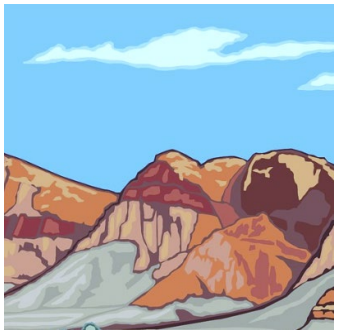
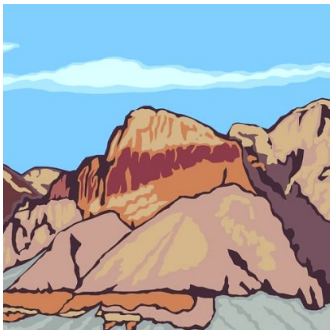
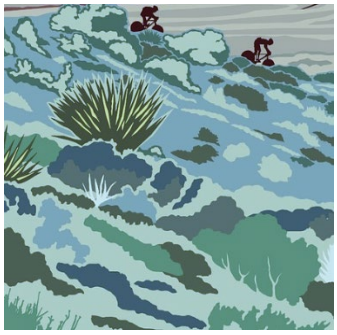
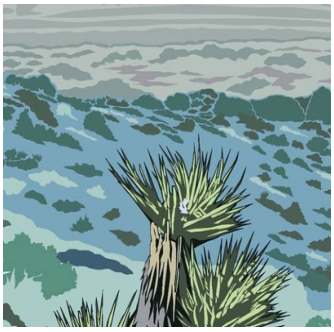
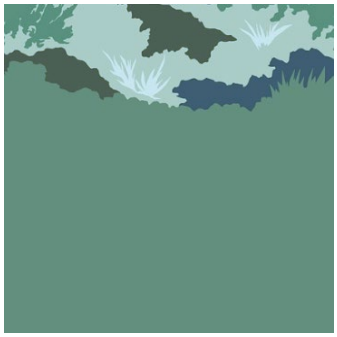
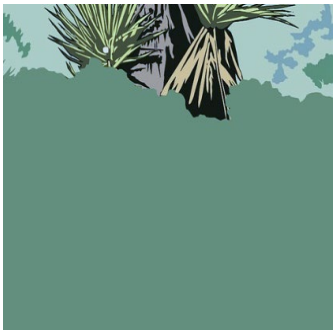
LOW DEDUCTIBLE PPO PLAN
MASTER PLAN DOCUMENT

PLAN YEAR 2026

(EFFECTIVE JULY 1, 2025 – JUNE 30, 2026)

Public Employees' Benefits Program

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Public Employees' Benefits Program
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Table of Contents

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.

Overview

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

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

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

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

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

This document does not provide information on eligibility and enrollment, only the components of this health plan.

Introduction

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

This Master Plan Document describes the 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 TPA 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, 2025**, and unless stated differently, replaces other PPO Plan documents/summary plan descriptions previously provided to participants.

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.

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

Participant Rights

- Participate with their health care professionals in making health care decisions and have their health care professionals provide information about their condition and treatment options.
- Receive the benefits for which they have coverage.
- Be treated with respect and dignity.
- Privacy of their personal health information, consistent with State and Federal laws, and the Plan's policies.
- Express respectfully and professionally any concerns had 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 their physician(s) of the medical consequences.

LD PPO Components

The Low-Deductible PPO Plan is a PEBP administered preferred provider organization (PPO) plan which provides both In-Network and Out-of-Network benefits. Participants 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 in making informed decisions about health care services. For more information visit *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	$0	$8,000 Individual family Member: $4,000	$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

A deductible is an amount a participant may owe during a coverage period (usually one year) for covered health care services before the Plan begins to pay. An overall deductible applies to all or

almost all covered items and services. In this Plan, there are both an individual deductible, a family deductible, and out of pocket maximums for both individual and family. Deductibles and out-of-pocket maximums apply to both in-network and out-of-network providers.

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 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.

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.

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**.

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**.

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**.

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**. 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. 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 participants share of the cost of a covered service

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

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

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

Copayments

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

Copays are usually set amounts and are typically paid at the time of service.

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

Cost-Share or Cost Sharing

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

Out-of-Pocket Maximums

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

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

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

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

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

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

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

In-Network Out-of-Pocket Maximums

The In-Network Out-of-Pocket Maximum (OOPM) is the maximum amount participants will pay for In-Network eligible medical and prescription drug expenses during the Plan Year.

- 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.

Out-of-Network Out-of-Pocket Maximum

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

Covered health services and billing for services use standards such as medically necessary, usual and customary, reasonable, and provider of health care.

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 participants 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.

Usual and Customary

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.

Usual and customary" in the context of healthcare and insurance refers to the typical fees charged by providers for a specific service or procedure in a particular geographic area. Insurance companies often use this as a benchmark to determine how much they will reimburse for a service.

Reasonable

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

- 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.

Provider of Health Care

A provider of health care is a licensed individual or facility that provides health care services. General examples include doctors, nurses, therapists, pharmacists, laboratories, and hospitals.

NRS 629.031 lists individual medical disciplines that fall under the auspice of a provider of health care, however, there are other synonymous terms such as health care professional, health care practitioner, health care worker, medical provider or medical practitioner that may be referenced within the document.

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

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

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

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

The TPA is responsible for managing network providers by confirming public information about the providers' licenses and other credentials but does not guarantee the quality of the services provided.

Provider Types

- **Provider:** An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.
    - **Primary Care Provider**: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps participants access a range of health care services.
    - **Specialist:** A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
    - **Facility:** An entity that provides health care or medical services. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located and is operated and equipped in accordance with applicable state law, and includes, but not limited to:
- Hospitals

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

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

The provider network is subject to change. Or In-Network providers may not be accepting new patients. If a provider leaves the network or is otherwise not available, participants must choose another In-Network provider to get In-Network benefits.

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

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. The TPA shall evaluate on a case-by-case basis.

In-Network Provider Benefits

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

Out-of-Network Provider Benefits

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

Out-of-Network health care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will pay benefits based on the Plan's Maximum Allowable Charge on non-discounted medically necessary services or supplies, subject to the Plan's cost-share (Deductibles, Copay, and/or Coinsurance).

Other Providers

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

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

Out-of-Network Benefit Exceptions

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

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

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 participants 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.

Directories of Network Providers

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

A list of In-Network providers is available to participants without charge by contacting the TPA. 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. The list of PPO providers is maintained and updated by the contracted network based on information supplied by Providers.

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

Eligible Medical Expenses

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

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

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

Generally, the Plan will not reimburse participants for all eligible medical expenses. Usually, participants will have to pay some portion of costs, known as cost-sharing such as Copayments, Deductibles, or Coinsurance toward the amount's participants incur that are eligible medical expenses. However, participants are only required to pay copayments and coinsurance for eligible medical expenses up to the Plan year individual or family out-of-pocket maximum.

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 ineligible for reimbursement, are excluded from the Plan, and do not accumulate towards participants Deductible and Out-of-Pocket Maximum.

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

- Not determined to be medically necessary (unless otherwise stated in this Plan).
- Determined to 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 participants are required to pay because of a penalty for failure to comply with the Plan's utilization management requirements described in the *Utilization Management* section of this document. If participants fail to follow certain requirements of the Plan's utilization management program, the Plan may pay a smaller percentage of the cost of those services, and participants may have to pay a greater percentage of those costs. The additional amount owed is in addition to the 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. Participants are responsible for paying these expenses out of their own pocket.

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

PPO Network Health Care Provider Services

If participants receive medical services or supplies from an In-Network PPO provider, participants will be responsible for paying less money out-of-pocket. Health care providers who are participating as providers of the PPO network have agreed to accept the PPO network negotiated amounts in place of their standard charges for covered services. Participants 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 participants 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.

Out-of-Country Medical, Prescription and Vision Purchases

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

Typically, providers in foreign countries do not accept payment directly from the Plan. Participants may be required to pay for medical and vision care services and submit their receipts to this Plan's TPA 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.

Prior to submitting receipts from a foreign country to this Plan's TPA, participants must complete the following:

- Proof of payment from the participant to the provider of service (typically a credit card invoice).
- Itemized bill to include complete description of the services rendered and admitting diagnosis(es).
- Itemized bill must be translated to English.
- Reimbursement request converted to United States dollars.
- Foreign purchases of medical care and services are subject to Plan limitations such as:
    - Benefit coverage
    - Coinsurance and deductibles

- Frequency maximums
- Annual benefit maximums
- Medical necessity
- FDA approval
- Usual and Customary or this Plan's Maximum Allowable Charge

The Plan Administrator and the TPA reserve the right to request additional information. If the provider will accept payment directly from the third-party claim's administrator, participants must also provide the following:

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

Once payment is made to the participant 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 the participant or to the out-of-country provider if the 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 TPA listed in the *Participant Contact Guide*.

Utilization Management

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

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

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

Utilization Management is conducted by an independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professionals, operating under a contract with the Plan to administer the Plan's utilization management services.

The health care professionals at the UM company focus their review on the medical necessity of hospital including medical necessity, 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 *Health and Welfare Wrap Plan* document. For example, benefits would not be payable if the participant's 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.

PEBP, the TPA, and the UM company are not engaged in the practice of medicine and are not responsible for the outcomes of health care services rendered (even if the health care services have been authorized by the UM company as medically necessary), or for the outcomes if the

patient chooses not to receive health care services that have not been authorized by the UM company as medically necessary.

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

Delivery of Services

Participants 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. These services, although not all-inclusive are those that generally:

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

Concurrent Review

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

In practice, this is a continued stay review, or an ongoing assessment of health care currently being provided inpatient, specifically a hospital or skilled nursing facility. The UM company monitors an inpatient stay by contacting physicians or other providers to ensure that continuation of medical services in the facility is medically necessary. The UM company will also help coordinate medical care with other healthcare benefits available under the Plan.

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

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

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 the physician or other providers of various options and alternatives for medical care available under this Plan.

Retrospective Review

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

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 participants and their family, caregivers, providers, the TPA, and the Plan Administrator or its designee to coordinate a quality, timely and cost-effective treatment program. Case management services are particularly helpful when the patient 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 the participant's 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 physicians or other providers and may contact the participant or their family to assist in making plans for continued health care services or obtaining information to facilitate those services.
The case manager will be available at any time to answer questions, make suggestions or offer information.

Prior-authorization Process

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

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

In practice, for a benefit to be covered, the UM company must approve and/or pre-certify the service**.** The UM company uses nationally recognized guidelines and criteria as standard measurement tools to determine whether benefits are approved and/or pre-certified.

Prior authorization also includes 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. Failure to obtain prior authorization may result in benefits being reduced or denied. Participants are ultimately responsible for ensuring prior authorization is obtained as necessary.

Services Requiring Prior Authorization

Inpatient Admissions

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

Outpatient and Physician – Surgery

- 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

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

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

Outpatient and Physician – Diagnostic Services

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

Outpatient and Physician – Continuing Care Services

- Applied Behavior Analysis (ABA) Therapy for Medical, Mental Health, and Substance Use Disorder
- Electroconvulsive Therapy (ECT)
- 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.

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

Services Not Requiring 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*. The participant's physician or the hospital should call the UM company to initiate the concurrent review. Even though a prior-authorization may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding UM, such as concurrent review.

How to Request Prior Authorization

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

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

The UM company will review the information and provide a determination for participants, the physician, the hospital or other provider, and the TPA as to whether the proposed health care services have been determined to be medically necessary. Additionally, the UM company may approve medical necessity but not of care. In these circumstances, the UM company will provide approved alternate locations for 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 the physician or other provider by telephone within (5) five business days of receipt of the request. The determination will then be confirmed in writing.

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

Participants are responsible for ensuring prior authorization is obtained. Centers of Excellence Benefit (Voluntary)

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

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 participant is eligible to participate in the benefit, and this determination is

separate from the Utilization Management process described elsewhere. If participants would like to use the Center of Excellence Benefit, please contact Carrum Health.

Second Opinion

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

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

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

A participating provider, including a primary care physician, may notify the UM company to obtain prior-authorization for the services described in Services Requiring prior-authorization.

2nd.MD

2nd.MD is PEBP's preferred second opinion Service.

Non-Emergency Hospital Admission

Prior authorization is required for all non-emergency hospital admissions due to elective surgeries.

The physician or provider shall notify the UM company a minimum of 5 business days before the hospital admission. 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 prior authorization for hospital admission as not covered or determines that the services do not meet the UM company's medical necessity criteria, the Plan's TPA will only pay benefits for inpatient that has been pre-certified, and/or benefits for the elective surgeries and inpatient hospital stays may be reduced by 50% of this Plan's Maximum

Allowable Charge. This provision applies to both In-Network and Out-of-Network surgery expenses. Expenses related to the penalty will not be counted to meet the Out-of-Pocket Maximum, if applicable.
Participants are responsible for ensuring prior authorization is obtained.

Emergency and Urgent Hospital Admission

Emergency and Urgent Hospital Admissions includes complications of pregnancy.

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

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

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

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

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

No Suprises Act

A federal law that shields people from paying unexpected medical bills when a participant accidentally or unknowingly receives treatment from an out-of-network provider. The No Surprises Act bans surprise billing in a few situations, including receiving emergency services at

an out-of-network facility and receiving non-emergency services at an in-network hospital, but with an out-of-network provider.

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

Other Exceptions

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

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

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

Due to cost variations for elective knee and hip joint replacement performed in Nevada, the TPA 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.

Inpatient or Outpatient Surgery

The participant is 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.

The physician or other provider may notify the UM company, but it is the participant's 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 TPA will only pay benefits for inpatient or outpatient surgery that is pre-certified, and the services/supplies are a covered benefit.

Outpatient Infusion Services

Prior authorization is required for outpatient infusion services. The UM company will review the request based on covered benefits, medical necessity, provider quality, cost, and location. If participants choose to receive an infusion at a non-exclusive hospital or infusion center, they 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 the 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.

Air/Flight Schedule Inter-Facility Transfer

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

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

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

Emergency Air Ambulance

This Plan provides coverage for emergency air ambulance transportation for participants whose medical condition at the time of pick-up requires immediate and rapid transport due to 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 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 treatment for gender dysphoria.

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

Case management services are available for gender dysphoria.

Health Care Services and Supplies Review

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

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

Summary of Benefits

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

Benefit Description	In-Network	Out-of-Network
Physician Office Visits		
Primary Care Physician (PCP)	$30 Copay	Plan pays 50% after Deductible
Mental Health 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. ***Copay applies to primary care physician (PCP) visits, mental health office visits, and specialist office visits for evaluation and management services only; imaging, surgery, and other services provided during a PCP, mental health, or specialist office visit are subject to the Plan Year 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 and testing for sexually transmitted infections (STI), HIV and HEP C	$0 Copay	Not Covered
Breastfeeding support, supplies, and counseling	$0 Copay	Not Covered
Contact the TPA 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

First two ultrasounds for pregnancy	$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 prior authorization. In emergencies in which a* participant *is admitted to hospital for an inpatient stay, the UM company must be notified within 24 hours, the next business day following the admission. ***See the Utilization Management section for prior-authorization 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, the participant is responsible for paying this Plan's copayment amount, plus any amount exceeding the Plan's Maximum Allowable Charge.*
***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 participant for any amount exceeding the benefits paid.**

For example, if the participant has already met any deductible for the plan year, and uses 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%	**$1,120**
The Out-of-Network Provider May Bill participants For	**$ 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 prior-authorization 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, the participant is responsible for the Plan's cost-share and any amount exceeding the Plan's Maximum Allowable Charge. See the Utilization Management section for prior-authorization 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
Diagnostic ultrasound (first two pregnancy related are preventative)	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Non-Specialty Imaging and Diagnostic testing: When performed Out-of-Network, the participant is 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 panels, 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. *Prior-authorization 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 prior-authorization 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 prior-authorization.		

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 prior authorization.		
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 more than $1,000 require prior authorization.		
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 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 prior-authorization requirements for the services listed above.		
Mental health office visit (No prior-authorization requirements)	$30 Copay per Visit	Plan pays 50% after Deductible

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 prior-authorization. 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	Plan pays 50% after Deductible

	Inpatient: Plan pays 80% 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 the patient's medical physician. For outpatient bereavement counseling services, see Hospice Services in the Schedule of Benefits. Prior authorization 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 participants fill a prescription at a* **Preferred Retail Network** *retail pharmacy. If participants fill a prescription at a non-Preferred Retail Network** *retail pharmacy, participants will pay an additional $10 per prescription. If participants currently use a non-***Preferred Retail Network** *pharmacy and want to avoid the $10*			

upcharge, call a **Preferred Retail Network** *pharmacy to transfer the 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.*

* 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 a 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 nutritional counseling services will be determined by the TPA 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	$10 Copay	$10 Copay
Limited to one screening per Plan Year which may or may not include refraction, per covered individual. The maximum benefit this Plan will pay per Plan Year, per covered individual is $100. ***There is no maximum benefit for pediatric vision benefits.*** When refraction is conducted in conjunction with an examination with a medical diagnosis, such as cataracts, it will be paid under the medical benefit, subject to Deductible and Coinsurance.		
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.* ***There is no maximum benefit for pediatric vision benefits.***		

Prescription Drug Benefits			
In-Network Pharmacy Benefits			
	Preferred Retail Network **Pharmacies*** (30-Day Supply)	**Smart90 Retail Pharmacies** (90-Day Supply)	**Home Delivery** (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	Participants 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 participants fill a prescription at a* **Preferred Retail Network** *retail pharmacy. If participants fill a prescription at a non-Preferred Retail Network** *retail pharmacy, participants will pay an additional $10 per prescription. If participants currently use a non-***Preferred Retail Network** *pharmacy and want to avoid the $10 upcharge, call a* **Preferred Retail Network** *pharmacy to transfer the 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. Prior-authorization is required for many services, plan benefit limitations apply to certain benefit categories, and out-of-network charges are not covered unless otherwise specified in this document.

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

> *Example: If both inpatient care in a skilled nursing facility and intermittent, part-time nursing care in the home would be medically appropriate, and if inpatient nursing care would be less costly, this Plan could limit coverage to the inpatient care. This Plan could limit coverage to inpatient care even if this means extending the inpatient benefit beyond the quantity provided in the 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*. The Explanations and Limitations may not include every limitation. For more information relating to a specific benefit, refer to *Utilization Management* (for any prior-authorization requirements), *Benefit Limitations and Exclusions*, 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

A technique for treating disorders of the body by passing long thin needles through the skin.

- Acupuncture and acupressure are covered under this Plan if performed by a licensed health care provider acting within the scope of that license. Where licensing is not required, the provider must be certified by the National Certification Commission for Acupuncturists (NCCA).
- Acupuncture and acupressure services must be provided by an In-Network provider 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.

Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require prior authorization.

Allergy Testing and Treatment

Covered when performed by a licensed provider acting within the scope of their license.

Allergy services include sensitivity testing (including skin patch or blood tests such as Rast or Mast); Desensitization and hypo-sensitization, allergy antigen solution, and allergy shots.

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 with prior authorization from the UM company.

Applied Behavior Analysis (ABA)

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

- Subject to copayment, deductible, and coinsurance.
- Must have and follow a treatment plan.
- Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

Autism Spectrum Disorders

Autism Spectrum Disorder is 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.

- The Plan covers screening for and diagnosis of autism spectrum disorders and treatment of autism spectrum disorders for individuals under the age of 18, or if enrolled in high school, until they reach age 22.
- Subject to copayment, deductible, and coinsurance.
- Must have and follow a treatment plan.

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

Bariatric/Weight Loss Surgery

Bariatric weight loss surgery benefits and pre-and post-surgery benefits are available only when performed at an in-network Bariatric Surgery Center of Excellence facility, by an in-network surgeon and ancillary providers. A Bariatric Surgery Center of Excellence Facility is a provider that has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP),

The TPA will determine the in-network Bariatric Surgery Center of Excellence facility. It is the participant's responsibility to ensure that bariatric surgery services providers are in-network and facilities chosen to provide services are in-network.

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 bariatric surgery, they are still eligible to have one bariatric procedure paid for under the Plan, provided that prior-authorization 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 prior authorization.

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 TPA 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 prior-authorization requirements. For the Plan to consider a participant's bariatric surgery a covered benefit; they will have to begin the prior-authorization 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.

Prior authorization/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 prior authorization process begins with initial contact with the UM company.
- Notifying the participant that prior-authorization requests presented to the UM company before the clinical criteria listed below have been completed will be denied. A prior-authorization 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 providers 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 participant and one additional person (spouse/domestic partner, family member, or friend) when associated with bariatric/weight loss surgery and is performed at a Center of Excellence that is located 50 or more miles from the participant'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 the 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.

Blood Transfusions

A blood transfusion is the use of donated blood for the purposes of surgeries, injuries,

diseases, or bleeding disorders.

Services include blood products, blood transfusions, and equipment for its administration. Includes autologous blood donations.

Chemotherapy

Chemotherapy is the treatment of a disease or cancer using chemical substances.
Services include chemotherapy drugs and supplies administered under the direction of a physician in a hospital, health care facility, physician's office or at home. Requires prior authorization.

Outpatient prescription drugs for chemotherapy are payable under the prescription drug benefits.

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

Chiropractic Services

Chiropractic services must be medically necessary by meeting the following:

1) participant has objective medical findings of a neuro-musculoskeletal disorder, and
2) a treatment plan has been established including treatment and discharge goals.

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

- Services are limited to 20 visits per Plan Year.
- Maintenance services are not covered.
- Refer to Radiology Services for X-Rays and other types of testing.
- Outpatient prescription drugs for neuro-musculoskeletal disorders are payable under the prescription drug benefits.

Clinical Trials

Experimental services refer to services, procedures, drugs, or equipment that is not considered standard medical care for a condition and have not been proven effective. A service, procedure,

drug, or equipment may be approved for one condition but not another. General criteria for experimental or Investigative Services if at least one of the following is met.

- The intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or
- Available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or
- The intervention is not proven to be as safe or effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or
- The intervention does not improve health outcomes; or
- The intervention is not proven to be applicable outside the research setting.
- Prior authorization is required.

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

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).

- Must be medical necessary and ordered by a physician.
- Glasses, contact lenses, hearing aids and durable medical equipment are referred to in other sections.

This Plan pays for the purchase of standard models. There is coverage for repair, adjustment, or servicing of the device or replacement of the device due to a change in the participant's physical condition that makes the original device no longer functional or if the device cannot be satisfactorily repaired.

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 and for training and education provided after the participant is 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.

Dialysis

Dialysis is a treatment that replicates the kidney's functions and cleans waste from blood for individuals with kidney disease or failure.

- Hemodialysis or peritoneal dialysis and supplies are covered under this Plan.
- Covered when ordered by a physician and administered in a hospital, health care facility, and physician's office or at home. Outpatient, inpatient or home dialysis must be prior authorized by PEBP's utilization management company.

Durable Medical Equipment (DME)

DME is equipment which can withstand repeated use, used for a medical purpose, used when someone is sick or injured, used at home, and expected to last at least three (3) years. Some items like wheelchairs may last a lifetime.

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 prior authorization from the UM company.

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 a participant's medical provider to treat a medical condition).

Enteral Formulas and Special Food Products

The Plan covers enteral formulas and special food products which are specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease in

accordance with NRS 689B.0353. These products are for use at home that are prescribed or ordered by a physician as medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after both, of amino acid, organic acid, carbohydrate, or fat.

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.

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.
Male condoms are covered under this plan for males and females aged 13 and above.

- The medical plan may reimburse the purchase
- May be obtained in an in-network pharmacy with a prescription

Gender Dysphoria

Gender dysphoria is a condition characterized by a significant and persistent distress or discomfort with one's assigned sex or gender identity. It is defined as:

- A marked difference between one's experienced gender and the sex assigned at birth.
- A strong desire to live and be recognized as the opposite gender.

- Significant distress or impairment in social, occupational, or other important areas of functioning due to the difference between experienced gender and assigned sex.

It is important to note that gender dysphoria is distinct from gender nonconformity, which refers to individuals whose gender expression or identity does not align with traditional expectations associated with their assigned sex but does not cause significant distress.

The Plan covers medically necessary treatment of conditions relating to gender dysphoria and gender incongruence, including medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by health care practitioners acting within the scope of their license.

For surgical intervention to be approved, the following must be met:

1) Recommended by a physician
2) Recommended by a mental health professional
3) The individual must express the desire to undergo treatment
4) Parental consent is obtained, if under 18
5) Meets medical necessity under standards of car.

If coverage for treatment of a condition relating to gender dysphoria or gender incongruence is denied on the basis that the requested treatment is not medically necessary, consideration of any appeal from such denial will include consultation with a health care provider who has experience in prescribing or delivering gender-affirming treatment.

This plan does not cover the following:

Treatment outside of the United States

- Cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary. “Cosmetic surgery” means a surgical procedure that does not meaningfully promote the proper function of the body, does not prevent or treat illness or disease, and is primarily directed at improving the appearance of a person.
- Reproductive services such as sperm preservation or cryopreservation of fertilized embryos

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.

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.

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 TPA to determine if proposed genetic testing is covered or excluded and the UM company for prior-authorization requirements. See also the exclusions related to prophylactic surgery or treatment later in this section.

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 participant.

Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing is not covered. Benefits include amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), alpha-fetoprotein (AFP), BRCA1 and BRCA2, apo E. This list is not all-inclusive for what genetic tests may be covered. Contact the UM company for coverage details and prior authorization requirements for covered genetic testing.

Hearing Aids

When air conduction hearing aids are medically necessary: each air conduction hearing aid is subject to a $50 copay (per device, per 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 TPA 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 PBM and is designed to help participants 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. Participants 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.

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

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.

- The maximum Plan benefit for home health care (skilled nursing care services) and supplies to provide home health care and home infusion services is 60 visits per person per Plan Year. Additional visits are subject to prior authorization by the UM Company.
- A home health care visit will be considered a periodic visit by a nurse or therapist, or four (4) hours of home health services.
- Charges are covered for private duty nursing by a licensed nurse (RN or LVN/LPN) only when care is medically necessary and not custodial in nature. Outpatient private duty nursing care on a 24-hour shift basis is not covered.

Excluded from home health care coverage are:

- Personal care, custodial care, domiciliary care, or homemaker services.

- 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 participants who are terminally ill with a life expectancy of six months or less.

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

Pre-Planned Hospital Services (Inpatient)

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

If participants are incapacitated and they nor (or a friend or relative) can notify the UM company within the above stated times in the UM section above, the UM Company must receive notification as quickly as reasonably possible after admission or they may be subject to reduced benefits as provided in this Plan.

Skilled Nursing Care

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 convenient in nature. Skilled nursing care includes medically necessary services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse. This Plan does not cover skilled nursing care that is not covered by CMS. Prior care in a hospital is not required before being eligible for coverage for care in a skilled nursing facility.

Medical Prescription Coupon Program

For drugs administered in an inpatient setting, there is a “UMR Prescription Copay Maximizer Benefit" where a participant may receive cost-share assistance. A UMR patient advocate will conduct outreach to participants and introduce the UMR Prescription Copay Maximizer Program. The participant can voluntarily enroll in qualifying copay assistance programs. This may help the participant 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.

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. Prior authorization is 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 laboratories 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 illness 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 a participant's residence, they 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.

To be covered at 100%, the lab must be used to proactively screen for protentional diseases for which a participant has no symptoms of. This includes, but not limited to, cholesterol to screen for heart disease.

- Labs used to diagnose or rule out conditions are diagnostic and subject to cost sharing.

Mastectomy and Reconstructive Surgery

Breast reconstructive surgery and internal or external prosthetic devices are covered for participants 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 participant or 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 a bra) that are needed 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).
- Implants and/or autologous tissue.

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 a leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy. The mastectomy and breast reconstruction may be performed together or separately and must be prior authorized.

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

Maternity and Newborn Services

This Plan covers hospital and birth center charges and professional fees for medically necessary maternity services.

Prenatal care and delivery are covered for an employee or spouse/domestic partner only.

- For covered dependent children, only prenatal coverage is provided for maternity, except for complications of pregnancy for the dependent child.

Some preventive prenatal services including, but not limited to, obstetrical office visits, breastfeeding support, screening for gestational diabetes, blood type, and Rh lab services for spouses and dependent children may be covered under the preventive care benefit. The preventive benefit does not include delivery of the newborn(s).

Coverage for newborn and adopted children and children placed for adoption includes coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center.

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.

Hospital length of stay for childbirth: This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the Plan or its UM Company for prescribing a length of stay not more than those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

Elective termination of pregnancy is covered in accordance with NRS 442.250.

When the participant has Employee-Only coverage, the newborn will be covered under the participant'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. Please see the Enrollment and Eligibility Master Plan Document for information about extending coverage for a newborn beyond the initial 31-day 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 with prior-authorization.

Coverage includes gestational carriers.

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 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.

Behavioral Health Services

A behavioral health condition/illness is 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.

Medically necessary behavioral 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.

Behavioral health services payable by this Plan include:

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

Prior authorization is required for inpatient admissions, partial hospitalization, partial day treatment, intensive outpatient programs, and day treatment.

The Plan provides benefits for intermediate levels of care for behavioral health disorders and/or chemical dependency disorders in parity with medical or surgical care of the same level. If the Plan provides benefits for a skilled nursing facility for medical or surgical treatment, the Plan will provide equal behavioral health disorder and/or chemical dependency disorder benefits for intensive outpatient therapy, partial hospitalization, residential treatment, and inpatient treatment.

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. Participants 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 defined as:

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 require immediate medical attention for a medical or mental health condition.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that would result in any of the following: (1) placing the person's health (or, with respect to a pregnant person, the health of the pregnant person or unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

A mental health condition is an emergency medical condition when it meets the requirements of the paragraph above or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true: The person is an immediate danger to themself or to others, or the person is immediately unable to provide for or use food, shelter, or clothing due to the mental disorder.

Urgent care is the middle ground between a primary care physician and an emergency room and is for medical conditions that require prompt attention but not serious enough to meet the definition of an emergency. No prior authorization is needed and both in and out-of-network providers will be reimbursed at the in-network rate. Deductibles, coinsurance, and out of pockets maximums apply.

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 their treatment and any advance limitations that the Plan may put on the treatment, of the names of any IN-NETWORK providers at the facility who are able to treat the participant, and that the participant 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 an Out-of-network Provider at an 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 an Out-of-network provider at an 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 an 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 an IN-NETWORK provider,
- Non-emergency items or services performed by an Out-of-network provider at an IN-NETWORK facility will be covered based the participant's 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 an Out-of-network provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on treatment, of the names of any In-Network providers at the facility who are able to treat participants, and that participants 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 oOut-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 an 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.

The 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

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

Transfer to another facility if deemed necessary. Requires prior authorization.

- As part of the prior authorization review, the Plan Administrator retains the discretionary authority to limit benefit availability to alternative providers of flight-based inter-facility patient transport if a provider fails to comply with the terms of the Plan, or the proposed charges exceed the maximum allowable charge in accordance with the terms of this Plan.
- Emergency air ambulance transportation when a medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness/injury.
- The patient's destination is an acute care hospital, and
- The Patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health, or
- Inaccessibility to ground transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.

The Plan Administrator retains discretionary authority to limit benefit availability for air emergency ambulance and/or inter-facility patient transfer when a provider fails to comply with the terms of this Plan, except where provided by the No Surprises Act.

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

- The Air Ambulance services received from an 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 an In-Network provider.
- In general, participants cannot be balanced billed for these items or services. The cost-sharing will be calculated as if the total amount that would have been charged for the services by an 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 made with respect to covered Air Ambulance services will count toward the Network (IN-NETWORK) deductible and Network (IN-NETWORK) out-

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

Payments to out-of-network Providers and Facilities (Emergency Services)

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 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 (Emergency Services)

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 participants are receiving continued medical treatment for a medical condition from a provider of health care, and the contract with the Network provider or facility terminates, or the 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. Participants will be notified in a timely manner of the contract termination and of their right to elect continued transitional care from the provider or facility; and
2. Participants 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.

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.

Incorrect In-Network Provider Information

A list of In-Network providers is available to participants without charge by visiting the website or by calling the phone number on the 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 participants 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 the claim, even if the provider was Out-of-network.

Obesity Care Management Program

The Obesity Care Management (OCM) Program is a disease management program that provides enhanced benefits to participants who have been diagnosed as obese by their physician and have enrolled in the OCM Program. This program is operated by the Pharmacy Benefit Manager (PBM).

Oral Surgery, Dental Services, and Temporomandibular Joint Disorder

Expenses for dental services may be covered under the medical plan if the expenses are incurred for the repair or replacement of injury to teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the medical Plan, an

accident does not include any injury caused by biting or chewing.

Treatment of injury to teeth must be provided by a dentist or physician and is limited to restoration of teeth or jaw to a functional level, as determined by the Plan Administrator or its designee.

Coverage for dental services as the result of an injury to teeth will be extended under the medical plan to a maximum of two years following the date of injury, regardless of date enrolled in the plan. Restorations past the two-year time frame may be considered under the dental benefits described in the PEBP Self-funded Dental PPO Plan Master Plan Document available at https://pebp.nv.gov/.

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; 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 participant when services are rendered in a hospital or outpatient surgical facility, when the 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, 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.

Prior-authorization 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:

- 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 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 participants 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 minimum inconvenience.

Rehabilitation Services (Physical, Occupational, and Speech Therapy) 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.
    - Maintenance Rehabilitation and coma stimulation services are not covered.

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 participant 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 <u>not</u> 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:

- Physical examinations (one preventive per Plan Year). Covered as preventive if routine and asymptomatic. Elements over and above the physical examination of someone who is asymptomatic are subject to coinsurance.
- Routine gynecologic examination. Includes a cytologic screening test (Pap smear), HPV testing, pelvic examination, urinalysis, and breast examination. Covered as preventive if routine and asymptomatic. The identification of problems, removal/biopsy are subject to coinsurance. The frequency is at the recommendation of the physician based on results.
- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics.
- Colorectal cancer screening at age 50 through 75 years of age. For adults aged 76-85, the decision to screen is individualized. Covered as preventive if routine and asymptomatic. The identification of problems, removal/biopsy are subject to coinsurance.
- 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.
    - 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.
- 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.
- HIV Screening in individuals 15 to 65 years of age.
- Mammography for women aged 40 and older. Additional mammography recommendations include high risk women (20% chance or greater of developing breast cancer) beginning at age 30, and some women with genetic mutations present beginning at age 20. Men at high risk or with genetic mutations presentation may receive breast cancer screenings, including mammograms and other diagnostic testing
- HIV, Hepatis B, and RH (D) incompatibility screening in pregnant women.

- Sexually transmitted diseases, including syphilis, screening in pregnant women and individuals aged 13 and above who are at increased risk.
- Tobacco use screening in pregnant women and non-pregnant adult,
- Blood pressure screenings is covered for individuals aged 18 and above.

Women's Contraception

This Plan covers FDA-approved contraceptive methods, 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.

Methods of covered contraception include: elective sterilization for women; surgical sterilization implants for women; implantable rods; copper-based intrauterine devices; progesterone-based intrauterine devices; injections; combined estrogen- and progestin-based drugs; progestin-based drugs; extended- or continuous-regimen drugs; estrogen- and progestin-based patches; vaginal contraceptive rings; diaphragms w/spermicide; sponges w/spermicide; cervical caps w/spermicide; female condoms; spermicide; combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; ulipristal acetate for emergency contraception.

Covered contraception also includes contraceptive injection or the insertion of a contraceptive device at a hospital immediately after an insured gives birth.

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 participants 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 beginning at age 40 years of age, or beginning at age 30 for participants with a high-risk (20% chance or greater) of breast cancer, when performed in-network. Some women with genetic mutations present beginning at age 20. Men at high risk or with genetic mutations presentation may receive breast cancer screenings, including mammograms and other diagnostic testing

Healthy Diet and Physical Activity Counseling 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 a physician.
- Benefits for over-the-counter products are limited to those that are FDA approved and recommendations by the Surgeon General.
- Over-the-counter smoking/tobacco cessation products may be obtained by presenting a physician's written prescription to an In-Network pharmacy, or participants can submit the purchase receipt for the product with a 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, The FDA currently prohibits 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.

Radiation Therapy

Medically necessary professional services related to radiation therapy are covered.

Real Appeal

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

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

A qualified enrolled participant will receive:

- Access to a coaches who will guide participants through the program and develop a custom plan that fits the participants needs, preferences, and goals.
- 24/7 access to digital tools and dashboards.
- A Real Appeal kit containing health and weight management tools that may include fitness guides, recipes, digital food and weight scales
- Support from online group classes with a coach and other participants 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 participants 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.
- 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 participants with direct access to elite specialists across the country 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*.

Participants 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 the participant's responsibility to ensure the providers used are in-network providers. Failure to use in-network providers will result in a denial of benefits and higher cost to the participant.

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 prior-authorization (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 accommodation 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.

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 the TPA.

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 participant and one additional person (travel companion). Travel expenses are covered when incurred in conjunction with the participant'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* , to the nearest care center for abortion services covered under this Plan.

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 participant is unable to obtain pre-approval because the organ or tissue transplant required immediate travel, the participant may submit travel costs to PEBP or its designee after the transplant surgery.
  -

Pre-approval will provide an estimation of the 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 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. participants may be liable for taxes and must consult their 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

One annual screening per Plan Year which may or may not include refraction, per covered individual. The maximum benefit this Plan will pay per Plan Year, per covered individual is $100.

When refraction is conducted in conjunction with an examination with a medical diagnosis, such as cataracts, it will be paid under the medical benefit, subject to Deductible and Coinsurance.

PEBP does not maintain a network specific to vision care; however, the PPO network does have a list of some vision providers. There is no maximum annual benefit amount for pediatric vision services.

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. There is no maximum annual benefit amount for pediatric vision services.

Schedule of Prescription Drug Benefits

Benefits for prescription drugs are provided through the prescription drug plan administered by the Pharmacy Benefit Manager (PBM), 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 the PBM for more information.

Certain OTC female contraception products are covered when presented with a prescription from a physician to a 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 the PBM, whose contact information is in the *Participant Contact Guide*.

Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. The following are considered routine vaccinations: Covid-19, dengue, diphtheria, tetanus, pertussis, Flu, Hepatitis A & B, Shingles & Herpes Zoster, HPV, Measles, Mumps, and Rubella (MMR), Meningococcal, Monkeypox, Pneumonia, TDAP (whooping cough), Polio, RSV, Rotavirus, and Varicella.

This plan allows for step therapy, which is a cost -savings measure that requires participants to try a less expensive medication before trying a more expensive one. Some classes of medications are excluded from step therapy.

This plan allows for three emergency refills per plan year.

- Prenatal & pediatric prescription vitamins
- Prescription female oral contraceptives
- Hormone therapy drugs: The following male to female drugs are covered: Estrace, Estradiol, Delestrogen, and Spironolactone. The following female to male drugs are covered: Testosterone Cypionate, Androgel Gel Pump, and Depo Testosterone. May require prior authorization.
- 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.

- Quantity limits include, but are not limited to, one Omni pod Kit within a rolling 720 days, and a maximum of 15 pods within a 21-day period.
- 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.
- Prescription drugs irregularly dispensed for purposes of synchronization of chronic medication pursuant to the provisions of NRS 695G.1665 Topical 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.
- HIV and HEP C testing (includes pregnancy women)
- Syphilis and other sexually transmitted disease testing (includes pregnant women)
- 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.
- Drugs approved by the U.S. Food and Drug Administration for medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone, naltrexone, and Lofexidine. Step therapy is not required for such drugs. Prior authorization is required.
- Under this benefit, some opioids are excluded under the National Preferred Formulary
- Drugs approved by the U.S. FDA for the treatment of cancer and cancer symptoms. Step therapy is not required for such drugs.
- Drugs approved by the U.S. FDA for the prevention of HIV.
- Anti-obesity branded products are excluded from this benefit. Only generic products are covered. Refer to the Obesity Care Management Program.

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 the PBM. 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 the PBM The Pharmacy Benefit Manager (PBM).

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

Specialty 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 the PBM to determine if the 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 the PBM 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 the 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 participants 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 the prescription plan, managed by the PBM. With this program, participants have two ways to get up to a 90-day supply of their long-term medications (those taken regularly for ongoing conditions). Participants can fill long-term prescriptions through home delivery from the Express Scripts Home Delivery Pharmacy or at a retail pharmacy in the Smart90 network.

 **Participants will need to move their long-term medications to both a 90-day supply and to either a participating retail pharmacy or Express Scripts Home Delivery Pharmacy. If, after the second 30-day supply courtesy fill of their long-term medication, they do not make the switch participants will pay a higher cost for their prescription medication and will not receive credit toward the 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 *the identified PBM*. Participants can also get pharmacy information by contacting the PBM. Participants can transfer medications easily in-store, by phone or online.

Home Delivery

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

If participants are enrolling a new prescription in home delivery:

- **Contact the doctor** and ask them to e-prescribe a 90-day prescription directly to

the PBM

- **OR send a request** by selecting "Forms" or "Forms & Cards" from the "Benefits" menu,print and mail-order form and follow the mailing instructions
- **OR call** the PBM and they will contact the doctor for participants.

Transfer retail prescriptions to home delivery by **clicking "Add to Cart"** for eligible prescriptions and check out. Participants can also refill and renew prescriptions. The PBM will contact the doctor and take care of the rest.

Participants may check the status and shipping of prescriptions online or with the PBMs mobile app, if applicable. Please allow 5 to 7 days from the time the prescription is received until it arrives at participants door. Please keep in mind, longer delivery times may be due to additional correspondence needed with prescribers, medication availability and/or delivery times from the shipping vendor.

Generics Preferred Program

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

- the doctor writes "dispense as written" (DAW) on the prescription; or
- participants request the brand-name drug at the time the prescription is filled.

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

If a generic is available, but the participant or their doctor request the brand-name drug, they 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 the participant chose the generic drug, they would pay:	$10

SaveonSP Program

As part of the 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 participants with the cost of the Program drug(s). The cost 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 the deductible or out-of-pocket maximum.

Participants 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 participants 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 the participant is taking is on the SaveOnSP *Non-Essential Benefit Specialty Drug List* and they 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 participants are taking or will be taking a medication that is on the Non-Essential Benefit Specialty Drug List, and the participant chooses not to participate in the SaveOnSP Program, they will be responsible for the copay outlined in the SaveonSP Program Drug List and that cost will not apply toward the Deductible or Out-of-Pocket Maximum.

Diabetes Care Value

The PBM offers a program that supports participants 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 the PBM and qualifying participants will receive a personal invitation, with instructions, to join the program.

Extended Absence Benefit

If participants are going to be away from their home for an extended period, either in the country or outside of the country, participants may obtain an additional fill (30 or 90-day supply) of the

prescription drugs from their 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. participants may be required to obtain a new written prescription from the physician and any necessary prior authorizations.

Out-of-Country Emergency Medication Purchases

This Plan may cover emergency prescription drugs purchased if participants reside in the United States and travel to a foreign country. Participants will need to pay for the drug at the time of purchase and later submit for reimbursement from the PBM. 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 the purchase is eligible for reimbursement, the participant 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, the participant is required to provide:

- A legitimate, legible copy of the written prescription completed by the physician.
- Proof of payment from the participant to the provider of service (typically a 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 PBM before traveling or moving to another country to discuss any criteria that may apply to a prescription drug reimbursement request.

Out-of-Network Pharmacy Benefit

Prescriptions filled at a domestic (inside the United States) out-of-network pharmacy location, are not authorized for reimbursement under the prescription drug Plan. Prescription drugs must be filled at a participating in-network pharmacy location.

The PBM offers helpful tools that allow participants to manage their prescriptions. The PBM has a free mobile app. Participants need their identification card available to register. The "Price a Medication" menu option under "Prescriptions" is used to determine estimated Out-of-Pocket cost. From this menu option, a prescription savings program called *My Rx Choices* is available to view side-by-side medication comparisons showingpotential savings with lower-cost alternatives along with any applicable coverage alerts such as "prior authorization required". See the *Participant Contact Guide* section or go to the PEBP website at *https://pebp.nv.gov/*.

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 participants pay toward services that are not covered or otherwise excluded will not count toward the 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 participants have questions about a service or supply, contact the TPA listed in the *Participant Contact Guide.*

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

This Plan places limitations on some benefits. In this policy, a benefit limitation refers to the maximum amount of money that the Plan will pay for a service, those expenses that do not count towards participants out of the pocket maximum, and service non-covered services.

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

The following is a list of services, supplies, or expenses that are limited or not covered (excluded) by this Plan. Participants may pay out of pocket for these, but any amount participants pay toward services that are not covered or otherwise excluded will not count toward the out-of-pocket maximum.

Alternative/Complimentary Health Care:

- 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 excess of copper or iron.
- Prayer, religious healing, or spiritual healing.
- Naprapathy services or treatment/supplies.
- Homeopathic treatments/supplies that are not FDA approved.

Autopsy: Autopsies are not covered.

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 Health Care Exclusions

- Expenses for behavioral health care services related to:
    - adoption counseling;
    - court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws);
    - custody counseling;
    - dance/poetry/art
    - developmental disabilities;
    - dyslexia,
    - learning disorders;
    - family planning counseling;
    - marriage and/or couples counseling
    - 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: Treatment for complications of non-covered services is excluded.

Concierge membership fees: Membership, retainer, or premiums that are paid to a concierge medical practice are not covered.

Corrective Appliance/Durable Medical Equipment (DME): The following corrective appliances and durable medical equipment are not covered.

- orthotic devices or orthotic braces that straighten or change the shape of a body part,
- prosthetic appliances, or
- durable medical equipment

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.: Preparation of medical reports, billing or claim forms, mailing, shipping, handling, charges for broken/missed appointments, general telephone calls not including telehealth, and photocopying fees are not covered.

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 are not covered, even if they are medically necessary. Custodial care are services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

Dental Services:
Dental prosthetics and orthodontia are not covered.

The following services are covered under the dental plan.

- 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 *Summary of Benefits or Schedule of Benefit* section).
- 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 require a prescription.
- Special Food Product (as defined in the Summary of Benefits or Schedule of Benefits 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*.
- 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 Corrective Appliances.

Health Education: Health education expenses are not covered. They include: 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 participants or their 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 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 an 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. Genetic testing and counseling not covered, unless otherwise specified in this Plan's Schedule of Benefits.

Gym Fees: Fees by personal trainers, exercise programs, exercise equipment, gyms or health club memberships are not covered

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 Education: Special education and associated costs related to sign language 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.

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 is not covered.

Illegal Act: Injuries sustained during the course/because of committing illegal acts is not covered.

Internet/Virtual Office Visit: Any type of virtual visit with an out-of-network provider is not covered.

Maternity/Family Planning:

- 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.

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.) is not covered.

No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

No 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.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: Expenses incurred by participants or you're their 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 are not covered.

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 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 TPA.

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.
- 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 is not covered.

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 is not covered.

Taxes: Sales taxes, unless specifically covered in the Plan.

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.

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. There is no limit for individuals through age 18.*

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 prior-authorization from the UM company will be denied.
- Expenses related to programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.
- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of an eating disorder (such as anorexia, bulimia, etc.). Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under any PEBP self-funded medical Plan (e.g., LD PPO Plan, CDHP, and 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 prior-authorization has been received from the UM company), behavioral training or therapy, milieu therapy (unless the care is otherwise medically necessary), biofeedback (unless included with psychotherapy), behavior modification, sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.
    - Charges that result from appetite control 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

A claim is an invoice or bill that is submitted by a medical provider to PEBP's Third Party Claim Administrator (TPA) after participants have received a service. Each claim has unique codes that describe the service participants received. There are three types of claims: medical, dental, and pharmacy. When Deductibles, Coinsurance or copayments apply, participants are responsible for paying their share of these charges.

When participants receive care from an in-network provider, that provider will submit the claim to the TPA, but if participants receive care from an out-of-network provider, that provider may bill participants directly. If this occurs, participants should follow the steps outlined in this section regarding How to File a Claim.

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.

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

- Obtain a claim form from PEBP's TPA or PEBP's 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 participants what documents or medical information are necessary to support the claim. The physician, health care practitioner or dentist can complete the health care provider part of the claim form, or participants 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.

Complete a separate claim form for each provider for whom Plan benefits are being requested.

To ensure that medical, pharmacy or dental expenses participants incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny Deductible and Out-of-Pocket Maximum credit or payment to a provider if the provider's bill does not include 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 TPA.

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 TPA.

Claims are processed by the TPA in the order that they are received. Participants will know within 30 business days of receipt of the claim if it is accepted or denied. However, claim processing may take much longer if the claim was not completed correctly or if all necessary information was not provided with the claim.

Steps in claims processing	Pass	Fail
Was the claim sent on the correct claims form?	Move to the next step.	Claim denies. The provider must resubmit it in the correct claim form.
Is there a date of service?		
Is there a provider ID?		

Is there a primary diagnosis code? Is there a procedure code? Is there a cost for the service?		
Is the claim for a covered individual?	Move to the next step.	Claim denies.
Is the medical service date within 12 months of the claim submission.	Move to the next step.	Claim denies.
Was the provider in-network.	Apply negotiated price/rate.	Apply out of network coverage. In some cases, the claim denies if out-of-network is not allowed for the services.
Is the service covered by the plan?	Move to the next step.	Claim denies.
Does the service meet medical necessity?	Move to the next step.	Claim denies.
If required, was there a prior authorization for the service?	Move to the next step.	Claim denies.

The last component of claims processing is verification of the participant's coinsurance status; whether or not the participant met their deductible, and what portion is the participant's responsibility

Once the claim has been processed, an Explanation of Benefits (EOB) will be provided to participants. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to participants Deductible, if participants out-of-pocket maximum has been reached, if certain services were denied and why, amounts participants need to pay to the provider, etc.

It is participant's responsibility to maintain copies of EOBs. They cannot be reproduced.

Where to Send the Claim Form

Send the completed claim form, the bill (retain a copy) and any other required information to the TPA at the address listed in the Participant Contact Guide in this document.

Appeals

Participants have the right to appeal 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).

All participants will receive an EOB for each processed claim. The EOB will explain the reasons for the Adverse Benefit Determination, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a **Level 1 Claim Appeal.** When applicable, the EOB will explain what additional information is required from participants and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

Level 1 Claim Appeal (NAC 287.670)

Participants have 180 days of the date they received the Explanation of Benefits (EOB) to request a Level 1 Claim Appeal. Participants forfeit the right to submit a Level 1 Claim appeal after 180 days have passed. Level 1 Claim appeals must be sent to PEBP's TPA.

The Level 1 Claim appeal must be in writing and include:

- 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.
  The TPA will review a participants claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process the request for appeal, it will be requested promptly.
- The TPA will issue a Level 1 Claim Appeal decision in writing within 20 days after receipt of the request for appeal. The Appeal Decision shall include an explanation of the appeal determination and references to Plan rules, Master Plan Documents, or other relevant documentation.
- The Appeal Decision will explain the steps necessary to proceed to a Level 2 Appeal if participants are not satisfied with the response of the Level 1 Claim Appeal.

Level 2 Claim Appeal

Level 2 Claim Appeals must be sent 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 contacting PEBP Customer Service.

A Level 2 Appeal must be submitted to PEBP within 35 days after participants receive the Level 1 Appeal determination. The Level 2 Appeal **must** include a copy of:

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

The Executive Officer or designee will use the 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 participants in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee.

The Appeal Decision shall include an explanation of the appeal determination and references to Plan rules, Master Plan Documents, or other relevant documentation.

The Appeal Decision will explain the steps necessary to proceed to an External Review if participants are not satisfied with the response of the Level 2 Claim Appeal.

External Claim Review (NAC 287.690)

The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that are considered experimental and investigation.

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process.

The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim. The independent review organization will use medical necessity as a component of their review which means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, 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 participant or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.

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. The OCHA will assign an independent external review organization within five 5 days after receiving the request.
A Request for External Claim Review must include:

- completed and signed External Review Request Form.
- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

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)/

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.

Prior Authorization/Utilization Management Appeal (NRS 695G)

If participants have a denied prior authorization request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue), participants may request an appeal.

Requests for an appeal must be made within 180 days of the date of the denial/non-certification. Appeals must be sent to PEBP's TPA. Appeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service

treatment will be completed within 20 days of receipt of the request. The results of the determination of a standard appeal will be provided in writing to the participant, managing physician, facility, and third-party claim's administrator.

A participant or their designee can choose to bypass the internal appeals process from adverse benefit determinations resulting from the UM company and request an external review.

Expedited Appeals (Level 1 and Prior Authorization/Utilization Management)

Requests for an expedited internal UM appeal review may be made by telephone or any other reasonable means to the UM company that will ensure the timely receipt of the information required to complete the appeal process. If a physician requests a consultation with the reviewing physician, this will occur within one business day. The UM company will decide on an expedited appeal within 72 hours of receipt of the information needed to complete the appeal. The results of the determination of an expedited appeal will be provided immediately to the managing physician by phone and in writing to the patient, managing physician, facility, and the third-party claim's administrator.

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 prior-authorization/pre-authorization; concurrent and/or continued stay review; discharge planning; retrospective review; and case management.

Pursuant to applicable NRS 695G, participants have the following appeal processes for any adverse benefit determination made during prior-authorization, 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

Participants may request an expedited appeal review of a denied prior-authorization of a hospital admission, availability of care, continued stay or health care service for which they 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 the participant's life or health or the life or health of their covered dependent or the ability for the participant 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 the 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 participant with an adverse benefit determination letter including the clinical rationale for the non-certification decision and the participant may pursue an external appeal as described in NRS 695G.241 - NRS 695G.275.

Standard Internal UM Appeal Review

If participants have a denied prior-authorization request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue) and participants do not qualify for an expedited appeal, participants may request a standard appeal review. Requests for standard appeal review may be made by writing to the UM company.

Requests for standard appeal review must be made within 180 days of the date of the denial/non-certification. Actual medical records are encouraged to be provided to assist the reviewer. Standard appeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service treatment will be completed within 20 days of receipt of the request. The results of the determination of a standard appeal will be provided in writing to the patient, managing physician, facility, and third-party claim's administrator.

A participant or their designee can choose to bypass the internal appeals process from adverse benefit determinations resulting from the UM company and request a review by an external review organization.

External UM Appeal Review

An external review may be requested by a participant and/or the participant's treating physician after participants have exhausted the internal UM appeal review process. This means participants may have the right to have the Plan Administrator or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgement as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment the participant 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 participants received a denial for a service, durable medical equipment, procedure, or other therapy because the third-party administrator or the UM company determined it to be experimental and/or investigational, or subject to the No Surprises Act, or rescission of coverage, participants may request an external review. To proceed with the experimental and/or investigational external review, participants must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.

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 Appeals

The PBM offers two types of reviews, a clinical review and an administrative review. A clinical review is initiated by a health care professional and an administrative review is initiated by the participant.

To initiate a clinical review, a health care professional may contact the PBM by phone or in writing using a Benefit Coverage Review Form. (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

To initiate an administrative review, the participant must submit the request in writing to the Benefit Coverage Review Department).

If the patient's situation meets the definition of urgent under the law, an expedited review may be requested and conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an expedited situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy, or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by calling the PBM.

If the necessary information is provided to the PBM so that a determination can be made, the initial determination and notification for a clinical coverage or administrative coverage review will be made within the timeframe below:

- Standard Pre-Service: 15 days for retail pharmacy and five (5) days for home delivery; and
- Standard Post-Service: 30 days.

Level 1 Appeal or Urgent Appeal

When an initial administrative or clinical coverage review request has been denied, a request for appeal of the denial may be submitted by the participant within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the PBM's 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. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

All level 1 appeals are reviewed by either a pharmacist, a physician, a panel of clinicians, a trained prior authorization staff member, or an independent third-party prescription drug utilization management company.

Level 1 Appeal Decisions and Notifications

The PBM 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 participant and health care professional 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, participants must request by mail or online form to the correct Clinical Coverage or Administrative Coverage Review Request department.

An urgent Level 2 Appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or

would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax to the correct Clinical Coverage or Administrative Coverage Review Request department (see the *Participant Contact Guide* section). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Level 2 Appeal Decisions and Notifications

The PBM will render Level 2 Appeal determinations within the following timeframes:

- Standard pre-service: 15 days.
- Standard post-service: 30 days; and
- Urgent: 72 hours.

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. Standard Post-Service: NAC 287.680.

External Reviews

All internal appeal rights must be exhausted prior to requesting an external review. The Pharmacy Benefits Manager handles all external reviews under pharmacy. An external review must be requested with 4 (four) months after the date of the Level 2 Appeal denial. (If the date that is 4 (four) months from that date is a Saturday, Sunday, or a holiday, the deadline will be the next business day).

The 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 participant will be notified within 1 (one) business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will be sent to the IRO within 5 (five) business days of assigning the IRO. The IRO will review the claim within 45 calendar days from receipt of the request and will send the participant the Plan and the pharmacy benefit manager written notice of its decision.

If the IRO has determined that the claim does meet the qualifications of an external review, the IRO will notify the participant in writing that the claim is ineligible for a full external review.

Urgent External Review

The Pharmacy Benefit Manager shall review every external appeal request to determine if it meets the level of an urgent situation. An urgent situation that could seriously jeopardize the life or health or the ability for the participant to regarding maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the review meets the criteria to be urgent, it will immediately be forwarded to an IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the participant written notice of its decision.

Timeframes for an external review may be adjusted if more information is requested by the IRO.

Coordination of Benefits (COB)

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

When participants have medical, dental or vision coverage from more than one source, a of Benefits (COB) determination is used to identify which payer will pay first (i.e., the primary plan) and which payer will pay second (i.e., the secondary plan). In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred.

Participants must let the TPA, or its designee, know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the participant is still required to meet their PEBP Plan Year medical and dental deductibles.

This Plan's prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.

Plan Type

- A participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such a 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 to implement the COB procedures, as set forth below.

COB Determination Rules

PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), to determine the primary plan and the secondary plan. Any plan that does not use these same rules will always be the primary plan. The order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

These rules are:

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.

In order to make a COB determination, PEBP 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 in accordance with NRS 687B.725.
- Once a payment is made, this Plan will be fully discharged from any liability it may have to the extent of such payment.
- This Plan follows the customary COB rule that the medical program coordinates with only other medical plans and the dental program coordinates only with other dental plans or programs. There is no cross coordination of a medical plan to a dental plan.
- When PEBP is the primary plan, it will consider the reasonable value of each service to be both the allowable expense, and the benefits paid. The reasonable value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.
- When PEBP is secondary, it will pay secondary benefits. In addition, 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.
- When PEBP is determined to be secondary, it will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to rights the participant 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.

Entitlement to Medicare Coverage

When a participant reaches Medicare eligible age, the Participant must enroll in Medicare and transition to the Medicare Exchange.

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 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.

When this Plan is secondary, it will assume that Medicare has paid 80% of Medicare Part A and Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part A and Part B expenses.

End-Stage Renal Disease (ESRD)

- A Participant becomes entitled to Medicare when diagnosed with end-stage renal disease (ESRD). In this case this Plan pays first and Medicare pays second for
- the first 30 months of Medicare ESRD coverage begins, or
  the first month in which the individual receives a kidney transplant.

This plan becomes secondary:

- the 31st month after Medicare ESRD coverage, or the first month after the individual receives a kidney transplant
- 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.

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 in which no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare Participant enters into such a contract this Plan will not pay any benefits for any health care services and/or supplies the Medicare Participant receives pursuant to it.

Coordination with Other Government Programs

- **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 in healthcare is a legal process that allows health insurance companies to recover costs from third parties who are responsible for illness or injury due to negligence by the third party.

Participants must comply with all recovery efforts of the Plan and do whatever is necessary or requested to secure and protect the subrogation rights of the Plan.