NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

1st Quarter—Plan Year 2023

Quarterly Newsletter

Inside This Issue

UMR

HealthSCOPE Benefits (HSB) has changed its name to UMR. UMR will be administering medical and dental claims effective 7/1/2022. Members should set up their UMR member account to find a provider, see their claims, shop and compare healthcare services and more. UMR has created an Online Services Member Guide to help you navigate their new platform.

Network Change

The Aetna Signature Administrators (ASA) network for the CDHP, LD PPO, and EPO plans has been relaced by Sierra Health-Care Options in southern Nevada, and United Healthcare Choice Plus Network for out-of-state and northern Nevada members. You can search for in-network providers on PEBP's Find a Provider page. Members are encouraged to confirm the network status of provider(s) before receiving health care services beginning July 1st , 2022. It is your responsibility to confirm the network status of a provider before assessing services. To confirm the status of a provider contact UMR at 1 -888- 7NEVADA (1-888-763- 8232).

HSA Bank

HSA Bank is the new HSA/HRA administrator for CDHP, LD PPO, and EPO members.

If you haven't already consented to move your HealthSCOPE HSA to HSA Bank, complete before the **July 31, 2022 deadline to avoid potential ongoing HealthSCOPE fees** and have your HSA funds all in one place. If you have an HRA no action is required.

How can I consent to move my previous HSA?

If you have an HSA balance in PY22 or earlier, you can complete the transfer authorization with the following steps:

- Access HSA Bank's E-Consent Site and enter access code: **9HTP4Y**
- Enter your full name and Social Security Number.
- Read the ESIGN authorization and consent information.
- Select "accept" or "decline."

Your HSA/HRA balance that was in your HSB account will be available at HSA Bank by August 30, 2022. Your $600 employer contribution for HSA/HRAs has already been added to your HSA Bank account for the new plan year.

HSA Bank customer service: 1-833-228-9364.

hsabank
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Obesity and Overweight Care Management Program

The Obesity and Overweight Care Management (OCM) Program is a disease management program for CDHP PPO, LD PPO, and Premier EPO plan members that provides enhanced benefits to participants who have been diagnosed as obese or overweight by their physician, who meet the specific criteria as outlined in the applicable master plan document, and have enrolled in the OCM Program. The OCM Program is a voluntary opt-in program that requires enrollment with UMR to determine if you meet the criteria for participation in the program. If UMR determines you to be eligible for the program, the effective date of enrollment and enhanced benefits is determined by UMR.

How to enroll in the OCM Program:

1. Search for in-network weight loss providers on PEBP's Find a Provider page, and obtain the OCM Enrollment and Initial Evaluation Form.
2. Schedule an appointment with a provider from the list of participating in-network weight loss providers.
3. Attend your scheduled appointment and have your provider complete, sign and submit the Enrollment and Evaluation Form to:

UMR
P.O. Box 8022
Wausau, WI 54402
Fax: 1-866-751-2440

4. UMR will review the information submitted by your provider and if the information indicates that you meet the criteria for the weight loss program benefits, UMR will enroll you in the program and notify the Pharmacy Benefit Manager of your enrollment. If you do not meet the criteria for the weight loss program and enhanced benefits, the third-party claims administrator will notify of the denial of the OCM Program's enhanced benefits.

Your OCM provider must submit monthly reports to include your weight loss and your compliance with the treatment plan. Submission of these reports will be a requirement for payment under the OCM Program's enhanced benefits. You and your weight loss provider will determine your final weight loss goal when you initially start participating in the OCM Program. Once you have met your final weight loss goal, the OCM Program's enhanced benefits will return to the standard CDHP benefits on the first day of the following month. The OCM Program does not provide enhanced benefits for ongoing maintenance care. Ongoing maintenance care will be subject to the standard plan benefits.

Obesity and Overweight Care Disease Management Program (Enhanced Benefits)

Benefit Description	In-Network
Office Visits	Plan pays 100%; not subject to deductible
Laboratory Test	Plan pays 100%; not subject to deductible
Nutritional Counseling Services	Plan pays 100%; not subject to deductible
Meal Replacement Therapy	Plan pays 50% of the cost, up to $50/month, not subject to and does not apply to the deductible
Weight Loss Medications **Preferred Generic**	$5 Copay (30-day supply) $15 Copay (90-day supply)
Preferred Brand	Not Covered
Non-preferred Brand	Not covered

Healthy Diet/Physical Activity Counseling and Obesity Screening/Counseling for adults aged 18 years and older are covered under the Wellness/Preventive Benefit when referred by a primary care practitioner for those who have a basal metabolic index (BMI) of 30 or greater and have additional cardiovascular disease risk factors. This wellness/preventive benefit is limited to 3 Healthy Diet/Physical Activity Counseling or Obesity Screening/Counseling visits per plan year. Additional visits are subject to deductible and co-insurance.

PEBP's Dental Coverage

All CDHP PPO, LD PPO, HMO, EPO, and Medicare Exchange Eligible Participants are eligible for PEBP's dental coverage. Excluding Medicare Exchange participants who have their medical plans through VIA Benefits, the dental benefit is bundled together with your medical, pharmacy and vision coverage through UMR. Preventive dental services are not subject to the individual plan year maximum dental benefit. Oral examinations are limited to four times per plan year. Prophylaxis, scaling, cleaning, and polishing is limited to four times per plan year. Bitewing x-rays are limited to twice per plan year. Fluoride treatment for individuals aged 18 years and under is payable twice per plan year. The application of sealants for children under age 18 years is considered preventive. Initial installation of a space maintainer to replace a primary tooth until a permanent tooth comes in is payable for individuals under age 16 years. For more information about dental care look for the PEBP PPO Dental Plan and Summary of Benefits Master Plan Document under Getting to Know Your Plan.

Dental Plan Preventive Services	In-Network
• Oral examination • Prophylaxis (routine cleaning of the teeth without the presence of periodontal disease) • Bitewing X-Rays • Topical application of sodium or stannous fluoride • Space maintainers • Application of sealants	• Covered 100% • Not subject to deductible • Does not apply towards Plan Year max benefit

"Don't forget to floss!" — moms everywhere

The Member Assistance Program

To help through difficult times, the Member Assistance Program (MAP) provides CDHP, LD, EPO and HMO members and their families with personal and confidential support.

The help you may need, at no extra cost:

- Unlimited phone access to master's-level specialists – 24/7
- Up to 3 referrals for face-to-face counseling sessions – The national network includes 218,000 clinicians
- Help dial down possible symptoms of stress, anxiety and depression – Sanvello® is an app that offers techniques and coping tools, community support and guided journeys
- One legal consultation for 30 minutes – Meet with an attorney by phone or in person, and you can retain an attorney for ongoing services at a 25% discounted rate
- A 30- to 60-minute financial consultation – Discuss estate taxes and other financial matters with credentialed financial professionals
- Access to liveandworkwell.com – Easily, securely find a provider and work-life resources, confidentially connect to expert guidance and explore thousands of articles

Access your MAP benefit by calling 1-877-660-3806, TTY 711.

Visit liveandworkwell.com. Enter anonymously using access code FP3EAP.

Access. Quality. Affordability.

Mental Health Services

Members enrolled in the CDHP PPO, LD PPO, or Premier EPO plans can search for in-network behavioral health practitioners such as psychiatrists, psychologists, or mental health or substance abuse counselors on PEBP's Find a Provider page. Medically necessary mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other qualified mental health care professional are covered according to the limits provided in each plan's individual Schedule of Medical Benefits in the related master plan document. All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require precertification. Mental health office visits that are not part of an alcohol or substance abuse program do not require precertification.

Behavioral Health		CDHP PPO	LD PPO	Premier Plan Northern EPO
Outpatient Visits		You pay 20% after deductible	$30 copay per visit	$20 copay per visit
Telemedicine	*Mental Health Therapy*	$79 (25 minutes)	$20 (25 minutes) $30 (50 minutes)	$20 (25 minutes) $20 (50 minutes)
	Psychiatry Initial Visit	$229	$30	$20
	Psychiatry Follow-Up	$99	$20	$20
In-Patient Admissions	*Elective hospitalization requires precertification*	You pay 20% after deductible ($1,500 individual; $2,800 for individual family member)	You pay 20% after deductible ($0 deductible for PY23)	$600 copay per admit

The Diabetes Care Management Program

The Diabetes Care Management (DCM) program is a voluntary opt-in disease management program that provides enhanced benefits to participants enrolled in the CDHP PPO, LD PPO, or EPO plan diagnosed with diabetes, and who are enrolled in and actively engaged in the program.

To enroll, obtain the Diabetes Care Management Form or contact UMR to request the DCM enrollment form. Complete the required information and have your in-network physician sign the form. Email the completed form to diabetes@umr.com. Questions? Call 888-763-8232. The effective date of the DCM program will begin on the first day of the month following UMR's receipt and processing of the DCM enrollment request. Annually, to continue receiving the DCM enhanced benefits for the next plan year, a new DCM form must be completed, signed by both you and your physician, and submitted to UMR for processing. Enrolled DCM participants must comply with requirements to receive the enhanced benefits. These include completing two office visits each Plan Year for a primary diagnosis of diabetes with your primary care physician or endocrinologist, complying with the diabetes medications as prescribed by your physician, complete the appropriate laboratory testing as ordered by your physician, and the participant must remain compliant with your physician's prescribed treatment plan in the Diabetes Care Management program.

Benefit Description	In-Network
Office Visits	Two office visits covered at 100% per plan year, not subject to deductible
Laboratory Test	Two routine lab tests covered at 100% per plan year, not subject to deductible
Preferred Generic	$5 Copay (30-day supply) $15 Copay (90-day supply)
Preferred Brand	$25 Copay (30-day supply) $75 Copay (90-day supply)
Non-Preferred brand	Not covered
Diabetic Supplies (test strips, insulin syringes, alcohol pads, and lancets) **Blood Glucose Monitor**	$50 Copay per supply item or the lessor of actual cost $0 Copay (limited to one per plan year)