollock Dr
Las Vegas, NV 89119
Phone: (702) 486-3587, (888) 333-1597
Web:
https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/

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, including those cases related to specialty drugs dispensed through Accredo specialty pharmacy.

Clinical Coverage Review

The initial clinical coverage review is a request for coverage or medication that is based on clinical conditions of coverage that are set by this Plan—for example, medications that require a prior authorization. To make an initial determination for a clinical coverage review request, the prescribing physician must submit specific information for review.

How to Request a Clinical Coverage Review

The preferred method to request an initial 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 1-800-753-2851 or the prescriber may submit a request in writing using a Benefit Coverage Review Form, which can be obtained by calling Express Scripts Member Services at 1-855-889-7708. (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

Administrative Coverage Review

The initial 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.

<u>Level 1 Appeal Decisions and Notifications</u>

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, 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 Participants have medical, dental or vision coverage from some other source, benefits are determined using Coordination of Benefits (COB). COB operates so that one of the plans (i.e., the primary plan) will pay its benefits first. The other plan or policy, (i.e., the secondary plan) may then provide additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

Participants must let the Plan Administrator, or its designee, know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and dental deductibles. This Plan's prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.

For the purposes of this COB section, the word "plan" refers to any group or individual medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual either on an individual basis or as part of a group of employees, retirees or other individuals.

A Participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such fully insured plan and the rules and procedures described in such fully insured plan's applicable Summary of Insurance.

A Participant in a self-insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures set forth herein PEBP delegates to the third-party administrator of such self-insured plan the duty to administer and interpret the COB provisions of this document and to adopt, document and communicate any rules and procedures necessary or appropriate to implement the COB procedures, as set forth below:

Which Plan Pays First: Order of Benefit Determination Rules

PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), 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 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.

Rule 1: Non-Dependent/Dependent

The plan that covers a person other than as a dependent (e.g., as an employee, retiree, member, or subscriber) is primary and the plan that covers the person as a dependent is secondary. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

- Secondary to the plan covering the person as a dependent;
- Primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);
- Then the order of benefits is reversed, so that the plan covering the person as a dependent will pay first; and the plan covering the person other than as a dependent (e.g., as a retired employee) pays second.

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 of time pays second.
- The word “birthday” refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are separated (whether they ever were married), or are divorced, and there is no court decree allocating responsibility for the child’s health care services

or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- The plan of the custodial parent pays first; and
- The plan of the spouse of the custodial parent pays second; and
- The plan of the non-custodial parent pays third; and
- The plan of the spouse of the non-custodial parent pays last.

Rule 3: Retired Employee

The plan that covers a person, as a retired employee or as a retired employee's dependent pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule (1) Non-Dependent/Dependent rather than by this rule.

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 of time pays second. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan.

Administration of COB

To administer COB, the Plan reserves the right to:

- Exchange information with other plans involved in paying claims;
- Require that Participants or Participants' health care provider(s) furnish any necessary information;
- Reimburse any plan that made payments this Plan should have made; or

- Recover any overpayment from a Participant's hospital, physician, dentist, other health care provider, other insurance company, or a Participant.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount the Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

This Plan follows the customary COB rule that the medical program coordinates with only other medical plans or programs (and not with any dental plan or program), and the dental program coordinates only with other dental plans or programs (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 a health maintenance organization (HMO), Exclusive Provider Organization (EPO) or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary Plan.

If this Plan is 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 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. The Enrollment and Eligibility Master Plan Document includes information regarding enrollment in the Medicare Exchange.

Entitlement to Medicare Coverage

- When a Participant reaches Medicare eligible age, the Participant must enroll in the Medicare plan for which the Participant is eligible. Generally, anyone age 65 years or older is entitled to Medicare Part A and Medicare Part B coverage. Anyone under age 65 years who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.
- *When the Participant Is Not Eligible for Premium Free Medicare Part A*
- This Plan will pay as primary for services that would have been covered by Part A when a Participant is not eligible for Premium Free Medicare Part A. However, a Participant must enroll in Medicare Part B and PEBP will be the secondary payer for Medicare Part B services. This Plan will always be secondary to Medicare Part B, whether or not a Participant has enrolled. This Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.
- *Coverage Under Medicare and This Plan When a Participant has End-Stage Renal Disease (ESRD)*
- If, while actively employed, a Participant becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins, or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage or the first month after the individual receives a kidney transplant, Medicare pays first, and this Plan pays second.
- If a Participant is under age 65 years and receiving Medicare ESRD benefits the Participant will not be required to transition to PEBP's Medicare Exchange program. When a Participant reaches age 65 years, the Participant will be transitioned to the Medicare Exchange in accordance with PEBP's eligibility requirements as stated in the *Enrollment and Eligibility Master Plan Document*.
- *How Much This Plan Pays When It Is Secondary to Medicare*
- When the Participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays as secondary to Medicare, with the Medicare negotiated allowable fee taking precedence. If a service is not covered under Medicare but is covered under this Plan, this Plan will pay as Primary with the Plan's allowable fee for the service taking precedence.
- When the Retiree or the Retiree's covered Spouse or Domestic Partner is enrolled in Medicare Part B, this Plan will pay secondary to Medicare Part B.
- If eligible Retirees or their covered Spouses or Domestic Partners are not enrolled in Part B, this Plan will estimate Medicare's Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

- *When the Participant Enters into a Medicare Private Contract*
- A Medicare Participant is entitled to enter into a Medicare private contract with certain health care practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare Participant enters into such a contract this Plan will not pay any benefits for any health care services and/or supplies the Medicare Participant receives pursuant to it.

Coordination with Other Government Programs

- **Medicaid:** If a Participant is covered by both this Plan and Medicaid, this Plan pays first, and Medicaid pays second.
- **Tricare:** If a Participant or their covered Dependent is covered by this Plan and Tricare (the program that provides health care services to active or retired armed services personnel and their eligible Dependents), this Plan pays first, and Tricare pays second. For an Employee called to active duty for more than 30 days, Tricare is primary, and this Plan is secondary.
- **Veterans Affairs Facility Services:** If a Participant receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan at the in-network benefit level at the usual and customary charge, only to the extent those services are medically necessary and are not excluded by the Plan.
- **Worker's Compensation:** This 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 if and when it is determined that they are covered under a Workers' Compensation or occupational disease law. However, before such payment will be made, a Participant must execute a Subrogation and reimbursement agreement (described in the Third-Party Liability Section 4.5) that is acceptable to the Plan Administrator or its designee.

Subrogation and Third-Party Recovery

Subrogation 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 manner in which 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). Any and all claims 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. Any and 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. Refer to the separate *Health and Welfare Benefits Wrap Plan* document for more information regarding third party liability and subrogation.

The Participant must cooperate fully, at all times, and provide information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order 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:

- Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation.
- 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
- Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate Health and Welfare Benefits Wrap Plan document available at *https://pebp.nv.gov/* for more information regarding third party liability and subrogation.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) 3427 Goni Road, Ste 109 Carson City, NV 89706 Customer Service: (775) 684-7000, (702) 486-3100, or (800) 326-5496 Fax: (775) 684-7028 https://pebp.nv.gov/	**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	**Third-party Claims Administrator/Third-party Administrator/PPO Network/ Disease Management Administrator** • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity 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
Sierra Health-Care Options, Inc PO BOX 15645 Las Vegas, NV 89144-5648 Customer Service : 888-323-1461 Fax : 800-288-2264	**Utilization Management and Case Management Company** • Pre-Certification/Prior Authorization • Utilization Management • Case Management • Transplants

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Express Scripts Pharmacy Customer Service (855) 889-7708 www.Express-Scripts.com Accredo Patient Customer Service: (800) 803-2523 Accredo Physician Service Line (800) 987-4904 option 5 Express Scripts / Accredo Prior Authorization (800) 753-2851 Electronic option: express-scripts.com/PA Specialty Medication SaveonSP copay assistance (800) 683-1074 www.saveonsp.com/pebp	**Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and EPO Plan** • Prescription drug information • Retail network pharmacies • Prior authorization • Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies • Accredo Specialty Drug Services • Coverage and Clinical reviews • Appeals • External Review Requests • Copay/Deductible/Coinsurance assistance
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** • HSA/HRA Claims and claim appeals
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

Participant Contact Guide	
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 www.myhpnstateofnevada.com/	**Southern Nevada Health Maintenance Organization (HMO)** • Medical claims/provider network
VIA Benefits 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888)598-7545 https://my.viabenefits.com/pebp Phone: (888) 598-7545; Fax: (402) 231-4310	**Medicare Exchange and Medicare HRA administrator** • Medigap (Supplemental) plans • Medicare Advantage Plans (HMO and PPO) • Voluntary Vision • Voluntary Dental • HRA claims administrator
United Healthcare Specialty Benefits 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 • Member Assistance Program • Global Travel Assistance
Office for Consumer Health Assistance 7150 Pollock Dr Las Vegas, NV 89119 Customer Service: (702) 486-3587 or (888) 333-1597 https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/	**Consumer Health Assistance** • Concerns and problems related to coverage • Provider billing issues • External review information
Corestream PEBP+ Customer Care: (775) 249-0716 E-mail: pebpcustomercare@corestream.com www.corestream.com Voluntary Life, Critical Illness, Accident, and Hospital Indemnity Insurance The Standard Insurance Company (888) 288-1270 www.standard.com/mybenefits/nevada	**PEBP+ Voluntary Benefits Administrator** • Accident Insurance • Auto Insurance • Critical Illness • Disability Insurance (Long-term and Short-term) • Home Insurance • Hospital Indemnity • Identity Theft • Legal Services • Life Insurance (Supplemental) • Pet Insurance • Vision Care

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.012 - 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.

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

Allogenic: Refers to transplants of organs, tissues, or cells from one person to another person. Heart Transplants are always Allogenic.

Allowable Expenses: The Maximum Allowable Charge for any medically necessary, eligible item of expense, at least a portion of which is covered under the Plan. When some other non-Medicare plan pays first in accordance with the application to benefit determinations provision in the *Coordination of Benefits* section, this Plan's allowable expenses shall in no event exceed the other non-Medicare plan's allowable expenses.

When some other non-Medicare plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of each service rendered, by determining the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other non-Medicare plan include the benefits that would have been payable had claim been duly made; therefore, whether or not it is made.

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

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated, and staffed primarily for performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets 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.

Ancillary services: for purposes of the No Surprises Act, are with respect to a PPO health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary of Department of Health and Human Services; and
- Items and services provided by a Out-of-network provider if there is no IN-NETWORK provider who can furnish such item or service at such facility.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional, or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Annual/Annually: For the purposes of this Plan, annual and annually refers to the 12-month period starting July 1 through June 30.

Appliance (Dental): A device to provide or restore function or provide a therapeutic (healing) effect.

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: A condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined.**Autologous:** Refers to transplants of organs, tissues, or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.

Average Wholesale Price (AWP): The average price at which drugs are purchased at the wholesale level.

Bariatric Surgery Center of Excellence: A provider that has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

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 (NRS 287.045).

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, or other provider who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

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

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated, and staffed primarily for providing a program for diagnosis, evaluation, and effective treatment of behavioral health disorders and which fully meets one of the following two tests:

- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets 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 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 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 weekdays, except Saturday, Sunday, Nevada holiday, 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, and who acts within the scope of their license or certification. Such individuals are payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

Chemical Dependency: This is another term for Substance Abuse. (See also the definitions of Behavioral Health Disorders and Substance Abuse).

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC) and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal column (vertebrae); and who acts within the scope of his or her license.

Chiropractic Services: PEBP considers chiropractic services to be medically necessary when 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: "Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent, or lasting indefinitely. "Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for improving a patient's adherence to a prescribed course of medication. This includes providing coverage for less than a 30-day supply to enable synchronization. See also NRS 695G.1665)

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

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

Coinsurance: That portion of *Eligible Medical Expenses* for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses more than the Plan's Deductible. The Coinsurance varies depending on whether In-Network or Out-of-Network providers are used.

Complications of Pregnancy: Any condition that requires hospital confinement for medical treatment, and if the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or, any condition that requires hospital confinement and if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.

Compound Drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Concierge Medicine: Is a relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of 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.

Continuing Care Patient: Under the NSA, an individual who, with respect to a provider or facility-

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how Plan benefits are payable when a person is covered by two or more health care plans.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. This can be in addition to Coinsurance amounts due on the same incurred charges. Copayments are limited to certain benefits under this program.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or device) and Prosthetic Appliance (or device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator, UM company, or its designee.

Cost-Efficient: See the definition of medically necessary for the definition of cost-efficient as it applies to medical services that are medically necessary.

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

Cost Sharing Amount: for Emergency and Non-emergency Services at IN-NETWORK Facilities performed by Out-of-network Providers and air ambulance services from Out-of-network providers will be calculated consistent with the federal No Suprises Act.

Covered Individual: Any employee or retiree (as those terms are defined in this Plan), and that person’s eligible spouse or dependent child who has completed required formalities for enrollment for coverage under the Plan and is covered by the Plan.

Covered Medical Expenses: See the definition of *Eligible Medical Expenses*.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed

medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

Customary Charge: See the definition of *Usual and Customary Charge*.

Deductible: The amount of eligible medical, prescription drug and dental expenses you are responsible for paying before the Plan begins to pay benefits. The dental Deductibles are discussed in the separate PPO Dental Master Plan Document.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the Temporomandibular Joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies coverage is provided in the PPO Dental Plan (refer to the separate PPO Dental Plan MPD available at https://pebp.nv.gov/) and are not covered under the medical expense coverage of this Plan unless the medical Plan specifically indicates otherwise in the *Schedule of Benefits*.

Dependent: Any of the following individuals: Dependent child(ren), spouse or domestic partner as those terms are defined in this document.

Dependent Child(ren): For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),

- any other person who:
  - Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
  - Is unmarried.
  - Has not attained the age set forth in 45 C.F.R. § 147.120(a).

- Either resides with the participant or is enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school or accredited trade or business school, on a full-time basis
- Satisfies one of the following conditions:
  a. Is currently under a permanent legal guardianship of the participant or his or her spouse or domestic partner pursuant to chapter 159 of NRS; or
  b. Was eligible to be claimed as a dependent on the federal income tax return of the participant or his or her spouse or domestic partner for the immediately preceding calendar year; and
- Is in a relationship with the participant or his or her spouse or domestic partner that is like a child-parent relationship. The participant or his or her spouse or domestic partner must complete and submit to the Program an affidavit attesting to the facts of the relationship.

Disability: A determination by the Plan Administrator or its designee (after evaluation by a physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as intellectual disability, cerebral palsy, epilepsy, neurological disorder, or psychosis.

Domestic Partner: A person whose domestic partnership with another has been legally reistered or recognized as set forth in NRS 122A.030.

Drug: See the definition for prescription drug.

Durable Medical Equipment: Equipment which;

- can withstand repeated use;
- is primarily and customarily used for a medical purpose;
- is 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, 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 Medical Condition: A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Care: Medical and health services provided for an Emergency Medical Condition as defined above.

Emergency Services means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished an emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

> The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
>
> The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a out-of-network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and

- The participant or beneficiary gives informed consent to continued treatment by the out-of-network provider, acknowledging that the participant or beneficiary understands that continued treatment by the out-of-network provider may result in greater cost to the participant or beneficiary.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness, or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.

Employer: Unless specifically indicated otherwise when used in this document, employer refers to an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

Enteral Formulas: Specialized liquid nutritional products designed to provide nutrition directly into the gastrointestinal tract. **Exclusions:** Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Experimental and/or Investigational Services: Coverage for certain treatment received as part of a clinical trial or study for treatment of cancer or chronic fatigue syndrome will be provided subject to the requirements and limitations set forth in NRS 695G.173.

Unless mandated by law, the Plan Administrator, UM company, 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, UM company, 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."

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: Distress or impairment in social, occupational or other areas of functioning caused by a marked difference between the gender identity or expression of a person and the sex assigned to the person at birth which lasts at least 6 months and is shown by at least two of the following:

(1) A marked difference between gender identity or expression and primary or secondary sex characteristics or anticipated secondary sex characteristics in young adolescents.
(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to prevent the development of anticipated secondary sex characteristics in young adolescents.
(3) A strong desire for the primary or secondary sex characteristics of the gender opposite from the sex assigned at birth.
(4) A strong desire to be of the opposite gender or a gender different from the sex assigned at birth.
(5) A strong desire to be treated as the opposite gender or a gender different from the sex assigned at birth.
(6) A strong conviction of experiencing typical feelings and reactions of the opposite gender or a gender different from the sex assigned at birth.

Generic; Generic Drug: A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the pharmacist as being generic. (See also the Prescription Drug section of the *Schedule of Benefits* and the *Prescription Drug* subsection of the *Medical Exclusion* section).

Genetic Counseling: Counseling services provided before or in the absence of genetic testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of genetic testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from genetic testing, or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations. Tests that assist the health care practitioner in determining the appropriate course of action or treatment for a medical condition.

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.

Government-Provided Services: 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.

Health Care Facility: (for non-emergency services) is each of the following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, or other provider who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Key Terms and Definitions* section).

Health Reimbursement Arrangement (HRA): A Health Reimbursement Arrangement (HRA) is an employer-funded spending account that can be used to pay qualified medical expenses. The HRA is 100% funded by the employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted or insurance coverage kicks in. The contribution amount per employee is set by the employer, and the employer determines what the funds can be used to cover and if the dollars can be rolled over to the next year. In most cases, if the employee leaves the employer, they cannot take the remaining HRA funds with them.

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 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 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 limited life expectancy. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family.

A hospice agency must meet one of the following tests:

- It is approved by Medicare; or is licensed as a hospice agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
  - It provides 24-hour-a-day, 7 day-a-week service.
  - It is under the direct supervision of a duly qualified physician.
  - It has a full-time administrator.
  - 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.
  - The main purpose of the agency is to provide hospice services.
  - It maintains written records of services provided to the patient.
  - It maintains malpractice insurance coverage.
- A hospice agency that is part of a hospital will be considered a hospice agency for the purposes of this Plan.

Hospital: A public or private facility or institution, other than one owned by the U.S Government, licensed and operating according to law, that:

- Is legally operated in the jurisdiction where it is located.
- Is engaged mainly in providing inpatient medical care and treatment for injury and illness in return for compensation.
- Has organized facilities for diagnosis and major surgery on its premises.
- Is supervised by a staff of at least two physicians.
- Has 24-hour-a-day nursing service by registered nurses; and
- Is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or skilled nursing facility or similar institution; or a Long-Term Acute Care Facility (LTAC).

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, birth (or birthing) center, hospice, skilled nursing facility, sub-acute care facility, or other place for rest, custodial care, or the aged shall not be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician, and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be an illness only for coverage under this Plan. However, infertility is not an illness for coverage under this Plan.

Independent Freestanding Emergency Department: A health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates, or fats, as diagnosed by a physician

using standard blood, urine, spinal fluid, tissue, or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an Inherited Metabolic Disorder under this Plan. See Special Food Products.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to teeth are payable under the medical Plan.

In-Network Provider: Means an In-Network provider that the network or one of its rental networks have contracted with or have arrangements with to provide health services to covered individuals. An In-Network provider has agreed to charge participants a discounted rate. To determine if a provider is an In-Network provider log on to https://pebp.nv.gov/. You may also call the number 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).
- Medicare Allowable.

The Plan will reimburse the actual charge(s) if they are less than the Plan's Maximum Allowable Charge amount(s). The Plan has the discretionary authority to decide if a charge is reasonable and appropriate, as well as medically necessary. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

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

1. Provided in accordance with generally accepted standards of medical practice;
2. Clinically appropriate with regard to type, frequency, extent, location and duration;
3. Not primarily provided for the convenience of the patient, physician or other provider of health care;

4. Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and
5. The most clinically appropriate level of health care that may be safely provided to the insured.

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

- It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility:
- The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

Medically Necessary for External Review: Means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.

Medical management technique: A practice which is used to control the cost or use/utilization of health care services, prescription drugs, or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.

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 types of medications. See also the definition of Nurse.

Morbid Obesity: Characterized by body mass index >40 kg/m(2) as defined by the National Library of Medicine.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage, or herbal tea. Note: Naturopathy providers, treatment, services, or substances are not a payable benefit under this Plan.

No Surprises Act means the federal No Surprises Act (Public Law 116-260, Division BB).

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but

not limited to) bandages, hypodermic syringes, diapers, soap, or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the *Schedule of Benefits* are covered by this Plan. All others are not.

Non-Network: See *Out-of-Network*.

Non-PPO emergency facility: An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively

Non-PPO Provider or Non-Participating Provider: A health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA) and authorized to administer Anesthesia in collaboration with a physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners under the laws of the state or jurisdiction where the services are rendered.

Obesity: Body mass index of 30 kg/m2 or higher is used to identify individuals with obesity as defined by the National Library of Medicine.

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 Rate: With respect to items and services furnished by a Non-PPO provider, Non-Network emergency facility or Non-PPO provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system

Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network services that are provided by a health care provider that is a member of the PPO. Greater expense could be incurred by the participant when using Out-of-Network providers.

Out-of-Pocket Maximum (OOPM): 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, 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 default 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 Doctor or Primary Care Physician (PCP): A physician or group of physicians who:

1. Provides initial and primary health care services to an insured;
2. Maintains the continuity of care for the insured; and
3. May refer the insured to a specialized provider of health care.

This may include a physician in family practice, internal medicine, pediatrics, obstetrics and gynecology. **Prognathism:** The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: Means the Public Employees' Benefits Program 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).

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 Medical Child Support Orders (QMCSO): QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce, and also include a National Medical Support Notice. A QMCSO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- Specifies your last known name and address and the child's last known name and address.
- Describes the type of coverage to be provided, or how the type of coverage will be determined.
- States the period to which it applies; and
- Specifies each plan to which it applies.

The QMCSO cannot require the Plan to cover any type or form of benefit that they do not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions. You and the affected child will be notified if an order is received.

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR 716-6(c).

Quantity Limit: The maximum amount of a medication the Plan covers during a period of time. These limits are set for safety reasons and to help reduce costs.

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

- The facts and circumstances giving rise to the need for the service or supply.
- Industry standards and practices as they are related to similar scenarios; and
- 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: A methodology that determines the cost for a covered service based on a market or industry benchmark or reference price. The Plan Administrator may utilize this method in determining the Maximum Allowable Charge.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, or medically necessary treatment of a behavioral health condition, and that is performed by a licensed therapist acting within the scope of his or her license. See the *Schedule of Benefits* and the *Exclusions* section of this document to determine the extent to which rehabilitation therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

Reimbursable Payments: Payments made by this Plan for benefits, including any payment for a covered pre-existing condition that are or become the responsibility of another party under the subrogation provisions as described in this MPD.

Rescission: A cancellation or discontinuance of coverage under the Plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the Plan if

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Retiree: Unless specifically indicated otherwise, when used in this document, Retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges and do not exceed the Plan's Maximum Allowable Charge or negotiated fee schedule.

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

Serious and Complex Condition: With respect to a participant, beneficiary, or enrollee under the Plan one of the following:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a condition that is—
  - is life-threatening, degenerative, potentially disabling, or congenital; and
  - requires specialized medical care over a prolonged period of time.

Service Area: The geographic area serviced by the In-Network providers who have agreements with the Plan's network.

Sickle Cell Disease: An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable. See also NRS 439.4927.

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 the following requirements:

- Is licensed pursuant to state and local laws.
- Is operated primarily for providing skilled nursing care and treatment for individuals convalescing from injury or illness.
- Is approved by and is a participating facility with Medicare.
- Has organized facilities for medical treatment.
- Provides 24-hour-a-day nursing service under the full-time supervision of a physician or registered nurse.
- Maintains daily clinical records on each patient.
- Has available the services of a physician under an established agreement.
- Provides appropriate methods for dispensing and administering drugs and medicines.
- Has transfer arrangements with one or more hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one physician; and
- Is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

A skilled nursing facility that is part of a hospital, as defined in this document, will be considered a skilled nursing facility for the purposes of this Plan.

Special Food Product: (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 and who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication.

Spinal Manipulation / Chiropractic Care: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by physicians.

Spouse: The employee's lawful spouse. The Plan will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

Standard Plan Benefits (Standard Benefits): Standard Plan Benefits or Standard Benefits under this Plan means the participant is covered under the Plan's Standard Benefits and is not eligible for enhanced benefits due to non-participating and or engaging in programs such as the Obesity Care and Overweight Management Programs.

State: When capitalized in this document, the term State means the State of Nevada.

Step Therapy: see also "Medical Management technique." A process designed to help control high medicine costs. If the Plan applies step therapy to your medication, it will require that you try a lower-cost medication that is proven effective to treat your condition, before it will cover a higher-cost medicine. If the lower cost medicine does not treat your condition effectively, the Plan's coverage will "step" you to a higher-cost medicine to find a medicine that treats your condition effectively at the lowest possible cost.

The Plan also complies with step therapy for treatment of cancer or cancer symptom that is part of step therapy protocol per NRS 695G.1675.

Sub-acute Care Facility: A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide sub-acute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, to the patient's home or to a suitable skilled nursing facility, and that meets of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Sub-Acute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and
- It maintains on its premises facilities necessary for medical care and treatment; and
- It provides services under the supervision of physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse; and
- It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
- It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current

edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of behavioral health disorders and chemical dependency.

Surgery/Surgeries: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the claims administrator will determine which multiple surgical procedures will be considered as primary, secondary, bilateral, add-on, or separate (incidental) procedures for determining benefits under this Plan.

Multiple Surgical Procedure Allowances:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: usual and customary, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Bilateral secondary procedure in same operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Add-on to secondary procedure in same operative area: limited to 100% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.
- Separate (incidental) procedure in same operative area as any of the above: not covered.
- Separate operative area: limited to 50% of usual and customary charge, subject to the Plan's Maximum Allowable Charge or negotiated fee.

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

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The Temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring, or hissing in one or both

ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Termination: Under the No Surprises Act, **i**ncludes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Therapist: A person trained in and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy. *See the Occupational, Physical and Speech Therapy* section.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, 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 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, vomiting, or bladder infections.

Urgent Care Claim: Means a claim for benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not urgent care claims could seriously jeopardize the participant's life, health, or the ability to regain maximum function by waiting for a routine appeal decision. An urgent care claim also means a claim for benefits that, in the opinion of a physician with knowledge of the participant's medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for precertification of an urgent care service was denied, the participant could request an expedited appeal for the urgent care claim.

Urgent Care Facility: A public or private hospital-based or free-standing facility, which includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an

urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance when the facility is open.

Usual and Customary: Covered expenses which are identified by PEBP, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) most patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, country, or such greater area as is necessary to obtain a representative cross- section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made.

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

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

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

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

Utilization Management (UM): A managed care process to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include (but is not limited to): precertification; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM, utilization review services, UR services, utilization management, concurrent review, or retro review services) are provided by licensed health care professionals employed by the utilization management company operating under a contract with the Plan.

Utilization Management Company (UM company): The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan's utilization management services.

Visit: See the definition of office visit.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary, even though they are not provided because of illness, injury, or congenital defect. The Plan's coverage of well-baby care is described under *Preventive Care/Wellness Services* and in the *Schedule of Benefits*.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.