NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
Quality.
Affordability.

Low Deductible PPO Plan

Master Plan Document

Plan Year 2022

Effective July 1, 2021 – June 30, 2022

Public Employees' Benefits Program
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Amendment Log

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

Laboratory Services

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Benefit Description	In-Network	Out-of-Network
Laboratory Services		
General Laboratory Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Routine/Preventive Lab Testing*	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Routine and Preventive Lab Services *****Routine/preventive lab services must be performed at a freestanding, non-hospital-based lab facility.*** *Medically necessary routine labs when ordered by a physician as part of comprehensive medical care.* • *Preventive laboratory services such as basic metabolic panel, lipid, or general health panel. Refer to the Preventive Care/Wellness Services for information regarding benefits for screening tests and preventive lab testing.* • *Routine/preventive lab tests performed at an outpatient hospital or hospital-based free-standing lab facility/draw station are not covered.* • ***Laboratory Services Related to Covid-19*** ○ ***COVID-19 Diagnostic Testing: virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person may have been infected with the virus, and according to the FDA, antibody tests should not be used to diagnose current infection. Covid-19 Diagnostic Testing will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network in accordance with the CARES Act or until the last date of the national public health emergency period.*** ○ ***COVID-19 Screening/Surveillance Testing: COVID testing conducted for purposes other than diagnostic (including, but not limited to, employer mandated, travel, social/entertainment purposes) is not a covered benefit.***		
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*		

Benefit Description	In-Network	Out-of-Network
outpatient surgery. Testing must be related to the sickness or injury for which admission or surgery is planned.		

Enteral Formula

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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 Medical Benefits.*		

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Enteral Formulas and Special Food Products

Enteral Formulas and Special Food Products are covered in accordance with NRS 689B.053 Enteral Formulas for use at home that are prescribed or ordered by a physician as medically necessary treatment of inherited metabolic diseases characterized by deficient metabolism or malabsorption originating from congenital defects or defects arising shortly after birth of, amino acid, organic acid, carbohydrate, or fat. For the purposes of this section only, Enteral Formulas including, without limitation, a formula that is ingested orally. Inherited metabolic diseases do not include obesity.

Special Food Product means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. Inherited metabolic disease does not include obesity. This term does not include a food that is naturally low in protein. Special Food Products for the medically necessary treatment of inherited metabolic disease are limited to a maximum benefit of $2,500 per Plan Year.

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

Special formulas, food supplements, or special diets including, but not limited to, total parenteral nutrition, except for acute episodes, are not covered.

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Free-Standing Laboratory Facility**:** Free-standing laboratory facilities are stand-along facilities that are not affiliated with a hospital system. Examples of preferred free-standing laboratory facilities include Labor Corp or Quest.

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Outpatient Hospital Laboratory and Outpatient Hospital-Based Laboratory Draw Station**:** Outpatient hospital-based laboratory facilities include lab services performed in a hospital outpatient setting. Outpatient hospital-based laboratory draw stations are hospital affiliated whereby the draw station collects specimens and sends them to the central hospital for processing.

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Special Food Product: [NRS 689B.0353] A Special Food Product means a food that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. Special Food Products do not include a food that is naturally low in protein or foods or formulas for persons who do not have an inherited metabolic disease as that term is defined in this document. This term does not include a food that is naturally low in protein.

Keeping in line with the Mental Health Parity and Addiction Equity Act (MHPAEA) the following is updated accordingly:

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Alcohol and Substance-Abuse Treatment

Intensive Outpatient Treatment Program: Copay was reduced to $30 Copay per Visit.
Outpatient Treatment: Copay was reduced to $30 Copay per Visit.

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Mental Health

Mental Health Outpatient Visits: Copay was reduced to $30 Copay per Visit.

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Doctor on Demand

Psychologist Visit (50 -minutes): Copay was reduced to $30 Copay per Visit
Psychiatrist Visit (45 minutes/initial visit): Copay was reduced to $30 Copay per Visit

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Coronavirus (COVID-19) Pandemic Benefits.

Benefit Description

COVID-19 Plan Benefits

Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (see *Key Terms and Definitions*)

Benefits apply during the Coronavirus Pandemic unless otherwise mandated by federal or state law, or as stated below in the Explanations and Limitations.

Explanations and Limitations

Coronavirus (COVID-19) Pandemic Benefits

The following benefits will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network during the national public health emergency period, currently schedule to end April 20, 2021, or until the last date of the national public health emergency period, if extended.

- **COVID-19 Diagnostic Testing:** virus/antigen detection (diagnostic) test determines if a person is currently infected with COVID-19. An antibody (serology) test may determine if a person may have been infected with the virus, and according to the FDA, antibody tests should not be used to diagnose current infection.
    - Medically appropriate, FDA-authorized, COVID-19 testing when ordered by a physician or health care professional for purposes of diagnosis or treatment.
    - *Diagnostic testing is different than COVID-19 screening/surveillance testing.*
- **COVID-19 Related** *Diagnostic* **Testing Visit:** COVID-19 testing related visits such as urgent care, emergency room, physician's office, telemedicine, and telehealth visits.
- ~~**COVID-19 Treatment:** Treatment for confirmed patients with a COVID-19 diagnosis, including formulary medications for the treatment of a confirmed COVID-19 diagnosis; non-formulary medications covered without prior authorization in the event of a supply shortage.~~
- **COVID-19 Preventive Health Services:** In accordance with the following, the Plan covers qualifying coronavirus disease 2019 (COVID-19) preventive services at 100% of the Plan's Maximum Allowable Charge for In-Network and Out-of-Network providers without any cost sharing (Copayment, Deductible, or Coinsurance):
    - An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; or (B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

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

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

This Plan shall comply with the CARES Act to the extent it applies *to the Plan*. The Plan shall cover COVID-19 testing and certain COVID-19 testing related items and services without cost sharing (deductibles, coinsurance, copayments), prior authorization or other medical management requirements. This coverage includes COVID-19 *diagnostic testing* and COVID-19

diagnostic testing-related visit to order or administer the test. A testing related visit may occur in a physician's office, via telehealth, in an urgent care center or emergency room. In-network and Out-of-Network costing sharing will not apply to *diagnostic testing*. To the extent it applies, this Plan will cover qualifying items, services, or immunizations intended to prevent or mitigate COVID-19 (qualifying coronavirus preventive services) without imposing cost sharing. To be covered, the services must be either (i) an evidenced-based item or service that has a "A" or "B" rating in the current recommendations from the United States Preventive Services Task Force, or (ii) an immunization with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Expansion of Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), and Health Reimbursement Arrangements (HRAs): Effective January 1, 2020, individuals may use HSAs, FSAs, and HRAs to purchase over-the-counter medicines without a prescription, and to purchase menstrual care products. To the extent it applies, this Plan shall allow early prescription refills to ensure members have sufficient supply of medication on hand. The refill shall stay consistent with the standards' supply previously filled by the member as allowed by the Plan (e.g., 30- or 90-days' supply). To the extent it applies, the Plan shall allow HSA members to continue to contribute to their 2019 HSAs to July 15, 2020 in accordance with IRS Notice IR-2020-58) This Act is effective March 18, 2020 to apply retroactively.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP offers medical, vision, dental, and life insurance. In addition, eligible employees and retirees may enroll in flexible spending and other voluntary benefits.

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

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

Master Plan Documents are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted in the Active Employee Health and Welfare Wrap Plan Document and Retiree Health and Welfare Wrap Plan Document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the *Participant Contact Guide.*

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

Sincerely,

Public Employees' Benefits Program

Introduction

This Master Plan Document describes the Low Deductible PPO Plan (also referred to as the LD PPO Plan). This Plan is available to eligible employees, retirees, and their eligible dependents participating in the Public Employees' Benefits Program (PEBP).

The LD PPO Plan offers both In-Network and Out-of-Network benefits and is a self-funded plan administered by PEBP and governed by the State of Nevada. The benefits offered with the LD PPO Plan include 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. An independent third-party Claims Administrator pays the claims for the medical, dental and vision benefits. An independent pharmacy benefit manager pays the claims for prescription drug benefits.

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

The Plan described in this document is effective July 1, 2021, and unless stated differently, replaces all other Low Deductible PPO Plan medical and prescription drug benefit plan documents/summary plan descriptions previously provided to you.

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

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, please contact PEBP at the number listed in the *Participant Contact Guide* section. The *Participant Contact Guide* provides you with contact information for the various components of PEBP.

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. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a

benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

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

Suggestions for Using this Document:

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

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

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

Accessing Other Benefit Information:

You will also want to access the following documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, Consolidated Omnibus Budget Reconciliation Act (COBRA), third-party liability and subrogation, Health Insurance Portability and Accountability Act (HIPAA) and Privacy and Security and mandatory notices. These documents are available at www.pebp.state.nv.us.

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

- Low Deductible PPO Plan Master Plan Document PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- Premier Plan Master Plan Document, Summary of Benefits and Coverage/Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

Participant Rights and Responsibilities

You have the right to:

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

You have the responsibility to:

- Establish a patient relationship with a participating primary care physician and a participating dental care provider. (Note: This Plan does not require you to designate a primary care physician.)
- Take personal responsibility for your overall health by adhering to healthy lifestyle choices.
    - If you use tobacco products, seek advice regarding how to quit.
    - Maintain a healthy weight through diet and exercise.
    - Take medications as prescribed by your health care provider.

  - Talk to your health care provider about preventive medical care.
  - Understand the wellness/preventive benefits offered by the Plan.
  - Visit your health care provider(s) as recommended.
- Choose In-Network participating provider(s) to provide your medical care.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your health care providers.
- Read all materials concerning your health benefits or ask for assistance if you need it.
- Supply information PEBP and/or your health care professionals need to provide care.
- Follow your physician's recommended treatment plan and ask questions if you do not fully understand your treatment plan and what is expected of you.
- Follow the Plan's guidelines, provisions, policies, and procedures.
- Inform PEBP if you experience any life changes such as a name change, change of address or changes to your coverage status because of marriage, divorce, domestic partnership, birth of a child(ren) or adoption of a child(ren).
- Provide PEBP with accurate and complete information needed to administer your health benefit plan, including if you or a covered dependent has other health benefit coverage.
- Retain copies of the documents provided to you from PEBP and PEBP's vendors. These documents include but are not limited to copies of:
  - The Explanation of Benefits (EOB) from PEBP's claims administrator. Duplicates of your EOB's may not be available to you. It is important that you store these documents with your other important paperwork.
  - Your enrollment forms and/or other eligibility documents submitted to PEBP.
  - Your medical, vision and dental bills.

The Plan is committed to:

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

Summary of the Low deductible PPO Plan Components

Highlights of the Plan

The Low Deductible PPO Plan is a PEBP administered preferred provider organization (PPO) low deductible plan which provides both In-Network and Out-of-Network benefits. As a member, you receive coverage for many medically necessary services and supplies, subject to any Plan *Benefit Limitations and Exclusions*. This is an open access PPO Plan and does not require a referral to see a specialist.

The Plan includes:

- Coverage for participants residing in-and outside of Nevada.
- In-and Out-of-Network benefits.
- Reimbursement for *Eligible Medical Expenses* described in this document (and as determined by the Plan Administrator) for participants residing permanently, part time, or while traveling outside of the United States. Refer to the *Out-of-Country Medical, 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 Medical Benefits* section for more information.
- Health care resources and tools to assist you in making informed decisions about your and your family's health care services. For more information log in to your E-PEBP member portal account at *www.pebp.state.nv.us*.

In-Network Deductibles and Out-of-Pocket Maximums		
In-Network	**Individual**	**Family**
Deductible	$500	Family: $1,000; Individual Family Member: $500
Out-of-Pocket Maximum	$5,000	Family: $10,000; Individual Family Member: $5,000

Out-of-Network Deductibles and Out-of-Pocket Maximums		
Out-of-Network	**Individual**	**Family**
Deductible	$500	Family: $1,000; Individual Family Member: $500
Out-of-Pocket Maximum	$10,600	Family: $21,200

Deductibles

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

- **Individual Deductible**: Individual Deductible applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible**: Family Deductible applies when two or more individuals are covered on the same Plan (e.g., Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductible may be met through a combination of Eligible Medical Expenses from all covered family members. The In-Network Family Deductible includes a "Individual Family Member" embedded Deductible. This means one single family member is only required to

meet the Individual Family Member Deductible before the Plan starts to pay Coinsurance for that member.

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

Deductible credit is only applied for eligible medical and specialty drug expenses and in the order in which the claims are received by the Plan. Non-eligible medical expenses and copayments do not count toward the Deductible.

In-Network Individual Deductible

The $500 In-Network Individual Deductible applies when only one person is covered on the Plan. Participants are responsible for paying out-of-pocket for eligible medical and Specialty pharmacy expenses up to the Plan Year Deductible. 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 Specialty pharmacy expense is received by the Plan and not on the date of service. Copayments do not apply toward Deductible but do apply to the Out-of-Pocket Maximum.

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 $1,000 (with a $500 "Individual Family Member" Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible In-Network medical and Specialty pharmacy expenses for the entire family after the $1,000 Family Deductible is met; or the Plan will pay benefits for one single family member who has met the $500 "Individual Family Member" Deductible. Under no circumstances will one family member be required to pay more than $500 toward the $1,000 Family Deductible. The $1,000 In-Network Family Deductible may be met by any combination of eligible medical and specialty pharmacy expenses from *two or more* covered individuals in the family. The Family Deductible (including "Individual Family Member" Deductible) accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or specialty pharmacy expense is received by the Plan and not on the date of service. Copayments do not apply toward Deductible but do apply to the Out-of-Pocket Maximum.

In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-and Out-of-Network provider expenses.

Out-of-Network Individual Deductible

The $500 Out-of-Network Individual Deductible applies when only one person is covered on the Plan. Participants are responsible for paying out-of-pocket for eligible medical and Specialty pharmacy expenses (Out-of-Network Specialty pharmacy expenses are not covered) up to the Plan Year Deductible. In-Network and Out-of-Network Deductibles are not interchangeable,

meaning the Deductibles accumulate separately for In-Network and Out-of-Network provider expenses. Deductible credit is based on the date the medical or Specialty pharmacy expense is received by the Plan and not on the date of service. Copayments do not apply toward Deductible but do apply to the Out-of-Pocket Maximum.

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 (with a $500 "Individual Family Member" Deductible. For a participant covered with one or more dependents, this Plan will pay benefits for eligible Out-of-Network medical (Specialty pharmacy expenses are not covered Out-of-Network) expenses for the entire family after the $1,000 Family Deductible is met; or the Plan will pay benefits for one single family member who has met the $500 "Individual Family Member" Deductible; under no circumstances will one single member of the family be required to pay more than the $500 toward the $1,000 Out-of-Network Family Deductible. The $1,000 Family Deductible may be met by any combination of Eligible Medical Expenses from *two or more* covered individuals in the family. The Family Deductible (including "Individual Family Member" Deductible) accumulates separately for In-Network provider and Out-of-Network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service. Copayments do not apply toward Deductible but do apply to the Out-of-Pocket Maximum.

Coinsurance

Coinsurance is the percentage of costs that is generally paid by both the participant and the Plan for Eligible Medical Expenses after the Deductible is met. Participants who receive covered health care services using an In-Network health care provider will pay less money out of pocket. The Plan generally pays 80% of the In-Network provider's contract rate and the participant is responsible for paying the remaining 20% for applicable medical/behavioral health services that are subject to Deductible and Coinsurance, and 30% for Specialty pharmacy. The Plan reduces benefits for Out-of-Network medical/behavioral health providers to 50% of the Maximum Allowable Charge. The Maximum Allowable Charge for air-ambulance services is the lower of the PPO contracted rate or 250% of the applicable Medicare rate. Participants are responsible for costs that exceed the Plan's Maximum Allowable Charge when accessing services Out-of-Network.

Copayments

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

In-Network Out-of-Pocket Maximum

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

Copayments, Deductible, and Coinsurance for eligible medical and prescription drug expenses apply to the OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges, penalties, and Out-of-Network charges, including emergent and urgent services that exceed this Plan's Maximum

Allowable Charge. This list is not all inclusive and may not include all services and supplies that do not apply to the OOP Maximum.

Individual and Family Out-of-Pocket Maximum:

- Individual (covered as self-only): $5,000
- Family coverage (participant plus one or more covered dependents): $10,000
  - The Family OOP Maximum includes a $5,000 "Individual Family Member" OOP Maximum. An "Individual Family Member" OOP Maximum means one single person will not pay more than $5,000 in the Plan Year for eligible medical and prescription drug expenses.

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

For this section only, all references to the OOP Maximum, Eligible Medical Expenses, Copayments, Deductibles and Coinsurance are specific to In-Network benefits, including benefits for Out-of-Network urgent and emergent services which are generally applied as an In-Network benefit, subject to the Plan's Maximum Allowable Charge.

Out-of-Network Out-of-Pocket Maximum

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

Only Eligible Medical Expenses subject to the Plan's Maximum Allowable Charge apply to the Out-of-Network OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges, penalties, and Out-of-Network charges that are greater than the Plan's Maximum Allowable Charge. This list is not all inclusive and may not include all services and supplies that do not apply to the OOP Maximum.

Individual and Family Out-of-Network OOP Maximum:

- Individual (covered as self-only): $10,600
- Family coverage (participant plus one or more covered dependents): $21,200

Once an Individual (self-only coverage) or Family (participant plus one or more dependents) satisfies the Out-of-Network OOP Maximum, the Plan will pay 100% of all eligible Out-of-Network medical expenses, subject to the Plan's Maximum Allowable Charge, and excluding Out-of-Network prescription drug expenses, which are not covered by this Plan, for the remainder of the Plan Year. The Out-of-Network OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year.

The accumulation of Eligible Medical Expenses toward the Out-of-Network OOP Maximum is based on the date the medical expense is received by the plan and not on the date of service, and subject to the Plan's Maximum Allowable Charge.

The Family Out-of-Network OOP Maximum does not include an embedded individual OOP Maximum; however, the $21,200 Family Out-of-Network OOP Maximum may be met by one person or by a combination of Out-of-Network Out-of-Pocket Eligible Medical Expenses from all covered family members.

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

Description of In-Network and Out-of-Network

Provider Network

The Plan or its designee arranges for providers to participate in a PPO network. For Plan Year 2022, the Plan's In-state and Out-of-State Network is **Aetna Signature Administrators or ASA**.
In-Network providers are hospitals, physicians, medical laboratories, and other health care providers located within a service area who have agreed to provide health care services and supplies at negotiated discount fees. Network providers are not the Plan's employees or employees of any Plan designee.

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

Before obtaining services, you should always verify the network status of a provider. A provider's network status may change. You are responsible for verifying a provider's network status prior to receiving services, even when you are referred by another In-Network provider. You can verify the provider's status by calling the third-party administrator or from the PEBP website located under *Find a Provider*.

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

Do not assume that an In-Network provider's agreement includes all Eligible Medical Expenses. Some In-Network providers agree to provide only certain covered expenses, but not all covered expenses. Some In-Network providers choose to be an In-Network provider for only some products/services. You may contact the third-party administrator for assistance in choosing a provider or with questions about a provider's network participation.

In-Network Provider/Benefits

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

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

If you receive medically necessary services or supplies from an In-Network provider, you will pay a lower coinsurance than if you received those services or supplies from a health care provider who is a non-PPO provider (Out-of-Network). In-Network providers have agreed to accept the Plan's payment (plus any applicable Coinsurance you are responsible for paying) as payment in full. The In-Network health care provider generally deals with the Plan directly for any additional amount due.

Out-of-Network Provider/Benefits

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

Out-of-Network health care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will pay benefits based on the Maximum Allowable Charge on non-discounted medically necessary services or supplies and the lower of the PPO contracted rate or 250 percent of the applicable Medicare rate for air ambulance services. Eligible Out-of-Network health care expenses are subject to the Plan's Out-of-Network applicable Copayments, Deductibles and Coinsurance. Out-of-Network health care providers can bill the participant for any balance that may be due in addition to the amount paid

by the Plan (called balance billing). You can avoid potential balance billing by always using In-Network providers.

Other Providers

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

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

Travel

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

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

Emergency Care

The Plan provides benefits for emergency care when required for stabilization and initiation of treatment as provided by or under the direction of a physician. Eligible Medical Expenses that are provided as a result of Urgent or Emergent care provided by In-Network providers are paid at the In-Network benefit level. Out-of-Network Urgent and Emergent care for Eligible Medical Expenses are paid at the In-Network benefit level, subject to the Plan's Maximum Allowable Charge.

Confinement in an Out-of-Network hospital following an emergency

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

Other Exceptions

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

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

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

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

If there is a specialty not available inside the participant's eligible PPO network, benefits may be paid as In-Network.

Preferred Provider Organizations (PPO Network)

LD PPO Plan members have access to a statewide and national PPO network. Information regarding the PPO network is in the *Participant Contact Guide* section of this document and is available on the PEBP website *www.pebp.state.nv.us*.

Service Area

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

Directories of Network Providers

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

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

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services, and supplies. The expenses for which you are covered are called eligible medical expenses. Eligible medical expenses are limited to the covered benefits specified in the *Schedule of Medical Benefits* and are:

- Determined by the Plan Administrator or its designee to be medically necessary (unless otherwise stated in this Plan), but only to the extent that the charges are usual and customary (U&C), provided in-network, do not exceed the Plan's Maximum Allowable Charge, costs that do not exceed the Plan's reference based pricing for services performed at exclusive facilities; (as those terms are defined in the *Key Terms and Definitions* section of this document);
- Are not excluded from coverage under this Plan; and
- The health care benefits, services and supplies are not in excess of the limited overall, lifetime and/or Plan year maximum benefits.

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

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

Generally, the Plan will not reimburse you for all Eligible Medical Expenses. Usually, you will have to pay some portion of costs, known as cost-sharing such as Deductibles, Copayments and Coinsurance toward the amounts you incur that are Eligible Medical Expenses. However, you are only required to pay Copayments and Coinsurance for Eligible Medical Expenses up to the Plan Year Individual or Family Out-of-Pocket Maximum.

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

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

A person who is continuously covered under 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., Out-of-Pocket Maximum, dental frequency maximums and annual benefit maximum) will continue without interruption.

Non-Eligible Medical Expenses

You are responsible for paying the full cost of all expenses that are not Eligible Medical Expenses, including expenses that are:

- Not determined to be medically necessary (unless otherwise stated in this Plan).
- Determined to be in excess of the usual and customary charges.
- Determined to be in excess of the Plan's Maximum Allowable Charge.
- Expenses for medical services or supplies that are not covered by the Plan, including but not limited to, expenses that exceed the PPO provider contract rate, excluded benefits as listed in the *Benefit Limitations and Exclusions* section, and dental expenses.
- Benefits exceeding those services or supplies subject to limited overall maximums for each covered individual for certain Eligible Medical Expenses.
- Additional amounts you are required to pay because of a penalty for failure to comply with the Plan's utilization management requirements described in the *Utilization Management*

- section of this document. If you fail to follow certain requirements of the Plan's utilization management program, the Plan may pay a smaller percentage of the cost of those services and you may have to pay a greater percentage of those costs. The additional amount you may have to pay is in addition to your Deductible or Out-of-Pocket Maximum.
- Preventive Care/Wellness benefits that are paid by the Plan at 100% do not accumulate towards the Out-of-Pocket Maximum.

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

This list is not all inclusive may not include all *Non-Eligible Medical Expenses*. For more information regarding *Non-Eligible Medical Expenses*, see the *Benefit Limitations and Exclusions* section.

PPO Network Health Care Provider Services

If you receive medical services or supplies from an In-Network PPO provider, you will be responsible for paying less money out-of-pocket. Health care providers who are participating providers of the PPO network have agreed to accept the PPO network negotiated amounts in place of their standard charges for covered health care services. You are responsible for any applicable Plan Copayment, Deductible and or Coinsurance requirements as outlined in this document and are described in more detail in the *Summary of Medical Benefits and Schedule of Medical Benefits*. Out-of-network providers may bill you their standard charges and any balance that may be due after the Plan payment. It is the participant's responsibility to verify the In-Network status of a chosen provider.

NOTE: In accordance with *NRS 695G.164*, if you are seeing a provider that is In-Network and that provider leaves the network, and you are actively undergoing a medically necessary course of treatment, and you and your provider agree that a disruption to your current care may not be in your best interest or if continuity of care is not possible immediately with another In-Network provider, PEBP will pay that provider at the same level they were being paid while contracted with PEBP's PPO network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

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

Out-of-Country Medical, Prescription and Vision Purchases

This Plan provides you with coverage worldwide. Whether you reside in the United States and travel to a foreign country, or if you reside outside of the United States permanently or on a part-

time basis, and require medical, prescription drug, or vision care services, you may be eligible for reimbursement of the cost.

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

Typically, providers in foreign countries do not accept payment directly from the Plan. You may be required to pay for medical and vision care services and submit your receipts to this Plan's third-party claims administrator for possible reimbursement. Medical and vision services received outside of the United States are subject to Plan provisions, coverage, limitations, exclusions, clinical review, if necessary, determination of medical necessity, and the Plan's Maximum Allowable Charge. The review may include regulations determined by the FDA. Out-of-country medication purchases are only eligible for reimbursement while traveling outside of the United States.

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

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

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

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

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

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

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

Active employees and retirees covered under this Plan and who meet the eligibility provisions for Basic Life Insurance benefits may be eligible for travel assistance services through Standard Insurance. For a description of the services, refer to the Standard Insurance Company website at *https://www.standard.com/mybenefits/nevada/index.html.*

If you are not eligible for emergency transportation services provided by the Standard Insurance Company or if you do not utilize the Standard Insurance travel assistance benefit, this Plan may provide benefits for the purposes of emergency medical transportation only. This Plan typically will pay for commercial transportation. For more information, contact this Plan's third-party claims administrator listed in the *Participant Contact Guide*.

Healthcare Bluebook Pricing Tool

Healthcare Bluebook (HCBB) is a resource that enables participants to find and compare high-quality, low-cost providers for various health care procedures. This service may be accessed by logging into the E-PEBP Portal and selecting Healthcare Bluebook. When you shop for certain procedures on Healthcare Bluebook and use a Fair Price™ (green-rated) facility, you are eligible for a reward. HCBB helps you identify reward-eligible procedures by including a Reward indicator on eligible procedure pages. Although a provider may be listed on the pricing tool, it is the participant's responsibility to verify the provider's network status prior to accessing services.

Healthcare Bluebook Incentive Reward

Participants earning a monetary reward from Healthcare Bluebook will have 180 days from the date the check is issued to cash the reward check; reward checks that are not cashed within 180 days will be forfeited and the funds will be returned to the Plan.

Utilization Management

The Plan is designed to provide you and your eligible dependents with financial protection from significant health care expenses. To enable the Plan to provide coverage in a cost-effective way, it has adopted a Utilization Management (UM) program designed to help control increasing health care costs by avoiding unnecessary services, directing participants to more cost-effective treatments capable of achieving the same or better results and managing new medical technology and procedures. If you follow the procedures of the Plan's UM program, you may avoid some Out-of-Pocket costs. However, if you do not follow these procedures, Plan benefits are reduced, and you will be responsible for paying more out of pocket.

The Plan's UM program is administered by an independent professional UM company operating under a contract with the Plan. The name, address and telephone number of UM company appears in the *Participant Contact Guide* section. The health care professionals at the UM company focus their review on the medical necessity of hospital stays and the medical necessity, appropriateness, and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of this 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 *Enrollment and Eligibility Master Plan Document* and the PEBP *Active Employee and Retiree Health and Welfare Wrap Plan Documents.* For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered, either in whole or in part, by an exclusion in the Plan.

Regardless of whether your physician recommends surgery, hospitalization, confinement in a skilled nursing or sub-acute facility, or your physician or other provider proposes or provides any medical service or supply does not mean the recommended services or supplies will be considered medically necessary for determining coverage under the Plan.

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

- The UM company does not authorize a proposed surgery or other proposed medical treatment as medically necessary; or

- The Plan will not pay regular benefits for a hospitalization or confinement in a skilled nursing or sub-acute facility because the UM company does not authorize a proposed confinement.

PEBP, HealthSCOPE Benefits, the third-party claims administrator, and American Health Holdings, Inc., 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 the medical judgement of licensed health care professionals.

Delivery of Services

You are entitled to receive medically necessary medical care and services as specified in this Plan's *Summary of Medical Benefits* and *Schedule of Medical Benefits*. These include medical, surgical, diagnostic, therapeutic, and preventive services. If a precertification is required and you do not obtain the required precertification, the service may not be covered, even if the service is medically necessary. These services, although not all inclusive are those that generally:

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

Precertification (Prior Authorization) Process

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

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

A precertification is required for referrals to physicians and providers for certain services. All benefits listed in this Plan may be subject to precertification requirements and concurrent or

retrospective review depending upon the circumstances associated with the services. Refer to the *Services Requiring Precertification* section below for more information.

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

Services Requiring Precertification (Prior Authorization)

All Inpatient Admissions

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

Outpatient and Physician - Surgery

- Back surgeries and hardware related to surgery
- Total hip and knee surgeries
- All remaining hip and knee surgeries
- Biopsies (excluding skin, colonoscopy, and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Vascular Access Devices for the Infusion of Chemotherapy (e.g., PICC and Central Lines)
- Thyroidectomy, partial or complete
- Open Prostatectomy
- Creation and Revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for Dialysis
- Oophorectomy, unilateral and bilateral
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Gender reassignment surgeries
- Bariatric/weight loss surgeries and adjustments to lap bands after the first 12 months post-surgery
- Sleep apnea related surgeries, limited to:
    - Radiofrequency ablation (Coblation, Somnoplasty)

  - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic) and reconstruction surgery
- Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Varicose vein surgery/sclerotherapy
- Any procedure deemed to be Experimental and/or Investigational (provider must indicate on the pre-certification request that the service/procedure is Experimental and/or Investigational and/or part of a clinical trial)

Outpatient and Physician – Diagnostic Services

- Computerized tomography (CT) Scan for non-orthopedic
- Magnetic resonance imaging (MRI) for non-orthopedic
- Position emission tomography (PET) Scan
- Capsule endoscopy
- Genetic Testing (including BRCA)
- Sleep Study

Outpatient and Physician – Continuing Care Services

- Dialysis
- Chemotherapy (including oral)
- Radiation Therapy
- Oncology and transplant related injections, infusions, and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric Oxygen
- Home Health Care
- Durable Medical Equipment exceeding $1,000
- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables exceeding $2,000, and infusions excluding services reviewed by the PBM
- Mental Health and Substance Abuse Intensive Outpatient Program
- Vein Therapy
- Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a combined visit limit of 90 visits per Plan year

The UM company should be notified upon confirmation of pregnancy, so they may better manage your benefits. You must comply and cooperate with the UM company. Services are subject to all the terms of this Plan.

Precertification is not required for medically necessary emergency services when a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

- 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 the emergency hospital admission within one business day, so the UM company can conduct a *Concurrent Review*. Your physician or the hospital should call the UM company to initiate the concurrent review. Even though a precertification may not be required for some services, like those listed above, the hospital or facility is still required to comply with the Plan's provisions regarding UM, such as concurrent review.

How to Request Precertification (Prior Authorization)

It is your responsibility to ensure that precertification occurs when it is required by this Plan. Any penalty or denial of benefits for failure to obtain precertification is your responsibility, not the provider's. You or your physician must call the UM company at the telephone number shown in the *Participant Contact Guide* to request precertification. Calls for elective services should be made at least 15 calendar days before the expected date of service. Failure to request precertification may result in a reduction or denial of benefits. Be prepared to provide all the following information:

- Employer's name.
- Employee's name.
- Patient's name, address, phone number and Social Security Number or medical card ID #.
- Physician's name, phone number or address.
- Name of hospital or outpatient facility or any other provider that will be providing services.
- Reason for the health care services or supplies; and
- Proposed date for performing the services or providing the supplies.
- Reason for the health care services or supplies; and
- Proposed date for performing the services or providing the supplies.

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

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

Hospital Admission

The UM company must be notified at least (5) five business days before any elective inpatient hospital admission to ensure to obtain precertification. Your physician or other provider may notify the UM company, but it is ultimately your responsibility to make sure they are notified. The UM company will review the physician/provider's recommendation and treatment plan to determine the level of care and place of service. If the UM company denies the precertification for hospital admission as not covered or they determine that the services do not meet the UM company's medical necessity criteria, the Plan's third-party administrator will only pay benefits for inpatient that has been pre-certified.

Emergent and Urgent Hospital Admission (including for all complications of pregnancy):

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

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

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

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

If you are confined in an Out-of-Network hospital after you receive emergency services, the UM company must be notified within 24 hours, the next business day, or as soon as reasonable after admission. The UM company may elect to transfer you to an In-Network hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network hospital after the date the UM company decides a transfer is medically appropriate, benefits for the continued stay will not covered under this Plan.

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

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

Due to cost variations for elective knee and hip joint replacement performed in Nevada, the third-party claims administrator has identified exclusive providers who meet the Plan's cost threshold for routine knee and hip replacement procedures. If you choose a provider on the exclusive list, you will potentially reduce your out-of-pocket costs in accordance with the standard plan benefits. However, if you choose to use a non-exclusive provider, the Plan will pay benefits in accordance with its cost threshold or Maximum Allowable Charge. You may be subject to balance billing for any amount exceeding this Plan's cost threshold. Amounts exceeding the Plan's established threshold will not apply to your Deductible (if applicable) or Out-of-Pocket Maximum.

Outpatient Surgery

You are responsible for notifying the UM company is notified at least 5 (five) business days before an outpatient surgery admission on to ensure that it is covered.

Your physician or other provider may notify the UM company, but it is ultimately your responsibility to make sure they are notified. The UM company will review the physician /provider's recommendation and treatment plan to determine the level of care and place of service. If the UM company denies the precertification for outpatient surgery admission as not covered or they determine that the services do not meet the UM company's medical necessity criteria, the Plan's third-party administrator will only pay benefits for outpatient surgery that has been pre-certified.

Inpatient and Outpatient Surgery

You are responsible for ensuring that the UM company is notified at least 5 (five) business days before elective inpatient or outpatient surgery is performed. Your physician or other provider may notify the UM company, but it is your responsibility to make sure they are notified. The UM company will review the physician's recommended course of treatment to ensure the requested treatment meets established medical necessity criteria and protocols. The claims administrator will only pay benefits for inpatient or outpatient surgery that is pre-certified, and the services/supplies are a covered benefit.

Outpatient Infusion Services

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

Air/Flight Scheduled Inter-Facility Transfer

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

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

- 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.

Gender Reassignment Surgery

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

- Notification to the participant that the precertification process begins with the initial contact to the UM company,
- Documenting that the participant meets all criteria specified in the Mental Health Care and the Gender Reassignment Procedures sections below, and
- Advising participants of providers who specialize in this type of treatment to include genital reconstruction.

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

Health Care Services and Supplies Review

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

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

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

Failure to Follow Required Utilization Management Procedures

Precertification is required before you obtain certain health care services. Obtaining required precertification protects you from expenses that result from receiving services that are not covered, not medically necessary or are otherwise excluded from coverage under this Plan. If precertification is required and you do not obtain the required precertification, the service may not be covered, even if the service is medically necessary. Non-compliance penalties imposed for failure to obtain precertification will not apply to the annual Out-of-Pocket Maximum.

Concurrent Review

Concurrent Review (continued stay) is the ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or skilled nursing or sub-acute facility. When you are receiving medical services in a hospital or other inpatient facility, the UM company monitors your stay by contacting your physician or other providers to assure that continuation of medical services in the facility are medically necessary. The UM company will also help coordinate your medical care with other health care benefits available under the Plan.

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

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

Retrospective Review

Retrospective Review is the review of health care services after they have been provided to determine if those services were medically necessary. The Plan will pay benefits only for those days or treatment that would have been authorized under the UM company and case management: The process whereby the patient, the patient's family, physician, or other providers work together with the Plan Administrator or its designee under the guidance of the UM company to coordinate a quality, timely and cost-effective treatment plan.

Case Management

Case management is a voluntary process administered by the UM company. Its medical professionals work with the patient, the patient's family, caregivers, providers, the Claims

Administrator, and the Plan Administrator or its designee to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly and/or high-technology services, or when assistance is needed to guide the patient through a maze of potential providers.

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

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

Second Opinion

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

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

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

Air Ambulance Services

This Plan provides coverage for emergency air ambulance and inter-facility patient air transport if there is a life-threatening situation, or the service is deemed medically necessary by the UM company. The air ambulance services are subject to the Plan Deductible, then the Plan will pay the lower of the PPO allowable for In-Network air ambulance providers, or for Out-of-Network providers, the Plan will pay up to the Maximum Allowable Charge, which for air ambulance services is 250% of the applicable Medicare rate. Amounts exceeding the Plan's Maximum Allowable Charge shall be the participant's responsibility and will not apply to the Out-of-Pocket Maximum.

See the *Utilization Management* section for air ambulance precertification requirements.

Air/Flight Scheduled Inter-Facility Transfer

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

Inter-facility transport may occur if there is a life-threatening situation, or 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. See Air Ambulance Services in the *Summary of Medical Benefits* and *Schedule of Medical Benefits,* and *Utilization Management sections* for details on plan benefits, coverage, and the Plan's Maximum Allowable Charge.

Emergency Air Ambulance

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

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

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

Emergency Hospitalization

You are not required to obtain precertification before you obtain services for a medical emergency. Further, if a medical emergency occurs, there may be no time to contact the UM company before you are admitted to the hospital. However, the UM company must still be

notified of the hospital admission within one business day to conduct a concurrent review. You, your physician, the hospital, a family member, or friend can call the UM company to initiate the concurrent review. Failure to follow the required utilization management process may result in a reduction or denial of benefits. Expenses related to the penalty will not be counted to meet your out-of-pocket maximum.

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

Failure to Follow Required Utilization Management Procedures

Precertification is required before you obtain certain health care services. Obtaining required precertification protects you from expenses that result from receiving services that are not covered, not medically necessary or are otherwise excluded from coverage under this Plan. If precertification is required and you do not obtain the required precertification, the service may not be covered, even if the service is medically necessary. Non-compliance penalties imposed for failure to obtain precertification will not apply to the annual out-of-pocket maximum.

Transplants (Organ, Bone Marrow and Tissue)

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

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

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

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

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

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

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

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

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

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

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

Travel Expenses

This Plan allows for the reimbursement of travel and hotel accommodation expenses for the patient and one additional person when the expenses are associated with the following services and have been pre-certified by the UM company:

- Organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence; or
- Elective surgeries performed as exclusive hospitals/ambulatory facilities; and
- Outpatient infusion services if the UM company requires you to travel more than 50 miles one way for a service subject to precertification.

Participants are required to use the least expensive method of transportation. Participants who use their personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center will be compensated for mileage from the participant's residence to and from the Center of Excellence or exclusive hospital/ambulatory surgical facility or outpatient infusion facility (based on an objective source such as Google Maps) at the standard mileage reimbursement rate for which a deduction is allowed for travel for federal income tax or the personal convenience mileage reimbursement rate depending on the circumstances and the cost of other methods of travel.

This Plan incorporates the travel expense reimbursement guidelines established in the Nevada State Administrative Manual (SAM) 0200 with certain limitations and exclusions as specified in this document. The SAM is an official publication of the State of Nevada Department of Administration and is issued under authority of the Governor and the Board of Examiners. The

SAM manual is located at
http://budget.nv.gov/uploadedFiles/budgetnvgov/content/Governance/SAM.pdf
NOTE: The Plan Administrator or its designee has full authority to approve or deny all or part of your travel expenses. The denial of travel expenses cannot be appealed.

In-State Travel (Nevada) – SAM 0212

Travel expenses incurred may be reimbursed at a rate comparable to the rates established by the US General Services Administration (GSA) for the State of Nevada. Maximum per diem reimbursement rates for Nevada's lodging, meals and incidental expenses are established by city/county and vary by season. Receipts are required for all lodging expenses. In addition to the reimbursable lodging rates, participants may be reimbursed for lodging taxes and fees. Lodging taxes are limited to the taxes on reimbursable lodging costs. For example, if the maximum lodging rate is $50 per night, and you elect to stay at a hotel that costs $100 per night, you can only claim the amount of taxes on $50 which is the maximum authorized lodging amount. 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.

Out-of-State Travel (Nevada) – SAM 0214

Travel expenses incurred may be reimbursed at a rate comparable to the rates established by the US General Services Administration (GSA) for the primary destination. Maximum per diem reimbursement rates for lodging, meals and incidental expenses are established by city/county and vary by season. Receipts are required for all lodging expenses. In addition to the reimbursable lodging rates, participants may be reimbursed for lodging taxes and fees. Lodging taxes are limited to the taxes on reimbursable lodging costs. For example, if the maximum lodging rate is $50 per night, and you elect to stay at a hotel that costs $100 per night, you can only claim the amount of taxes on $50 which is the maximum authorized lodging amount. Meals will be reimbursed in accordance with the meals and incidental expense (M&IE) allowance for the primary destination. Receipts are not required for the M&IE allowance. Participants should refer to the GSA's website *https://www.gsa.gov/* and the link "Per Diem Rates" for the most current rates.

Additional Requirements

Reimbursement for meals while traveling must meet the following guidelines:

- Breakfast – must depart at or before 7:00 a.m.
- Lunch- must depart at or before 11:00 a.m.; Return at or after 1:30 p.m.; and
- Dinner- must depart at or before 5:30 p.m.; Return at or after 7:00 p.m.

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

- Transplant or bariatric surgery performed at a Center of Excellence (does not include pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon; or

- Elective surgery performed at an exclusive hospital/ambulatory surgery facility approved by the UM company (including pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon; or
- Travel expenses for infusion services performed at an exclusive outpatient facility.

Eligible Travel Expenses Include:

- Flight expenses for commercial air (economy rate).
- Mileage reimbursement for personal vehicle.
- Travel meals (for patient and travel companion only).
- Hotel accommodations.
- Parking or vehicle storage fees for private automobiles and commercial transportation costs (i.e., taxi, shuttle, etc.); and/or
- Rental car expense.
- Receipts are required for reimbursement for all expenses except for meals which are based on the number of days and time of travel.

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 surgery are not eligible for reimbursement.
- Travel expenses are subject to the annual cost sharing requirements.

Note: PEBP will not reimburse travel or any other expense to any participant covered under PEBP's Premier Plan, the self-funded Consumer Driven Health Plan (CDHP), or the Low Deductible PPO Plan twice for any service or event.

PEBP does not provide advance payment for travel expenses.

Pre-Approval of your Travel Expenses

Unless there are extenuating circumstances, travel expenses must be pre-approved by PEBP or its designee. Travel expenses not pre-approved by PEBP or its designee will not be eligible for reimbursement.

If the participant is unable to obtain pre-approval by PEBP or its designee because the organ or tissue transplant required immediate travel, the participant may submit all associated travel costs to PEBP or its designee after the transplant surgery for consideration. The participant should designate someone to notify PEBP or its designee regarding the emergency travel and the circumstances surrounding such travel. Travel claims must be submitted within 12 months of the date of surgery to be considered eligible. All other requests for travel expenses require pre-approval.

Pre-approval will provide an approximation of your travel reimbursement. Final reimbursement will be based on actual expenses using the actual number of days and travel times and may differ from the pre-approved approximation. The Pre-approval Travel Expense Request form is available at www.pebp.state.nv.us.

Submitting your Travel Expense Receipts

A claim for travel expense reimbursement must be submitted to PEBP on a Travel Expense Reimbursement claim form. All relevant sections of the form must be completed including the start and end times, destination, and purpose of trip. The claimant should sign the travel expense claim form attesting to the accuracy of the claim.

Travel expense reimbursement claims should be accompanied by original itemized receipts which include the name(s) of the person(s) incurring the expense. If the travel includes a commercial airline flight, an itinerary should be attached for meal justification.

Reimbursement of eligible travel expenses, including any eligible travel expenses relating to a travel companion, will be payable to the primary participant (employee or retiree) and not to the service vendor (credit card company, hotel, hospital, restaurant, etc.).

Transplants (Organ, Bone Marrow and Tissue)

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

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 directly related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his/her Plan

will pay first and benefits under this Plan will be reduced by the amount payable under the donor's Plan.

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

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

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

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

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

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

Travel Expenses

This Plan allows for the reimbursement of travel and hotel accommodation expenses for the patient and one additional person when the expenses are associated with the following services and have been pre-certified by the UM company:

- Organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence; or
- Elective surgeries performed as exclusive hospitals/ambulatory facilities; and
- Outpatient infusion services if the UM company requires you to travel more than 50 miles one way for a service subject to precertification.

Participants are required to use the least expensive method of transportation. Participants who use their personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center will be compensated for mileage from the participant's residence to and from the Center of Excellence or exclusive hospital/ambulatory surgical facility or outpatient infusion facility (based on an objective source such as Google Maps) at the standard mileage reimbursement rate for which a deduction is allowed for travel for federal income tax or the personal convenience mileage reimbursement rate depending on the circumstances and the cost of other methods of travel.

This Plan incorporates the travel expense reimbursement guidelines established in the Nevada State Administrative Manual (SAM) 0200 with certain limitations and exclusions as specified in this document. The SAM is an official publication of the State of Nevada Department of Administration and is issued under authority of the Governor and the Board of Examiners. The SAM manual is located at https://budget.nv.gov/uploadedFiles/budgetnvgov/content/Governance/SAM.pdf

NOTE: The Plan Administrator or its designee has full authority to approve or deny all or part of your travel expenses. The denial of travel expenses cannot be appealed.

In-State Travel (Nevada) – SAM 0212

Travel expenses incurred may be reimbursed at a rate comparable to the rates established by the US General Services Administration (GSA) for the State of Nevada. Maximum per diem reimbursement rates for Nevada's lodging, meals and incidental expenses are established by city/county and vary by season. Receipts are required for all lodging expenses. In addition to the reimbursable lodging rates, participants may be reimbursed for lodging taxes and fees. Lodging taxes are limited to the taxes on reimbursable lodging costs. For example, if the maximum lodging rate is $50 per night, and you elect to stay at a hotel that costs $100 per night, you can only claim the amount of taxes on $50 which is the maximum authorized lodging amount. 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.

Out-of-State Travel (Nevada) – SAM 0214

Travel expenses incurred may be reimbursed at a rate comparable to the rates established by the US General Services Administration (GSA) for the primary destination. Maximum per diem reimbursement rates for lodging, meals and incidental expenses are established by city/county and vary by season. Receipts are required for all lodging expenses. In addition to the reimbursable lodging rates, participants may be reimbursed for lodging taxes and fees. Lodging taxes are limited to the taxes on reimbursable lodging costs. For example, if the maximum lodging rate is $50 per night, and you elect to stay at a hotel that costs $100 per night, you can only claim the amount of taxes on $50 which is the maximum authorized lodging amount. Meals will be reimbursed in accordance with the meals and incidental expense (M&IE) allowance for the primary destination. 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.

Additional Requirements

Reimbursement for meals while traveling must meet the following guidelines:

- Breakfast – must depart at or before 7:00 a.m.
- Lunch- must depart at or before 11:00 a.m.; Return at or after 1:30 p.m.; and
- Dinner- must depart at or before 5:30 p.m.; Return at or after 7:00 p.m.

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

- Transplant or bariatric surgery performed at a Center of Excellence (does not include pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon; or
- Elective surgery performed at an exclusive hospital/ambulatory surgery facility approved by the UM company (including pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon; or
- Travel expenses for infusion services performed at an exclusive outpatient facility.

Eligible Travel Expenses Include:

- Flight expenses for commercial air (economy rate).
- Mileage reimbursement for personal vehicle.
- Travel meals (for patient and travel companion only).
- Hotel accommodations.
- Parking or vehicle storage fees for private automobiles and commercial transportation costs (i.e., taxi, shuttle, etc.); and/or
- Rental car expense.
- Receipts are required for reimbursement for all expenses except for meals which are based on the number of days and time of travel.

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 surgery are not eligible for reimbursement.
- Travel expenses are subject to the annual cost sharing requirements.

Note: PEBP will not reimburse travel or any other expense to any participant covered under PEBP's Premier Plan, the self-funded Consumer Driven Health Plan (CDHP), or the Low Deductible PPO Plan twice for any service or event.

PEBP does not provide advance payment for travel expenses.

Pre-Approval of your Travel Expenses

Unless there are extenuating circumstances, travel expenses must be pre-approved by PEBP or its designee. Travel expenses not pre-approved by PEBP or its designee will not be eligible for reimbursement.

If the participant is unable to obtain pre-approval by PEBP or its designee because the organ or tissue transplant required immediate travel, the participant may submit all associated travel costs to PEBP or its designee after the transplant surgery for consideration. The participant should designate someone to notify PEBP or its designee regarding the emergency travel and the circumstances surrounding such travel. Travel claims must be submitted within 12 months of the date of surgery to be considered eligible. All other requests for travel expenses require pre-approval.

Pre-approval will provide an approximation of your travel reimbursement. Final reimbursement will be based on actual expenses using the actual number of days and travel times and may differ from the pre-approved approximation. The Pre-approval Travel Expense Request form is available at www.pebp.state.nv.us.

Submitting your Travel Expense Receipts

A claim for travel expense reimbursement must be submitted to PEBP on a Travel Expense Reimbursement claim form. All relevant sections of the form must be completed including the start and end times, destination, and purpose of trip. The claimant should sign the travel expense claim form attesting to the accuracy of the claim.

Travel expense reimbursement claims should be accompanied by original itemized receipts which include the name(s) of the person(s) incurring the expense. If the travel includes a commercial airline flight, an itinerary should be attached for meal justification.

Reimbursement of eligible travel expenses, including any eligible travel expenses relating to a travel companion, will be payable to the primary participant (employee or retiree) and not to the service vendor (credit card company, hotel, hospital, restaurant, etc.).

Coronavirus (COVID-19) Pandemic Benefits

Benefit Description

COVID-19 Plan Benefits
Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (see *Key Terms and Definitions*)

Benefits apply during the Coronavirus Pandemic unless otherwise mandated by federal or state law, or as stated below in the Explanations and Limitations.

Explanations and Limitations
Coronavirus (COVID-19) Pandemic Benefits

The following benefits will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network during the national public health emergency period, currently schedule to end April 20, 2021, or until the last date of the national public health emergency period, if extended.

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

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

Summary of Medical Benefits

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

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

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

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

Benefit Description	In-Network	Out-of-Network
ACA Wellness/Preventive Office Visits and Preventive Screenings The Plan covers recommended preventive care services without participant cost-sharing when services are received by In-Network providers. For more details see *Preventive Services* in the ***Summary of Medical 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 all other services provided in an office setting subject to Deductible and Coinsurance*		

Benefit Description	In-Network	Out-of-Network
Wellness/Preventive Office Visits and Preventive Screenings		
Mammography screening	$0 Copay	Not Covered
Limit: One 2D or 3D mammogram screening per Plan Year for women aged 40 years and older.		
Papanicolaou (Pap) test	$0 Copay	Not Covered
Prostate Specific Antigen (PSA) screening	$0 Copay	Not Covered
Colorectal screening	$0 Copay	Not Covered
Colorectal Screening: Starting at age 45 in accordance with the American Cancer Society's screening guidelines.		
Counseling for sexually transmitted infections (STI), HIV counseling and testing	$0 Copay	Not Covered
Breastfeeding support, supplies, and counseling	$0 Copay	Not Covered
Contact the third-party claims administrator for the purchase of covered breast pumps. Rental for heavy duty electrical (hospital grade) covered only when medically necessary and only during the newborn's inpatient hospital stay.		
Screening for interpersonal and domestic violence	$0 Copay	Not Covered
Contraceptives/In-office counseling	$0 Copay	Not Covered
FDA approved injections, implants, and contraceptive devices not covered under the pharmacy benefits.		
Screening for Gestational Diabetes	$0 Copay	Not Covered
High-risk Human Papillomavirus (HPV) testing	$0 Copay	Not Covered
For more information, refer to the Preventive Services in the Schedule of Medical 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	$750 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
Skilled Nursing Facility Limit: 100 days per Plan Year	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Rehabilitation, Habilitation Facility (Limited to 60 days per Plan Year)	Plan pays 80% after Deductible	Plan pays 50% after Deductible
*All hospital facility services require precertification. In emergencies in which a member is admitted to hospital for an inpatient stay, the UM company must be notified with 24 hours, the next business day following the admission. *See the Utilization Management section for precertification requirements, including emergency hospital admissions.*		

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

Benefit Description	In-Network	Out-of-Network
Urgent and Emergency Services		
Ambulance (ground)	Plan pays 80% after Deductible	Plan pays 80% after Deductible, subject to the Maximum Allowable Charge
Ambulance (air/water)*	Plan pays 80% after Deductible	Plan Pays 80% after Deductible, subject to the Maximum Allowable Charge*
**When using Out-of-Network ambulance providers you are responsible for paying your Deductible and Coinsurance, in addition to amounts exceeding the Plan's applicable Maximum Allowable Charge for air ambulances, including ground and water ambulance services. See the Utilization Management and Schedule of Medical Benefits for precertification requirements (inter-facility patient air transfer/transport), including the Maximum Allowable Charge for air ambulance.*		

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

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

Benefit Description	In-Network	Out-of-Network
Laboratory Outpatient Services		
General Laboratory Services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Routine/Preventive Lab Testing*	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Routine and Preventive Lab Services **** Routine/preventive lab services must be performed at a freestanding, non-hospital-based lab facility.*** • *Medically necessary routine labs when ordered by a physician as part of comprehensive medical care.* • *Preventive laboratory services such as basic metabolic panel, lipid, or general health panel.* • *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		

Benefit Description	In-Network	Out-of-Network
***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.*		
Benefit Description	In-Network	Out-of-Network
Outpatient Short-Term Rehabilitation 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
Precertification required; speech, occupational, and physical therapy visits are limited to a combined 90 visits per Plan Year.		

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
Limited to medically necessary services; 60 visits per Plan Year for all modalities combined.		
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 all precertification requirements.		

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

Benefit Description	In-Network	Out-of-Network
Medical Supplies, Equipment, and Prosthetics		
Durable Medical Equipment	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Durable Medical Equipment (DME): Limited to one purchase, repair, or replacement of a specific item of DME every 3 years. DME rental to purchase in accordance with Medicare guidelines. The purchase or rental of DME, including oxygen related equipment in excess of $1,000 requires precertification.		
Orthopedic and prosthetic devices	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Orthopedic and prosthetic devices: Limited to a single purchase of a type of prosthetic device, including repair and replacement, every 3 years. Orthopedic and prosthetic devices in excess of $1,000 require precertification.		
Hearing Aids	$50 Copay per Device	$50 Copay per Device
Hearing Aids: Coverage for medically necessary, FDA approved air conduction hearing aids. Subject to a $50 Copay per device, Maximum benefit $1,500 per device, per each ear, every 3 years.		
Special Food Product	Plan pays 80% after Deductible	Plan pays 50% after Deductible
*Special Food Product: $2,500 maximum benefit per Plan Year for Special Food Products for the treatment of a person with inherited metabolic diseases. See **Enteral Formulas and Special Food Products** in the Schedule of Medical 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 Medical Benefits.*		

Alcohol and Substance-Abuse Treatment		
Inpatient/Residential Rehabilitation	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Intensive Outpatient Treatment Program	$30 Copay per Visit	Plan pays 50% after Deductible
Partial Hospitalization Program	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Outpatient treatment	$30 Copay per Visit	Plan pays 50% after Deductible
Psychological testing	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Inpatient and outpatient programs for alcohol and substance abuse treatment require precertification. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require precertification. Refer to the Utilization Management section for precertification requirements.		

Benefit Description	In-Network	Out-of-Network
Mental Health		
Inpatient Admission for medically necessary services for mental health disorders	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Mental health outpatient visits	$30 Copay per Visit	Plan pays 50% after Deductible
Applied Behavioral Therapy for the treatment of autism disorders	$30 Copay per Visit	Plan pays 50% after Deductible
Applied Behavioral Therapy for the treatment of autism disorders: Maximum benefit per Plan Year is the actuarial equivalent of $72,000 *Inpatient admission requires precertification. Refer to the Utilization Management section for more information.*		

Benefit Description	In-Network	Out-of-Network
Other Medical Services – Doctor on Demand, Telehealth, 2nd.MD		
Doctor on Demand Telemedicine Visit		
Medical Visit	$10 Copay per Visit	Not Covered
Psychology Visit (25-minutes)	$20 Copay per Visit	Not Covered
Psychologist Visit (50 -minutes)	$30 Copay per Visit	Not Covered
Psychiatrist Visit (45 minutes/initial visit)	$30 Copay per Visit	Not Covered
Psychiatry Visit (15-minute follow-up visit)	$20 Copay per Visit	Not Covered
Telehealth Visit		
Primary Care Visit	$30 Copay per Visit	Plan pays 50% after Deductible
Specialist Care Visit	$50 Copay per Visit	Plan pays 50% after Deductible
2nd.MD (Second Opinion Services)		
2nd.MD (Second Opinion Services)	$0 Copay per Visit	Not Covered

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

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Home Health Care	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Home Health Care: Limited to 60 visits per Plan year; may provide for private duty nursing in the home; requires precertification.		
Office-based infertility services	Plan pays 80% after Deductible	Plan pays 50% after Deductible
Medically necessary services 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		
Temporomandibular Joint (TMJ) Disorder Services*		
Office-based services (excluding surgical services)	**Specialist Visit:** $50 Copay **Other office-based services:** Plan pays 80% after Deductible	Plan pays 50% after Deductible
TMJ Surgical Services (including surgical services)	**Outpatient Surgery:** $500 Copay **Inpatient:** Plan pays 80% after Deductible	Plan pays 50% after Deductible
TMJ disorder and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Limited to two (2) surgeries in a lifetime.		

Benefit Description	In-Network	Out-of-Network
Other Medical Services		
Hospice	Plan pays 80% after Deductible	Plan pays 50% after Deductible
The hospice care program administers palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill patients with a life expectancy of 6 months or less as certified by patient's medical physician. For outpatient bereavement counseling services, see Hospice Services in the Schedule of Medical Benefits. Precertification is required for both inpatient and outpatient hospice services exceeding 185 days. *For a description of the hospice care benefits, see Hospice Services in the Schedule of Medical Benefits.*		

Benefit Description	In-Network		Out-of-Network
Obesity and Overweight Care Management (OCM) Program (Disease Management Program)			
Weight Loss Medication	*EAN -Retail 30-Day Supply	Retail/Home Delivery 90-Day Supply	
Preferred/Formulary Generic	$5 Copay	$15 Copay	Not Covered
Preferred/Formulary Brand	Not Covered	Not Covered	Not Covered
Non-Preferred/Non-Formulary Brand	Not Covered	Not Covered	Not Covered
**Express Advantage Network (EAN) Pharmacies: Copayments apply if you fill your prescription at a EAN retail pharmacy. If you fill your prescription at a non-EAN retail pharmacy, you will pay an additional $10 per prescription. If you currently use a non-EAN pharmacy and you want to avoid the $10 upcharge, call an EAN pharmacy to transfer your prescription. See the Schedule of Pharmacy Benefits for instructions on how to find an EAN pharmacy. Certain weight loss medications may not be available in 90-day supply. Contact Express-Scripts for information about your prescribed medication.*			

Benefit Description	In-Network	Out-of-Network
Obesity and Overweight Care Management (OCM) Program (Disease Management Program)		
Office Visit (OCM weight loss provider)	$0 Copay	Not Covered
Laboratory test	$0 Copay	Not Covered
Outpatient laboratory test services as determined by your weight loss provider (and as covered under this Plan). Outpatient laboratory tests must be performed at an in-network, free-standing, non-hospital-based lab facility such as Lab Corp or Quest. See Outpatient Laboratory Services for more information.		
Nutritional Counseling Services	$0 Copay	Not Covered
Nutritional Counseling Services are covered for enrolled OCM participants who are actively engaged in the program. Nutritional counseling services must be provided by a registered dietician or nutritionist. The frequency of the nutritional counseling services will be determined by the third-party claims administrator and will be based on medical necessity and engagement in the OCM program.		
Meal Replacement Therapy	Plan pays 50% of cost, maximum $50/month	Not Covered
Meal replacement therapy (MRT) prescribed/dispensed by an OCM provider. OCM benefits subject to requirements/compliance with the OCM program as indicated in the Schedule of Medical Benefits Section.		

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

Prescription Drug Benefits			
In-Network Pharmacy Benefits			
	Express Advantage Network Retail Pharmacies* (30-Day Supply)	**Smart90 Retail Pharmacies** (90-Day Supply)	**Home Delivery Express Scripts Pharmacy** (90-Day Supply)
Preferred Formulary Generic	$10 Copay	$20 Copay	$20 Copay
Preferred Formulary Brand	$40 Copay	$80 Copay	$80 Copay
Non-Preferred/Non-Formulary Brand	$75 Copay	$150 Copay	$150 Copay
Specialty Drugs			
Specialty Drugs Accredo Specialty Mail Order Pharmacy	N/A	N/A	You pay 30% after Deductible (30-Day Supply)

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

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

See the Schedule of Medical Benefits in this document for important information related to pharmacy benefits, including how to find an EAN and Smart90 pharmacy.

Schedule of Medical Benefits

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

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

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

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

The *Summary of Medical Benefits and Schedule of Medical Benefits* should be read in conjunction with the *Benefit Limitations and Exclusions* and *Key Definitions Terms and Definitions*.

Professional Services

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

Acupuncture and Acupressure Services

Acupuncture and acupressure are covered under this Plan if performed by a licensed MD, DO, acupuncturist or Oriental Medicine Doctor. Acupuncture and acupressure services must be provided by In-Network and are limited to 20 visits per Plan Year, maximum 100 visits per lifetime.

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. The main purpose of medical detoxification is to rid the body of toxins, monitor heart rate, blood pressure and other vital signs, manage withdrawal symptoms and administer medications as needed.

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

Allergy Testing and Treatment

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

Autism Spectrum Disorders

This Plan provides coverage for the screening of, diagnosing of and treatment of autism spectrum disorder. NRS 695G.1645 [January 1, 2019] provides the language specific to autism spectrum disorder coverage and is provided below for convenience:

1. A health care plan must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the group health plan under the age of 18 years or, if enrolled in high school, until the person reaches the age of 22 years.
2. Coverage provided under this section is subject to:
   a. A maximum benefit of the actuarial equivalent of $72,000 per year for applied behavior analysis treatment; and
   b. Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a group health insurance to the same extent as other medical services or prescription drugs covered by the plan.
3. A health plan that offers or issues a policy of group health insurance which provides coverage for outpatient care shall not:
   c. Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for outpatient care related to autism spectrum disorders that is required for other outpatient care covered by the policy; or
   d. Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future any of the services listed in subsection 1.
4. Except as otherwise provided in subsections 1 and 2, an insurer shall not limit the number of visits an insured may make to any person, entity, or group for treatment of autism spectrum disorders.
5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavioral therapy, or therapeutic care that is:
   e. Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
   f. Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist, or behavior analyst. An insurer may request a copy of and review a treatment plan created pursuant to this subsection.

6. A policy subject to the provisions of this chapter that is delivered, issued for delivery, or renewed on or after January 1, 2011, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which conflicts with subsection 1 or 2 is void.
7. Nothing in this section shall be construed as requiring governing body of any county, school district, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance to provide reimbursement to a school for services delivered through school services.

As used in this section:

a. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.
b. "Autism spectrum disorder" has the meaning ascribed to it in NRS 427A.875 [autism spectrum disorder means a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined].
c. "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst, registered behavior technician or state certified behavior interventionist.
d. "Evidenced-based research" means research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.
e. "Habilitative or Rehabilitative" means counseling, guidance and professional services and treatment programs, including, without limitations, applied behavior analysis, that are necessary to develop, maintain and restore to the maximum extent practicable, the functioning of a person.
f. "Licensed Assistant Behavior Analyst" means a person who holds current certification as a Board-Certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.
g. "Licensed Behavior Analyst" means a person who holds current certification as a Board-Certified Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and is licensed as a behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services.

h. Prescription Care means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medication.
i. Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
j. Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
k. Registered Behavior Technician has the meaning ascribed to it in NRS 437.050.
l. "Screening for Autism Spectrum Disorders" means medically necessary assessments, evaluations, or tests to screen and diagnose whether a person has an autism spectrum disorder.
m. State Certified Behavior Interventionist has the meaning ascribed to it in NRS 437.055.
n. "Therapeutic care" means services provided by licensed or certified speech-language pathologists, occupational therapists, and physical therapists.
o. "Treatment plan" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

Note: Capitalized terms in this Autism Spectrum Disorders section have the definitions assigned to them in NRS 689B.0335 and not necessarily the definitions in this MPD.

Blood Services for Surgery

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

Chemotherapy

Chemotherapy and other drug therapies that are medically necessary to treat cancers and other diseases and conditions are covered services.

Clinical Trials

The routine medical treatment costs, including all items and services that are otherwise generally available to Plan participants, received as part of a clinical trial or study, may be covered. A clinical trial is the process for testing of new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases.

Costs incurred are covered if:

- The medical treatment is provided in a Phase I, Phase II, Phase III, or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III, or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome.

The clinical trial or study is:

- Approved by an agency of the National Institutes of Health as set forth in applicable law.
- Approved by a cooperative group, a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health.
- FDA-Approved as an application for a new investigational drug.
- Approved by the United States Department of Veterans Affairs; or
- Approved by the United States Department of Defense.

In the case of:

- A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer: or
- A Phase II, Phase III, or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner.
- There is no medical treatment available that is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study.
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment.
- The clinical trial or study is conducted in Nevada; and
- You have signed, before your participation in the clinical trial or study, a statement of consent indicating that you have been informed of, without limitation:
    - The procedure to be undertaken.
    - Alternative methods of treatment; and
    - The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks; and

The medical treatment is limited to:

- Coverage for any drug or device that is FDA-Approved for sale without regard to whether the approved drug or device has been approved for use in your medical treatment.
- The cost of any reasonable, necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III, or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III, or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered services.
- The cost of any routine health care services that would otherwise be covered services for your participation in a Phase I clinical trial.
- The initial consultation to determine whether you are eligible to participate in the clinical trial or study; or

- Health care services required for the clinically appropriate monitoring of you during a Phase II, Phase III, or Phase IV clinical trial or study.

Services for the following clinical trial services are excluded:

- Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical, or medical industry.
- Coverage for a drug or device described above that is paid for by the manufacturer, distributor, or Provider of the drug or device.
- Health care services that are specifically excluded from coverage in this *Schedule of Medical Benefits,* regardless of whether such services are provided under the clinical trial or study.
- Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to participants in the trial or study.
- Extraneous expenses related to you in the clinical trial or study including but not limited to travel, housing, and other expenses that you may incur.
- Any expenses incurred by a person who accompanies you during the clinical trial or study.
- Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of you; and
- Any costs for the management of research relating to the clinical trial or study.

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

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

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

Family Planning

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.

Bariatric/Weight Loss Surgery

Covered services include medically necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese *with* associated illnesses. These services will not be covered unless you receive precertification.

Bariatric weight loss surgery benefits, pre-and post-surgery, are available only when performed at an in-network Bariatric Surgery Center of Excellence facility, by an in-network surgeon and all ancillary providers. The third-party Claims Administrator will determine the in-network Bariatric Surgery Center of Excellence facility. It is the participant's responsibility to ensure that all

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

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

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

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

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

Participants must receive treatment in a Bariatric Surgery Center of Excellence which has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

1. Behavior modification program supervised by a qualified professional.
2. Consultation with a dietician or nutritionist.
3. 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.
4. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise therapist or other qualified professional.
5. Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
6. Reduced-calorie diet program supervised by dietician or nutritionist.

If a participant has started any type of program to meet the pre-surgery criteria outlined below with an out-of-network provider (including a facility), those services will NOT be considered part of the Plan's mandatory precertification requirements. For the Plan to consider your bariatric surgery a covered benefit under this Plan; you will have to begin the precertification process again with the appropriate providers.

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

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

- Notifying the participant that the precertification process begins with the initial contact to UM company.
- Notifying the participant that precertification requests presented to the UM company before the clinical criteria listed below has been completed will be denied. A precertification request may be reconsidered upon completion of the clinical criteria.
- Informing the participant of the requirement to access and participate in a weight management and nutrition program.
- Documenting participant completion of the associated assessments required to be considered for the procedure.
- Educating the participant on how to access wellness/preventive services and how to proceed with meeting the clinical indications listed below; and
- Advising participants of Centers of Excellence in bariatric surgery provider in their geographic area.

Clinical Criteria for Weight Loss Surgeries
Treatment indicated by ANY ONE of the following:

- Patient has a basal metabolic index (BMI) exceeding 40 kg/m2: or
- Patient's BMI is greater than 35 kg/m2 and two or more clinically serious conditions exist (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension (high blood pressure), cardiomyopathy, musculoskeletal dysfunction, joint replacement, gastroesophageal reflux disease (GERD), hypertriglyceridemia or hypercholesterolemia, back pain, urinary incontinence, renal failure, arthritis).
- Surgical intervention indicated because patient has met ALL the following:
    - Patient is well-informed and motivated and has failed previous non-surgical weight loss attempts.
    - No thyroid disorder (excluding thyroid problems currently being successfully treated) found by your physician [e.g., an endocrine (hormone) disorder].
    - Must have obtained full growth and be over the age of 18 years.
    - Documentation of a pre-operative psychological evaluation by a licensed clinical psychologist or psychiatrist within the last 90 days to determine if the patient has the emotional stability to follow through with the medical regimen that must accompany the surgery.

- Physician-supervised nutrition and exercise program: participant has complied for at least six (6) months (without a gap) within the 12-month period prior to the scheduled surgical intervention in a physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record at each visit. The physician-supervised nutrition and exercise program must meet all the following criteria:
  - Participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the participant's participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. For participants who participate in a physician-administered nutrition and exercise program (e.g., MediFast, OptiFast), program records documenting the participant's participation and progress may substitute for physician medical records.
  - Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists, with a substantial face-to-face component (must not be entirely remote).
  - Nutrition and exercise program(s) must be for a cumulative total of six (6) months or longer in duration and occur within the 12-month period prior to the scheduled surgical intervention; and
  - Patient has lost 10% of their initial weight per documentation in the medical record received from their supervising weight loss physician.
  - Patient must agree to attend monthly support meetings for one-year post-surgery (provided by in-network providers). The Program will allow an online-waiver for patients residing 50 miles or more from the obesity surgeon's office or facility where the support meetings are held.

Contraindications for Weight Loss Surgery

Requests for weight loss surgery will be denied if any one or more of the following conditions are present:

- Untreated major depression or psychosis.
- Binge-eating disorders.
- Current drug or alcohol abuse.
- Severe cardiac disease with prohibitive anesthetic risks.
- Severe coagulopathy; or
- Inability to comply with nutritional requirements including life-long vitamin replacement.

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, unless medically necessary and are covered as described above.

Gender Reassignment

This Plan considers gender reassignment surgery medically necessary when all the following criteria (a through e) are met
Persistent, well-documented gender dysphoria.

- Gender dysphoria is a marked incongruence between a person's experienced/expressed gender and assigned gender, of at least six (6) months duration, as manifested by two or more of the following:
  - Marked incongruence between of a person's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
  - Strong desire to be rid of a person's primary and/or secondary sex characteristics because of a marked incongruence with a person's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
  - Strong desire for the primary and/or secondary sex characteristics of the other gender
  - Strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
  - Strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
  - Strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
- The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Capacity to make a fully informed decision and to consent for treatment.
- Age of majority (18 years of age or older).
- If significant medical or mental health concerns are present, they must be reasonably well controlled; *and*
- In the case of:

Mastectomy for female-to-male patients:

- A Referral letter from a qualified mental health professional (see Requirements of a Referral Letter below).
- (Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.)

Gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):

- Two Referral Letters from a qualified mental health professional, one in a purely evaluative role (see requirements of a referral letter below); *and*
- Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones).

Genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male;

penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female) and Augmentation Mammoplasty (breast augmentation)

- Two referral letters from qualified mental health professionals, one in a purely evaluative role (see requirements of a Referral Letter below).
- Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has medical contraindication or is otherwise unable or unwilling to take hormones; or
- For breast augmentation mammoplasty, twelve months of continuous hormone (estrogen) therapy and breast tissue growth failed to result in a Tanner Stage 5 on the puberty scale, as determined by the provider, or the recipient has a medical contraindication to hormone therapy. The Plan Administrator will determine authorization and consent to care based on medical necessity; *and*
- Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

Requirements of a Referral Letter from a qualified mental health professional for gender reassignment must include all the following:

- Client's general identifying characteristics.
- Results of the client's psychosocial assessment, including any diagnoses.
- The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date; There is no minimum duration of relationship required with mental health professional. It is the professional's judgment as to the appropriate length of time before a referral letter can appropriately be written. A common period is three (3) months, but there is significant variation in both directions. When two (2) letters are required, the second referral is intended to be an evaluative consultation, not a representation of an ongoing long-term therapeutic relationship, and can be written by a medical practitioner of sufficient experience with gender dysphoria.

- An explanation that the World Professional Association for Transgender Health (WPATH) criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery.
- A statement about the fact that informed consent has been obtained from the patient.
- A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this; *and*
- A statement indicating that the qualified mental health professional:
    - Has a master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board and has documented credentials from the relevant licensing board or equivalent.
    - Is competent in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes.
    - Can recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

- Is knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and
- Has attended continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

Evaluation of candidacy for sex reassignment surgery by a mental health professional is covered under the member's medical benefit, unless the services of a mental health professional are necessary to evaluate and treat a mental health problem, in which case the mental health professional's services are covered under the member's behavioral health benefit.

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for female to male trans identified persons who have not undergone a mastectomy.
- Prostate cancer screening may be medically necessary for male to female trans identified persons who have retained their prostate.

Gonadotropin-releasing hormone is considered medically necessary to suppress puberty in transgender identified adolescents if they meet WPATH criteria (see CPB 501 - Gonadotropin-Releasing Hormone Analogs and Antagonists).

For a listing (not an all-inclusive list) of excluded cosmetic procedures that may be performed as a component of a gender reassignment see Cosmetic Services in the *Benefit Limitations and Exclusions* section.

Genetic Counseling/Testing

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

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

Genetic testing may only be done after consultation with an appropriately certified genetic counselor and/or, in our discretion, as approved by a physician that we may designate to review

the utilization, medical necessity, clinical appropriateness, and quality of such genetic testing. Medically necessary genetic counseling will be covered in connection with pregnancy management with respect to the following individuals:

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

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

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

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

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

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

Hearing Aids

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

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

Participants who meet the above hearing loss criteria: Each air conduction hearing aid is subject to a $50 copay (per device, per each ear), with maximum plan benefit of 1,500 per device every three (3) years.

Participants may submit a copy of their hearing aid payment receipt from the hearing aid provider to the third-party claims administrator to request reimbursement for the hearing aid benefit, less applicable copayment(s), and to receive credit towards the Out-of-Pocket Maximum.

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 appropriate therapist.

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

Excluded from coverage as home health care are:

- Personal care, custodial care, domiciliary care, or homemaker services.
- In-home services provided by certified nurse aides or home health aides.
- 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 Medical Benefits*.

Infertility Services

Medically necessary services to diagnose problems of infertility are covered for one workup per Plan Year up to three (3) evaluations per lifetime. Up to six (6) cycles of artificial insemination are

covered per lifetime for covered participants. For the covered female, services include the preparation of the sperm and the insemination, provided that the sperm has not been purchased or the donor compensated for his biological material or services, and that the donor is covered under this Plan. Costs related to the actual insemination of a non-covered person, are not covered under the terms of this benefit Plan. For infertility services that are not covered under this Plan, see the *Benefit Limitations and Exclusions* section.

Mastectomy Reconstructive Surgery

Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. Subject to all the terms and conditions of this *Schedule of Medical Benefits*, if a covered mastectomy or other breast cancer treatment is performed, we will also provide coverage 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.
- Prostheses; and
- Physical complications for all stages of mastectomy, including lymphedemas.

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 all the terms, conditions, and exclusions contained in the Plan at the time of reconstructive surgery.

Medical Care

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

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

Note: The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the Surgery/Surgeries definition in the *Key Terms and Definitions* section.

Assistant surgeon fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. See Certified Surgical Assistant in the *Key Terms and Definitions* section.

Mental Health Services

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

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. This Plan provides all mental health and substance abuse benefits in accordance with the *Mental Health Parity and Addition Equity Act of 2008.*

Newborns

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

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

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

Services that are not covered include:

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

Obesity Care Management Program

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

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

- Services provided by an in-network provider certified by the American Board of Bariatric Medicine (ABBM) and specializes in weight loss services or if there is no certified provider within 50 miles of a participant's residence, services may be provided by any in-network provider.
- Laboratory tests provided by an in-network free-standing, non-hospital-based outpatient laboratory facility such as Lab Corp or Quest.
- Nutritional counseling services when provided in-network, frequency is determined by the Claims Administrator and is based on medical necessity.
- Meal replacement therapy benefit for individuals who are diagnosed as morbidly obese only. Morbid obesity means that a person is more than 100 pounds over normal weight or has a BMI of 40 or higher. This must be confirmed by your weight loss medical provider.
- Meal replacements must be prescribed and dispensed by the weight loss medical provider.
- Participant is required to pay for the meal replacements and request reimbursement by submitting claims to the Claims Administrator.
- Reimbursement if the OCM Program participant is considered actively engaged in each of the three months following the month the expense was incurred.
- Excludes Weight Watchers, Lean Cuisine, Nutri-System, Atkins or other similar prepared meals or meal replacements.
- Meal replacement costs do not apply to the Out-of-Pocket Maximum.

Weight Loss Medications:

- The Plan covers certain only short-term use obesity/weight loss generic medications as identified by the Plan's Pharmacy Benefits Manager. Contact the Pharmacy Benefit Manager or refer to the Plan's prescription drug formulary to determine what weight loss medications are covered by the enhanced benefit. Long-term weight loss medications are excluded.
- Copayments for Tier 1 (Generic) drugs apply to the Out-of-Pocket Maximum. Copayment for a 31-90-day supply is subject to three times the listed 30-day retail copayment.
- This Plan does not coordinate prescription drug plan benefits.

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

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

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

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

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

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

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

1. Services must be provided by:

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

2. The patient's BMI must be greater than 30 kg/m^2, with or without any co-morbid conditions present, or greater than 25 kg/m^2 (or waist circumference greater than 35 inches in women, 40 inches in men) if one or more of the following co-morbid conditions are present:

    a. Coronary artery disease.
    b. Diabetes mellitus type 2.
    c. Hypertension (Systolic Blood Pressure greater than or equal to 140 mm Hg or Diastolic Blood Pressure greater than or equal to 90 mm Hg on more than one occasion).
    d. Obesity-hypoventilation syndrome.
    e. Obstructive sleep apnea.
    f. Cholesterol and fat levels measured (Dyslipidemia):
    g. HDL cholesterol less than 35 mg/dL.
    h. LDL cholesterol greater than or equal to 160 mg/dL; or
    i. Serum triglyceride levels greater than or equal to 400 mg/dL.

For children two to 18 years:

1. Services must be provided by an in-network provider who specializes in childhood obesity; and

2. Child must present a BMI ≥ 85th percentile for age and gender.

Engagement in the Program
In addition to meeting the requirements listed under the section titled "Criteria for Obesity/Overweight Weight Loss Benefits", you must remain actively engaged in a medically supervised weight loss program.

Monitoring Engagement
The Claims Administrator will assist your weight loss provider with completing monthly progress reports. The initial report should include your weight and BMI or waist circumferences, and a description of your treatment plan to include weekly weight loss goals, final weight loss goal, exercise regimen, diet, and nutrition instructions. Subsequent monthly reports should provide information regarding your weight loss progress and adherence to the treatment plan. Submission of these reports will be a requirement for payment under the enhanced wellness benefits. If your monthly weight loss reports are not received by the Claims Administrator, your benefits under this program will end, and your coverage will return to the standard LD PPO Plan benefits where other Plan limitations will apply. The effective date of the return to the standard Low Deductible PPO Plan benefits will be the first day of the month following the non-compliance notification received from the Claims Administrator.

How to Enroll in the Obesity Care Management Program

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

Benefits under the Obesity Care Management Program

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

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

Oral Surgery, Dental Services, and Temporomandibular Joint Disorder

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

- Accidental injury to the jaw bones or surrounding tissues when the injury occurs, and the repair takes place while a member. Services must commence within 90 days after the accidental Injury. *Services that commence after 90 days are not covered*.
- 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 sound and natural 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 dependent child when services are rendered in a hospital or outpatient surgical facility, when enrolled dependent child is being referred because, in the opinion of the dentist, the child:
        - Is under age 18 and has a physical, mental, or medically compromising condition; or
        - Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly, or an allergy; or
        - Patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient.
        - Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.

- No payment is extended toward the dentist or the assistant dental provider under this Plan. Refer to the dental benefits described in the PEBP Self-funded PPO Dental Plan Master Plan Document available at *www.pebp.state.nv.us*.

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

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

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

- Except as described above as an inclusion, services involving treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; and repairs and restorations except for appliances that are medically necessary to stabilize or repair sound and natural teeth after an injury as set forth above;
- Dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth above.
- Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and near the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and
- Other supplies and services including but 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.
- Devices provided in connection to an illness or injury that occurred after your effective date of coverage.
- Adjustment of initial prosthetic device; and
- The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.
- Repair and replacement of prosthetic devices is not covered except in limited situations involving mastectomy reconstructive surgery.

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

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

Ostomy Care Supplies

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

Partial Hospitalization Services

Partial hospitalization services are covered for mental illness and substance abuse according to the benefits listed in the *Schedule of Medical Benefits*. The same services covered for inpatient services are also covered for partial hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One partial treatment day is defined as no less than three and no more than 12 hours of therapy per day. Partial day treatment is covered only when the member receives care through a day treatment program. Every two (2) partial-day treatments count as one full inpatient day and will be applied against the participant's maximum inpatient benefit.

Podiatry Services

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

The following services are not covered:

- Non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and routine foot care.

Preventive Services

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

- Periodic physical examinations and routine immunizations.
- Routine gynecologic examination (one per Plan Year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination.
- Screening mammograms every 1-2 years for women 40 years of age or older.
- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics.
- Colorectal cancer screening starting at age 45 years in accordance with:
  - The guidelines published by the American Cancer Society; or
  - Other guidelines or reports concerning such screening that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data.
- Immunizations, including influenza, pneumococcal, Haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, measles, diphtheria, human papillomavirus (HPV), pertussis (whooping cough), poliovirus, rotavirus, varicella (chickenpox), shingles (herpes zoster) and tetanus, if such immunizations have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (Note: Immunizations related to foreign travel or employment are excluded.);
- Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.
- Evidence-based items or services that have an "A" or "B" Recommendation by the United States Preventive Services Task Force (USPSTF) and Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v) (229) of the 2015 Consolidated Appropriations Act.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services; 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.

Women's Contraceptives

This Plan covers all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The FDA requires the services to be "prescribed" by a physician even for over-the-counter methods. The following is a list of the FDA approved female contraceptive methods:

1. Elective sterilization for women.
2. Surgical sterilization implants for women.
3. Implantable rods.
4. Copper-based intrauterine devices.
5. Progesterone-based intrauterine devices.
6. Injections.
7. Combined estrogen- and progestin-based drugs.
8. Progestin-based drugs.
9. Extended- or continuous-regimen drugs.
10. Estrogen- and progestin-based patches.
11. Vaginal contraceptive rings.
12. Diaphragms with spermicide.
13. Cervical caps with spermicide.
14. Sponges with spermicide.
15. Spermicide.
16. Female condoms.
17. Combined estrogen-and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
18. Ulipristal acetate for emergency contraception (morning after pill)

Colorectal Cancer Screening

Colorectal screening tests are covered at 100% when provided in-network for adults aged 45 years and older who are at average risk of colorectal cancer in accordance with the American Cancer Society's qualified recommendations; or beginning at age 40 for members with a high-risk of colorectal cancer. For more information regarding colorectal screening guidelines, contact the Claim's Administrator.

Screening Mammograms (2-D or 3-D)

The first 2-D or 3-D mammogram of the Plan Year is covered at 100% for women age 40 years and older, regardless of diagnosis, when performed in-network and in accordance with the U.S. Preventive Services Task Force and Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, and the 2002 recommendation available at https://uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P

Healthy Diet/Physical Activity Counseling and Obesity Screening/Counseling

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 have a basal metabolic index (BMI) of 30 or greater; and have additional cardiovascular disease (CVD) risk factors. This wellness/preventive benefit is limited to three (3) Health Diet/Physical Activity Counseling or Obesity Screening/Counseling sessions per Plan year.

For more information, please visit:

Preventive Services for Adults and Families*: Visit the U.S. Preventive Task Force at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations*

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

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

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

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

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

Preventive care services identified through the above links is recommended services. It is up to the participant and their physician or provider of care to determine which services to provide. The Plan Administrator has the authority to determine which services and quantity limits will be covered at the 100% wellness benefit; unless otherwise mandated by the Affordable Care Act or mandated in accordance with applicable Nevada Revised Statutes.

This Plan covers preventive care services as recommended by the:

- U.S. Preventive Services Task Force (USPSTF) A&B Recommendations.
- Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v) (229) of the 2015 Consolidated Appropriations Act; and
- Health Resources and Services Administration (HRSA) for Women and Children. This Plan's coverage may change if the recommendations of the USPSTF or HRSA change.

Note: This Plan complies with SB233, Sections 54-57 and AB249, Section 25 [2017 Legislative Session] as related to contraceptive methods, utilization management, step therapy, prior authorization, categorization of prescription drugs (meaning Preferred Generic, Preferred Brand

and Non-Preferred Brands), and cost-sharing. For more information, refer to SB233 or AB249 at *https://www.leg.state.nv.us/Session/79th2017/Reports/*

Radiation Therapy

Medically necessary professional services related to radiation therapy are covered.

Rehabilitative and Habilitative 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.

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.

Spinal Manipulation (non-surgical)

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

Spinal manipulation and adjustment mean the detection, treatment, and correction of structural imbalance, subluxation, or misalignment of the vertebral column in the human body, for alleviating pressure on the spinal nerves and its associated effects related to such structural imbalance, misalignment, or distortion, by physical or mechanical means.

Transplant Services

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

- Bone marrow.
- Cornea.
- Heart.
- Heart and lung.
- Intestinal and liver.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Pancreas and kidney; and
- Stem cell.

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

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

Coverage for related transplant services is limited to:

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

The following services are excluded from coverage:

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

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

Inpatient Care

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

- Services for medical conditions treated in an acute care hospital inpatient environment.
- Semi-private room and board (private room when medically necessary).

- General nursing care facilities, services, and supplies on an inpatient basis.
- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility. For related covered services refer to Other Services and Supplies in the *Schedule of Medical 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 60 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 Medical Benefits*.

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

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

The UM company must be notified for all emergency admissions within 24 hours, the next business day, or as soon as reasonable after admission. If you are incapacitated and you (or a friend or relative) cannot notify the UM company within the above stated times, they must receive notification as soon as reasonably possible after the admission or you may be subject to reduced benefits as provided in this Plan.

Medically necessary care at a skilled nursing facility (limited to 100 days per Plan Year) for non-custodial care is covered. A skilled nursing facility is a facility that is duly licensed by the state and/or federal government and that provides inpatient skilled nursing care, rehabilitation services, or other related health services that are not custodial or convenience in nature. Skilled

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

Outpatient Care

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

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

- Services for medical conditions treated in an acute care hospital outpatient environment.
- Semi-private room and board (private room when medically necessary) if patient is in observation status.
- General nursing care facilities, services, and supplies on an outpatient basis.
- Diagnostic services that are provided in a facility, whether such facility is a hospital or a freestanding facility.
- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Outpatient, short-term rehabilitative services.
- Outpatient alcohol and substance abuse rehabilitation services in a hospital, hospital residential treatment facility, or day treatment program; and
- Outpatient mental health services.

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

- Short-term speech, physical, and occupational habilitative and rehabilitative therapy for acute conditions that are subject to significant clinical improvement over a 90-day period from the date outpatient therapy commences or to maintain function in an individual. Precertification required for habilitative and rehabilitative therapy exceeding a combined visit limit of 90 visits per Plan Year: 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.

Emergency and Urgent Care Services

General

Medically necessary hospital services are covered in the case of an emergency. Emergency care is available through participating providers 24 hours per day, seven days per week. If you have an emergency:

- Get help as soon as possible. Call 911 for help or go to the nearest emergency room, hospital, or other emergency facility. Call an ambulance if necessary.
- For hospital admissions, notify the UM company about your admission within 24 hours, the next business day or as or as soon as reasonable after admission.

Emergency medical and hospital services are limited to situations that require immediate and unexpected treatment. Notwithstanding anything in in this *Schedule of Medical Benefits* to the contrary, coverage for emergency services will be provided:

- Without the need for any precertification determination whether the health care provider furnishing such emergency services is a participating provider with respect to such services.
- Without regard to whether the provider furnishing the emergency services is a participating provider with respect to the services.
- If the emergency services are provided out-of-network, you will be responsible for applicable copayments and any amount that exceeds the usual and customary amount as determined by the Plan Administrator. This Plan will not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers.
- Without regard to any other terms or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, as permitted by law, or applicable cost-sharing).

Out-of-Network Emergency Inpatient Admission Notification

Out-of-network medically necessary emergency care services are covered as stated in the *Schedule of Medical Benefits*, only if the UM company is notified no more than 24 hours after onset of the emergency care, except as otherwise specified in the *Schedule of Medical Benefits*.

Extended Notification

If you are unable to contact the UM company of an emergency inpatient hospital admission within 24 hours due to shock, unconsciousness, or otherwise, you (or a friend or relative) must, at the earliest time reasonably possible, contact the UM company to provide them with information about the event, relevant circumstances and to request authorization as specified in the *Utilization Management* section.

Follow-Up Care (Outside of the Service Area/Non-Contracted Facility)

Continuing or follow-up treatment for an emergency service outside of this Plan's service area or from a non-preferred provider is limited to care required before you can, without harmful or injurious consequences, return to this Plan's service area and receive care from participating providers as determined by the Plan Administrator. Benefits for continuing or follow-up treatment(s) are otherwise covered only in this Plan's service area from participating providers, subject to all provisions of this Plan.

Routine or non-emergency follow-up care at an out-of-network provider emergency room facility is not covered.

Follow-up Care if Temporarily Outside the Geographic Service Area

Continuing or follow-up care for urgent care is limited to care required before you can, without medically harmful or injurious consequences, return to this Plan's geographic service area to receive services from participating providers as determined by the Plan's Administrator. Routine follow-up care is not a covered urgent care service.

Limitations

Urgent care services obtained at a "hospital emergency facility" will have a higher copayment. Please refer to this Plan's *Schedule of Medical Benefits*. If urgent care services are received from an out-of-network provider, refer to Balance Billing below.

Balance Billing

Balance billing is a practice in which an out-of-network provider bills you for amounts in excess of the Plan's Maximum Allowable Charge. This usually occurs during emergency room, emergency hospital admission or urgent care visits utilizing out-of-network providers.

In emergency situations you may go to a non-participating provider. However, because the provider is not contracted with this Plan's network, that provider may bill you amounts in excess of this Plan's maximum allowable amount. Even if you go to a contracted facility in an emergency,

some providers at that facility may not be participating providers and may bill you for amounts exceeding this Plan's maximum allowable amount.

Other Services and Supplies

Ambulance Services

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

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

Durable Medical Equipment (DME)

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

- Can withstand repeated use.
- Is not disposable.
- Is appropriate for use in the home.
- Is not useful in the absence of an illness or injury.
- Is prescribed by a physician.
- Meets CMS guidelines for coverage; and
- Is not primarily for convenience or comfort but serves a medical purpose.

Durable medical equipment includes, but is not limited to the following:

- Oxygen equipment (all oxygen and oxygen related equipment, except for oxygen while traveling on an airline).
- Wheelchairs.
- Hospital beds.
- Glucose monitors; and
- Warning or monitoring devices for infants (defined as a child 24-months old or less) suffering from recurrent apnea.

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

Items not covered under this benefit include, but are not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal

hygiene, comfort, care, convenience or beautification items, deluxe equipment, and any other primarily non-medical equipment, except as otherwise covered and described within this *Schedule of Medical Benefits* and the *Benefit Limitations and Exclusions* sections.

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

Enteral Formulas and Special Food Products

Enteral Formulas and Special Food Products are covered in accordance with NRS 689B.053. Enteral Formulas for use at home that are prescribed or ordered by a physician as medically necessary treatment of inherited metabolic diseases characterized by deficient metabolism or malabsorption originating from congenital defects or defects arising shortly after birth of, amino acid, organic acid, carbohydrate, or fat. For the purposes of this section only, Enteral Formulas including, without limitation, a formula that is ingested orally. Inherited metabolic diseases do not include obesity.

Special Food Product means a food product that 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. Inherited metabolic disease does not include obesity. This term does not include a food that is naturally low in protein. Special Food Products for the medically necessary treatment of inherited metabolic disease are limited to a maximum benefit of $2,500 per Plan Year.

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

Special formulas, food supplements, or special diets including, but not limited to, total parenteral nutrition, except for acute episodes, are not covered.

Healthcare BlueBook

Healthcare Bluebook (HCBB) is a resource that enables participants to find and compare high-quality, low-cost providers for various health care procedures. This service may be accessed by logging into the E-PEBP Portal and selecting Healthcare Bluebook. When you shop for certain procedures on Healthcare Bluebook and use a Fair Price™ (green-rated) facility, you are eligible for a reward. HCBB helps you identify reward-eligible procedures by including a Reward indicator on eligible procedure pages. Although a provider may be listed on the pricing tool, it is the participant's responsibility to verify the provider's network status prior to accessing services.

Healthcare Bluebook Incentive Reward

Participants earning a monetary reward from Healthcare Bluebook will have 180 days from the date the check is issued to cash the reward check; reward checks that are not cashed within 180 days will be forfeited and the funds will be returned to the Plan.

Hospice Services

The following hospice care services are covered for members with a life expectancy of six months or 185 days or less as certified by his or her provider (limited to a lifetime benefit maximum of 185 days):

- 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 all family members combined if they are not otherwise eligible for mental health benefits under their specific plan). Counseling must be provided by:
  - A psychiatrist.
  - A psychologist; or
  - A social worker.
- Respite care providing nursing care for a maximum of 8 inpatient respite care days per Plan Year and 37 hours per Plan Year for outpatient respite care services. Inpatient respite care will be provided only when the UM company determines that home respite care is not appropriate or practical.

Lab and Diagnostic Services

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

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

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

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

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

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

2nd.MD Opinion

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

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 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 *www.pebp.state.nv.us* or the *Summary of Medical Benefits*.

Services available include:

- Medical visit
- Psychologist visit
- Psychiatry visit

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

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

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

Continued Coverage Following Termination of a Provider Contract

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 45th day after:
  - The date of delivery; or
  - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Prescription Drugs

Benefits for prescription drugs are provided through the prescription drug plan administered by Express-Scripts. 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.

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

Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. Contact the pharmacy benefit manager listed in the Participant Contact Guide or visit *www.express-scripts.com* to check vaccine coverage and locate your nearest in-network pharmacy.

Coverage is also provided for, but not limited to:

- COVID-19 vaccinations
- Vaccinations such as shingles, HPV, Flu, pneumonia, Herpes Zoster, TDAP (whooping cough)
- Prenatal & pediatric prescription vitamins
- Prescription female oral contraceptives
- Insulin, diabetic supplies (such as lancets, syringes, test strips) and insulin pumps (insulin pump supplies are not covered under the pharmacy benefit)
- Orally Administered Chemotherapy: The Copayment or Coinsurance amount for orally administered chemotherapy drugs will be consistent with the drug's formulary tier for retail, home delivery and Specialty pharmacy; and in accordance with NRS 695G.167, the

cost will not exceed $100 per prescription. For more information, see *Key Terms and Definitions* section.
- Chronic medication synchronization (for details see *Key Terms and Definitions* section).
- Topical Ophthalmic Products (for details see *Key Terms and Definitions* section).

Prescription Retail Drugs

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

Special pharmaceuticals, which include injectables, oral medications, and medications given by other routes of delivery, may be delivered in any setting. Special pharmaceuticals are pharmaceuticals that typically have:

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

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

30-Day Retail Program

Express Advantage Network Program (30-Day Supply)
For short-term medications (such as antibiotics), use an *Express Advantage Network (EAN)* retail pharmacy for lower copays and to maximize your pharmacy benefit. You may still use a non-EAN retail pharmacy, but you will pay $10 more 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.

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

90-Day Retail and Home Delivery Program

Smart90 Retail Pharmacy: To find a participating Smart90 Retail Pharmacy, register or log in to *express-scripts.com/findapharmacy* or call Express-Scripts' Member Services at 855-889-7708. Transfer your medications easily in-store, by phone or online.

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

If you are enrolling a new prescription in home delivery:

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

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

Check **Order Status** to track the shipping of your prescriptions. After we receive your prescription from your doctor, you will receive your medication within 7 days. Please keep in mind, longer delivery times may be due to additional correspondence need with prescribers, medication availability and/or delivery times from the shipping vendor.

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

- Your doctor writes "dispense as written" (DAW) on the prescription; or

- You request the brand-name drug at the time you fill your prescription.

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

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

Example:

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

Specialty Drug Program

Specialty drugs are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. 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*). Through Accredo, patients receive an enhanced level of individual service such as one-on-one clinical support, a resource to help manage possible side effects and (for certain conditions) Accredo nurses to help administer your medication. Plan participants are encouraged to register with the Accredo Specialty Pharmacy before filling their first prescription for a specialty drug. Check with Express-Scripts to determine if your prescription is considered specialty.

SaveonSP Program

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

The medications included in the SaveonSP Program are classified as Non-Essential Health Benefits under the Affordable Care Act. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your deductible or out-of-pocket maximum.

Members currently taking a medication, or those who will be taking a medication, captured under this Program are eligible to participate.

- Select medications on the *Non-Essential Benefit Specialty Drug List* will be free of charge ($0) to members who participate.
- Prescriptions must be filled through Accredo Specialty Pharmacy.
- The medications and associated copays included in this program are subject to the Pharmacy Benefit Manager's clinical rules.
- If the medication you are taking is on the SaveOnSP *Non-Essential Benefit Specialty Drug List* and you wish to participate, call SaveOnSP at 1-800-683-1074.
- The SaveonSP Program drug list can be found at *www.saveonsp.com/pebp*

Extended Absence Benefit

If you are going to be away from your home for an extended period, either in the country or outside of the country, you may obtain an additional fill (30 or 90-day supply) of your prescription drugs from your local retail or mail order pharmacy. This limited benefit must be requested in advance by the participant to the pharmacy benefit manager listed in the *Participant Contact Guide*. A maximum of two (2) early refills are allowed every 180 days. You may be required to obtain a new written prescription from your physician and any necessary prior authorizations.

Out-of-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.

Express-Scripts offers helpful tools that allow participants to manage their prescriptions. Go to www.express-scripts.com or download the free mobile app and have your identification card available to register. The "Price a Medication" menu option under "Prescriptions" is used to determine estimated Out-of-Pocket cost. From this menu option, a prescription savings program called *My Rx Choices* is available to view side-by-side medication comparisons showing

potential savings with lower-cost alternatives along with any applicable coverage alerts such as "prior authorization required". See the *Participant Contact Guide* section or go to the PEBP website at *www.pebp.state.nv.us*.

Out-of-Network Pharmacy Benefit

Prescriptions filled at a domestic (inside the United States) out-of-network pharmacy are not covered by this Plan. Prescription drugs must be filled at a participating in-network pharmacy location.

Out-of-Country Emergency Medication Purchases

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

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

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

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

Benefit Limitations and Exclusions

This Plan does not cover certain services. This chapter lists the general medical and pharmacy benefit exclusions of this Plan. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum. Additional exclusions that apply to only a service or benefit are listed in the description of that service or benefit in the *Summary of Medical Benefits* and *Schedule of Medical Benefits* sections. This list is not all-inclusive; if you have questions about a service or supply, contact the Claims Administrator listed in the *Participant Contact Guide*.

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

The Plan never pays benefits equal to all the medical expenses you may incur. You are always responsible for paying for certain expenses for medical services and supplies yourself. The following services do not accumulate toward the out-of-pocket maximum, and you will be responsible for paying these expenses out of your own pocket.

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

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

Benefit Limitations

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

Lifetime Maximum

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

Exclusions Under the Medical Plan

The following is a list of services and supplies or expenses not covered by this Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and terms of the Plan and determines eligibility and entitlement to Plan benefits. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your out-of-pocket maximum.

Abortion: Termination of pregnancy is excluded, other than medically indicated abortions that are medically necessary to save the life of the mother.

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

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

Bariatric and Overweight Surgery 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. PEBP or its designee will determine the in-network Center of Excellence facility.

Behavioral (Mental) Health Services

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

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

1. A managed care organization that offers or issues a health care plan which provides coverage for prescription drugs:
   a) Must authorize coverage for and may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for synchronizing the insured's chronic medications:
      1. The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the insured; and
      2. The insured requests less than a 30-day supply.

b) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the managed care organization.
c) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).

2. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery, or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.
3. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.
4. As used in this section:
(a) "Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent, or lasting indefinitely.
(b) "Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for improving a patient's adherence to a prescribed course of medication.
(c) "Unit-of-use packaging" means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

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

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge medical practice to have access to the medical services provided by the concierge medical practice.

Contraception or its Therapeutic Equivalent: 2017 Legislative Session - AB 249

1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:
(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent, which is lawfully prescribed or ordered, and which has been approved by the Food and Drug Administration.
(b) Any type of device for contraception or its therapeutic equivalent, which is lawfully prescribed or ordered, and which has been approved by the Food and Drug Administration.
(c) Insertion or removal of a device for contraception.
(d) Education and counseling relating to contraception.
(e) Management of side effects relating to contraception; and
(f) Voluntary sterilization for men and women.
2. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an

alternate therapeutic equivalent prescribed by a provider of health care must be covered by the managed care organization.

3. A managed care organization that offers or issues a health care plan shall not:
   (a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit included in the health care plan pursuant to subsection 1.
   (b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefits.
   (c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefits.
   (d) Penalize a provider of health care who provides any such benefits to an insured, including, without limitation, reducing the reimbursement of the provider of health care.
   (e) Offer or pay any type of material inducement, bonus, or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefits to an insured; or
   (f) Impose any other restrictions or delays on the access of an insured to any such benefits, including, without limitation, a program of step therapy or prior authorization.
4. Coverage pursuant to this section for a covered spouse or the covered dependent of an insured must be the same as for the insured.
5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery, or renewed on or after January 1, 2019, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

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

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge medical practice to have access to the medical services provided by the concierge medical practice.

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

1. The provisions of this section apply to a health care plan offered or issued by a managed care organization if an insured covered by the health care plan receives health care through a defined set of providers of health care who are under contract with the managed care organization.
2. Except as otherwise provided in this section, if an insured who is covered by a health care plan described in subsection 1 is receiving medical treatment for a medical condition from a provider of health care whose contract with the managed care organization is terminated during the medical treatment, the health care plan must provide that:
3. The insured may continue to obtain medical treatment for the medical condition from the provider of health care pursuant to this section, if:
   a. The insured is actively undergoing a medically necessary course of treatment; and
   b. The provider of health care and the insured agree that the continuity of care is desirable.

4. The provider of health care is entitled to receive reimbursement from the managed care organization for the medical treatment the provider of health care provides to the insured pursuant to this section, if the provider of health care agrees:
    a. To provide medical treatment under the terms of the contract between the provider of health care and the managed care organization with regard to the insured, including, without limitation, the rates of payment for providing medical service, as those terms existed before the termination of the contract between the provider of health care and the managed care organization; and
    b. Not to seek payment from the insured for any medical service provided by the provider of health care that the provider of health care could not have received from the insured were the provider of health care still under contract with the managed care organization.
    1. The coverage required by subsection 2 must be provided until the later of:
        (a) The 120th day after the date the contract is terminated; or
        (b) If the medical condition is pregnancy, the 45th day after:
            i. The date of delivery; or
            ii. If the pregnancy does not end in delivery, the date of the end of the pregnancy.
5. The requirements of this section do not apply to a provider of health care if:
6. The provider of health care was under contract with the managed care organization and the managed care organization terminated that contract because of the medical incompetence or professional misconduct of the provider of health care; and
   (b) The managed care organization did not enter into another contract with the provider of health care after the contract was terminated pursuant to paragraph (a).
7. An evidence of coverage for a health care plan subject to the provisions of this chapter that is delivered, issued for delivery, or renewed on or after October 1, 2003, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal thereof that conflicts with this section is void.
8. The Commissioner shall adopt regulations to carry out the provisions of this section.
9. (Added to NRS by 2003, 3370)

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

1. Except as otherwise provided in subsection 2, a managed care organization shall not:

(a) Deny a claim under a health care plan solely because the claim involves an injury sustained by an insured because of being intoxicated or under the influence of a controlled substance.

(b) Cancel participation under a health care plan solely because an insured has made a claim involving an injury sustained by the insured because of being intoxicated or under the influence of a controlled substance.

(c) Refuse participation under a health care plan to an eligible applicant solely because the applicant has made a claim involving an injury sustained by the applicant because of being intoxicated or under the influence of a controlled substance.

2. The provisions of subsection 1 do not prohibit a managed care organization from enforcing a provision included in a health care plan to:

(a) Deny a claim which involves an injury to which a contributing cause was the insured's commission of or attempt to commit a felony.
(b) Cancel participation under a health care plan solely because of such a claim; or
(c) Refuse participation under a health care plan to an eligible applicant solely because of such a claim.

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

Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken/missed appointments, telephone calls and/or photocopying fees.

Corrective Appliance, Orthotic Device Expenses, and Appliances: Any items that are not corrective appliances, orthotic devices or orthotic braces that straighten or change the shape of a body part, prosthetic appliances, or durable medical equipment (as each of those terms is defined in the *Key Terms and Definitions* section), including, but not limited to, personal comfort items like air purifiers, humidifiers, electric heating units, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, orthopedic mattresses, water beds, and air conditioners are excluded. Expenses for cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome. Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment are not covered. Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.

Cosmetic Services and Surgery:

The Plan excludes expenses for cosmetics, or any drugs used for cosmetic purposes or to promote hair growth even for documented medical conditions, including but not limited to health and beauty aids. This Plan excludes expenses related to surgery or medical treatment to improve or preserve physical appearance, but not physical function, and complications thereof, are not covered. Cosmetic surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation, removal of unwanted or excess skin, for example but not limited to abdominoplasty (tummy tuck), blepharoplasty, body contouring (liposuction of the waist), face-lifting, facial bone reduction, feminization of torso, hair removal (e.g., electrolysis, laser hair removal), lip enhancement/reduction, thyroid chondroplasty, rhinoplasty, skin resurfacing (dermabrasion, chemical peel), and voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of vocal cords), which have been used in feminization, are considered cosmetic. Similarly, chin implants, lip reduction, masculinization of torso, and nose implants, which have been used to assist masculinization, are considered cosmetic, brow lift, calf implants, cheek/malar implants, collagen injections, construction of clitoral hood, drugs for hair loss growth, facial feminization and masculinization surgery, forehead lift, jaw reduction (jaw contouring), mastopexy, neck tightening, nipple reconstruction, nose implants, pectoral implants, pitch-raising surgery, rhinoplasty, tracheal shave, voice therapy/voice lessons or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

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

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

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

Prophylactic surgery is covered under certain circumstances:

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

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

This Plan excludes expenses related to cosmetic procedures performed as a component of a gender reassignment, including, but not limited to the following services:

- Abdominoplasty
- Blepharoplasty
- Breast augmentation*
- Brow lift
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Construction of a clitoral hood
- Drugs for hair loss or growth
- Face-lifting
- Facial bone reduction
- Forehead lift
- Hair removal
- Hair transplantation
- Lip enhancement or reduction
- Mastopexy
- Neck tightening
- Pectoral implants
- Reduction thyroid chondroplasty
- Removal of redundant skin
- Rhinoplasty
- Skin resurfacing
- Voice modification surgery (laryngoplasty or shortening of the vocal cords)
- Voice therapy/voice lessons

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

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

Custodial Care: Expenses for custodial care as defined in the *Key Terms and Definitions* section of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, except when custodial care is provided as part of a covered hospice program.

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

Dental Services: Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness, or injury affecting the mouth or another part of the body. Except as described as an inclusion in the *Schedule of Medical*

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

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).

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

Drugs, Medicines, Nutrition or Devices Exclusions:

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been prescribed for a medically necessary indication or are experimental and/or investigational (as defined in the *Key Terms and Definitions* section of this document).
- Non-Prescription (non-legend or over the counter) drugs or medicines.
- Foods and nutritional/dietary supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs, and minerals (whether they can be purchased over the counter or require a prescription), except when provided during hospitalization; prenatal vitamins or minerals requiring a prescription.
- 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 Medical Benefits* section.
- Medical marijuana and any derivative, including CBD, THC, edibles, etc. are not a covered benefit under this Plan.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the *Prescription Drug Program*.

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

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

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

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefit as described in the *Summary and Schedule of Medical Benefits* sections.

Expenses Exceeding Usual and Customary Charges, Maximum Allowable Charge, Prevailing Rates and Plan Contracted Rates: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the usual and customary charge, prevailing rates or Plan contracted rate as defined in the *Key Terms and Definitions* section.

Expenses for Which a Third Party Is Responsible: Expenses for services or supplies for which a third party actually paid because of the negligence or other tortious or wrongful act of that third party (see Subrogation and Third Party Recovery section in this document or the separate Health and Welfare Benefits Wrap Plan document available *at www.pebp.state.nv.us*.)

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. For information regarding COBRA, refer to the separate Health and Welfare Benefits Wrap Plan document.

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

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

Fertility and Infertility Services: Except as otherwise specified in the *Schedule of Medical Benefits* section, all other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) except services directly related to artificial insemination services up to the maximum benefit limit are excluded. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy; the promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the participant's ability to become pregnant or to carry a pregnancy to term; and any payment made by or on behalf of a participant

who is contemplating or has entered into a contract for surrogacy to a provider or individual related to any services potentially included in the scope of surrogacy services; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are also excluded.

Foot/Hand Care Exclusions
Expenses for non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and expenses for routine foot care (including but not limited to: trimming of toenails, removal of corns and callouses, preventive care with assessment of pulses, skin condition and sensation) or hand care, (including manicure and skin conditioning), unless the Plan Administrator or its designee determines such care to be medically necessary. Routine foot care from a podiatrist for treatment of foot problems such as corns, calluses and toenails are payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

Genetic Testing and Counseling:
- Coverage is not available for tests solely for research, or for the benefit of individuals not covered under this Plan.
- Expenses for genetic testing and counseling are excluded, unless otherwise specified in this Plan's *Schedule of Medical Benefits*.

Government-Provided Services: Expenses for health care services provided to a covered participant that federal, state, or local law (e.g., Tricare/Champus, VA, except the Medicaid program), expenses for care required by a public entity and care for which there would not normally be a charge.

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

Home Birth/Delivery: Planned birth/delivery at home and associated services are not covered by this Plan. Guidelines for Perinatal Care published by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG) that the hospital, including a birthing center within the hospital complex, or a freestanding birthing center, provides the safest setting for labor, delivery, and the postpartum period. The use of other settings is not covered by this Plan. Facilities providing obstetrical care should have the services listed as essential components of a Level 1 hospital.

Home Health Care:
- Expenses for any home health care services that are not medically necessary, other than part-time, intermittent skilled nursing services and supplies.
- Expenses under a home health care program for services that are provided by an immediate relative or someone who ordinarily lives in the patient's home or is a parent,

spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a physician.

- Expenses for a homemaker, custodial care, childcare, adult care, or personal care attendant, except as provided under the Plan's hospice coverage.
- Expenses for any home health care services that is not provided by an organization or professional licensed by the state to render home health services.
- In-home services provided by certified nurse aids or home health aides.
- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*.
- Expenses for any services provided substantially or primarily for the participant's convenience or the convenience of a caregiver.

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

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

1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.
2. A health care plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.
3. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery, or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal thereof which conflicts with subsection 1 is void.
4. For the purposes of this section, "human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

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

Intensive Outpatient Program: An intensive outpatient program (IOP) is a kind of treatment service and support program used primarily to treat eating disorders, depression, self-harm, and

chemical dependency that does not rely on detoxification. IOP operates on a small scale and does not require the intensive residential or partial day services typically offered by the larger, more comprehensive treatment facilities.

Internet/Virtual Office Visit: Expenses related to an online internet consultation with an out-of-network physician or other health care practitioner (also called a virtual office visit/consultation), physician-patient web service or physician-patient e-mail service (including receipt of advice, treatment plan, prescription drugs or medical supplies obtained) from an online internet provider who is not a participating provider in the Plan network. **Note**: This Plan has an exclusive in-network provider agreement with Doctor on Demand for telemedicine services for this Plan.

Maternity/Family Planning:
Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms; childbirth courses; and nondurable supplies.

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

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

Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary, as defined in the *Key Terms and Definitions* section.

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required because of an injury, illness, or disability of a participant, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc.)

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

No Provider Recommendation: Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician, except for covered services provided by a behavioral health practitioner, midwife or nurse midwife, nurse practitioner, physician assistant, chiropractor, dentist, homeopath, podiatrist, or certain wellness/preventive screening services.

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

Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses) of a health care provider, participant except where otherwise specified in the *utilization management* section for organ/ tissue transplants and bariatric weight loss surgery or certain surgeries performed in a surgery center, inpatient hospital or outpatient setting as determined by this Plan's UM company.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: All expenses incurred by you or any of your covered dependents arising out of or during employment if the injury, illness, or condition is subject to coverage, in whole or in part, under any Workers' Compensation, or occupational disease (or similar) law.

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

1. A managed care organization which offers or issues a health care plan that provides coverage for prescription drugs shall not deny coverage for a topical ophthalmic product which is otherwise approved for coverage by the managed care organization when the insured, pursuant to NRS 639.2395, receives a refill of the product:
   (a) After 21 days or more but before 30 days after receiving any 30-day supply of the product.
   (b) After 42 days or more but before 60 days after receiving any 60-day supply of the product; or
   (c) After 63 days or more but before 90 days after receiving any 90-day supply of the product.
2. The provisions of this section do not affect any deductibles, copayments or coinsurance authorized or required pursuant to the health care plan.
3. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2016, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void. As used in this section, "topical ophthalmic product" means a liquid prescription drug which is applied directly to the eye from a bottle or by means of a drop.

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

1. Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.
   a) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.
   b) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.
2. An evidence of coverage for a health care plan subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery, or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.
3. Nothing in this section shall be construed as requiring a managed care organization to provide coverage for the treatment of cancer using chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

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

Partial Hospitalization Service: Partial hospitalization service, also known as PHP, is a type of program used to treat mental illness and substance abuse in which the patient continues to reside at home, but commutes to a treatment center up to seven days a week. This service model focuses on the overall treatment of the individual and is intended to avert or reduce in-patient hospitalization. Services are typically provided in either a hospital setting or by a free-standing community mental health center. Treatment during a typical day may include group therapy, psych-educational groups, skill building, individual therapy, and psychopharmacological assessments, and check-ins. Programs are available for the treatment of alcoholism and substance abuse, Alzheimer's disease, anorexia and bulimia, depression, bipolar disorder, anxiety disorders, schizophrenia, and other mental illnesses.

Personal Comfort Items: Expenses for patient convenience, including (but not limited to) care of family members while the 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.

Prophylactic Surgery or Treatment: Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery (as defined in the *Key Terms and Definitions* section), when the services, procedures, Prescription of Drugs, or Prophylactic surgery is prescribed or performed for:

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

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

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.

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

1. A health care plan issued by a managed care organization that provides coverage for the treatment of prostate cancer must provide coverage for prostate cancer screening in accordance with:
    a) The guidelines concerning prostate cancer screening which are published by the American Cancer Society; or
    b) Other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.
2. A health care plan issued by a managed care organization that provides coverage for the treatment of prostate cancer must not require an insured to obtain prior authorization for any service provided pursuant to subsection.
3. Any evidence of coverage for a health care plan issued by a managed care organization that provides coverage for the treatment of prostate cancer which is delivered, issued for delivery, or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with subsection 1 is void.

Rehabilitation Therapy (Inpatient or Outpatient):

- Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing, and related services.

- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
- Expenses for maintenance rehabilitation, as defined in the *Key Terms and Definitions* section.
- Expenses for speech therapy for functional purposes including (but not limited to) stuttering, stammering and conditions of psychoneurotic origin, or for childhood developmental speech delays and disorders.
- Expenses for treatment of delays in childhood speech development, unless as a direct result of an injury, surgery, or the result of a covered treatment.
- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living.
- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment of mental retardation, Down syndrome, or autism (unless specified otherwise within the *Summary of Medical Benefits* and *Schedule of Medical Benefits* sections) that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency.

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

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

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

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

1. A health care plan issued by a managed care organization for group coverage must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.

A managed care organization shall not:

(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1.
(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1.
(c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or
(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.

2. A health care plan of a managed care organization must not require an insured to obtain prior authorization for any service provided through telehealth that is not required for the service when provided in person. Such a health care plan may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or by other means.
3. The provisions of this section do not require a managed care organization to:
   (a) Ensure that covered services are available to an insured through telehealth at an originating site.
   (b) Provide coverage for a service that is not a covered service or that is not provided by a covered provider of health care; or
   (c) Enter into a contract with any provider of health care or cover any service if the managed care organization is not otherwise required by law to do so.
4. Evidence of coverage that is delivered, issued for delivery, or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which conflicts with this section is void.
5. As used in this section:
   (a) "Distant site" has the meaning ascribed to it in *NRS 629.515*.
   (b) "Originating site" has the meaning ascribed to it in *NRS 629.515*.
   (c) "Provider of health care" has the meaning ascribed to it in *NRS 439.820*.
   (d) "Telehealth" has the meaning ascribed to it in *NRS 629.515*.

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

1. A managed care organization which offers or issues a health care plan that provides coverage for prescription drugs shall not deny coverage for a topical ophthalmic product which is otherwise approved for coverage by the managed care organization when the insured, pursuant to NRS 639.2395, receives a refill of the product:
   (a) After 21 days or more but before 30 days after receiving any 30-day supply of the product.
   (b) After 42 days or more but before 60 days after receiving any 60-day supply of the product; or
   (c) After 63 days or more but before 90 days after receiving any 90-day supply of the product.

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

Transplant (Organ and Tissue):

- 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 all complications thereof, except those transplant services as described under Transplants in the *Schedule of Medical Benefits*.
- Expenses related to non-human (Engrafted) organ and/or tissue transplants or implants, except heart valves.
- Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this plan.

Travel Outside of the United States: Any services received outside the United States are excluded unless deemed to be urgent or emergency care.

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

Vision Care: Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery); and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded, except as otherwise specified in this Plan's *Summary of Medical Benefits* and *Schedule of Medical Benefits*.

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

Weight Management and Physical Fitness:

- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs, and prescription drugs, except those services specified in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*. Surgery for

weight reduction must be performed at a Bariatric Center of Excellence. Expenses for weight loss surgery performed without a precertification from the UM company will be denied.

- Expenses related to programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.
- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of anorexia, bulimia, or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by physicians to determine normal body weight.
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under any PEBP self-funded medical Plan (e.g., LD PPO Plan, CDHP and Premier Plan).

Other Benefit Exclusions

- Stress reduction therapy or cognitive behavior therapy for sleep disorders.
- Sleep therapy (except for central or obstructive apnea when medically necessary and when a precertification has been received from the UM company), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy.
- Charges that result from appetite control, food addictions, eating disorders (except documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by us and present significant symptomatic medical problems) or any treatment of obesity, unless otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*.
- Except as otherwise provided in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.
- Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (BEST), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.
- Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or Chiropractor's office, or at a retail location are excluded, unless otherwise specified in the *Summary of Medical Benefits* and *Schedule of Medical Benefits*

Medical Claims Administration

How Medical Benefits are Paid

Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to the Claims Administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When coinsurance or copayments apply, you are responsible for paying your share of these charges.

If services are provided through the Plan's network, the health care provider may submit the proof of claim directly to the Claims Administrator; however, you will be responsible for the payment to the health care provider for any applicable coinsurance or copayments.

If a health care provider does not submit a claim directly to the Claims Administrator and instead sends the bill to you, you should follow the steps outlined in this section regarding *How to File a Claim.* If, at the time you submit your claim, you furnish evidence acceptable to the Plan Administrator or its designee (the Claims Administrator) that you or your covered dependent paid some or all of those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan year coinsurance or copayments amounts are met.

How to File a Medical Claim

All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

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

- Obtain a claim form from the Claims Administrator or PEBP's website (see the *Participant Contact Guide* section in this document for details on address, phone, and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information is necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains all the following information:
- A description of the services or supplies provided including appropriate procedure codes.
- Details of the charges for those services or supplies.
- Appropriate diagnosis code.
- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).

- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Claims Administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another Plan is the primary payer, send a copy of the other Plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny 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 (TIN).
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- Providers such as hospitals and other facilities that bill for items, such as orthopedic devices/implants or other biomaterial to provide to the Claims Administrator, a copy of the manufacturer's/organization's single or bulk-unit invoice that directly supplied such medical devices to the health care provider. This Plan will deny payment for such medical devices until the hospital or facility provides a copy of the invoice to the Claims Administrator.

NOTE: Claims are processed by the Claims Administrator in the order they are received. If a claim is held or "soft denied" that means the third-party Claims Administrator is holding the claim to receive additional information, either from the participant, the provider or to get clarification on benefits to be paid. A claim that is held or soft denied will be paid or processed when the requested additional information is received. Claims filed while another claim(s) is held or soft denied may be paid or processed even though they were received later.
It is your responsibility to maintain copies of the Explanation of Benefits (EOB) provided to you by the Claims Administrator or prescription drug administrator. Copies of EOB documents are available on the third-party Claims Administrator's website but cannot be reproduced. PEBP and its third-party Claims Administrator do not provide printed copies of EOBs outside of the original mailing.

Where to Send the Claim Form

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

Appeals Procedures Under the Plan

What Can Be Appealed?

You have the right to ask PEBP or its designees to reconsider an adverse benefit determination resulting in a denial, reduction, termination, failure to provide or make payments (in whole or in part) for a service or treatment, or rescission of coverage (retroactive cancellation).

Discretionary Authority of the Plan Administrator and its Designee

In carrying out their respective responsibilities under this Plan, the Plan Administrator and its designees have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in this document.

Medical and Dental Claim Appeals

Written Notice of Adverse Benefit Determination

The Plan or its designee, the third-party Claims Administrator, will notify you in writing of an adverse benefit determination resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal. When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or State of Nevada) in a court proceeding.

The appeal process works as follows:

Level 1 Claim Appeal NAC 287.670

If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third-party Claims Administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause is demonstrated. The written request for appeal must include:

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit your own comments in writing. The third-party Claims Administrator will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

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

Level 2 Claim Appeal NAC 287.680

If you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. Claim Appeal Request forms are available at *http://www.pebp.state.nv.us* or by request by contacting PEBP Customer Service at 775-684-7000 or 800-326-5496. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal must include a copy of:

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

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

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. A Level 2 Appeal determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.

Standard Request for External Claim Review NAC 287.690

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. An External Review Request Form is available on the PEBP website at *www.pebp.state.nv.us*. The OCHA will assign an independent external review organization within five (5) days after receiving the request. The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

A Request for External Claim Review must include:

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

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

Appealing a Utilization Management Determination

The UM company is staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer utilization review services. The review includes a process to determine the medical necessity, appropriateness,

location, and cost effectiveness of health care services. Depending on the service, a review may occur before, during, or after the services are rendered, including, but not limited to precertification/pre-authorization; concurrent and/or continued stay review; discharge planning; retrospective review; and case management.

Pursuant to applicable NRS 695G, you have the following appeal processes for any adverse benefit determination made during the precertification, concurrent review, retrospective review, or case management. An appeal may be initiated by the participant, treating provider, parent, legal guardian, or person authorized to make health care decisions by a power of attorney.
The UM company will utilize a physician (other than the physician who rendered the original decision) to review the appeal. This physician is Board Certified in the area under review and is in active practice. Refer to the *Participant Contact Guide* for the UM company's contact information.

Internal UM Appeals Review

Expedited Internal UM Appeal Review

You may request an expedited appeal review of a denied precertification of a hospital admission, availability of care, continued stay or health care service for which you received emergency services but have not been discharged from the facility providing the care; or if the physician certifies that failure to proceed in an expedited manner may jeopardize your life or health or the life or health of your covered dependent or the ability for you or your covered dependent to regain maximum function.

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

If the appeal review request is denied, the UM company will provide the member with an adverse benefit determination letter including the clinical rationale for the non-certification decision and the member may pursue an external appeal as described in NRS 695G.241 - NRS 695G.275.

Standard Internal UM Appeal Review

If you have a denied precertification request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, or case management issue) and you

do not qualify for an expedited appeal, you may request a standard appeal review. Requests for standard appeal review may be made by writing to the UM company.

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

An external review may be requested by a participant and/or the participant's treating physician after you have exhausted the internal UM appeal review process. This means that you may have a right to have the Plan Administrator's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

For requests involving adverse benefit determinations resulting from the utilization management program only, a participant or their designee can choose to bypass the UM company's expedited appeal process and standard appeal process and request a review by an external review board.

Expedited Request for External Review (Pre-Service UM Appeal)

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 months after the date of receipt of a notice of an adverse benefit determination and the patient's treating provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered individual or would jeopardize the covered individual's ability to regain maximum function. Pursuant to NRS 695G.271, the Office for Consumer Health Assistance (OCHA) will approve or deny a request for an external review of an adverse determination not later than 72 hours after receipt from the provider. If OCHA determines the request qualifies for expedited review, a final of the external review will made by the external review organization within 72 hours of receipt and the provider and participant will be notified within 24 hours.

A participant may file a request for an expedited external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. An

expedited external review request form, which includes a certification of treating provider for expedited consideration can be found on the PEBP website at *www.pebp.state.nv.us*.
The request must be submitted to:

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

Standard Request for External UM Review

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

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

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

Experimental and/or Investigational Claim/UM External Review

If you received a denial for a service, durable medical equipment, procedure, or other therapy because the third-party administrator or the UM company determined it to be experimental and/or investigational, you may request an external review. To proceed with the experimental and/or investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not received.

A "Physician Certification of Experimental/Investigational /Denials" is located under "Forms" on the PEBP website at *www.pebp.state.nv.us*.

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

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

Prescription Drug Review and Appeals

A participant has the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. The Pharmacy Benefit Manager reviews both clinical and administrative coverage review requests.

Clinical Coverage Review

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

How to Request a Clinical Coverage Review

The preferred method to request an initial clinical review is for the prescribing physician to submit the prior authorization request electronically. Alternately, the participant's prescribing physician or pharmacist may call Express-Scripts at 1-855-889-7708 or the prescriber may submit a completed Initial Coverage Review form obtained online at *www.express-scripts.com*. Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.

Administrative Coverage Review

The initial administrative coverage review is a request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Administrative Coverage Review

To request an initial administrative coverage review, the participant must submit the request in writing to Express-Scripts to the attention of the Benefit Coverage Review Department (see *Participant Contact Guide* section).

For an administrative coverage review request, the participant must submit information to the pharmacy benefits manager to support the request.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by calling Express-Scripts at 1-800-753-2851.

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

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

Level 1 Appeal or Urgent Appeal

When an initial administrative or clinical coverage review request has been denied, a request for appeal of the denial may be submitted by the participant within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to Express-Scripts' Benefit Coverage Review Department:

- Name of patient.
- Participant ID number.
- Phone number.
- The Drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the initial adverse benefit determination; and
- Any additional information that may be relevant to the appeal, including physician/prescriber statements/letters, bills, or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone at 1-800-753-2851 or fax 1-877-852-4070 to Express-Scripts. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Express-Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are by Express-Scripts' pharmacist, physician, panel of clinicians, trained prior authorization staff member, or an independent third-party UM company.

Level 1 Appeal Decisions and Notifications

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

- Standard pre-service: 15 days.
- Standard post-service: 20 days; and
- Urgent*: 72 hours.

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse benefit determination.

Level 2 Appeal

When a Level 1 Appeal has been denied, a request for a Level 2 Appeal may be submitted by the participant within 35 days from receipt of notice of the Level 1 Appeal denial. To initiate a Level

2 Appeal, you must request by mail or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department.

An urgent Level 2 Appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

Level 2 Appeal Decisions and Notifications

Express-Scripts will render Level 2 Appeal determinations within the following timeframes:

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

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

External Reviews

The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental and investigation. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to the independent review organization (see *Participant Contact Guide*) within four (4) months of the date of the Level 2 Appeal denial. (If the date that is four (4) months from that date is a Saturday, Sunday, or a holiday, the deadline will be the next business day).

Standard External Review: The Pharmacy Benefit Manager will review the external review request within five (5) business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within one (1) business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO within five (5) business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgement or rescission, the letter will describe the claimant's right to submit additional information within ten (10) business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the Pharmacy Benefit Manager for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and the Pharmacy Benefit Manager written notice of its decision. If the IRO has determined that the claim does not involve medical judgement or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review

Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regarding maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Coordination of Benefits

Which Benefits are Subject to Coordination?

When you or your covered dependents also have medical, dental or vision coverage from some other source, benefits are determined using coordination of benefits (COB). In many of those cases, one plan serves as the primary plan or program and pays benefits or provides services first. In these cases, the other plan serves as the secondary plan or program and pays some or all the difference between the total cost of those services and payment by the primary Plan or program. Benefits paid from two (2) different plans can occur if you or a covered dependent is covered by this Plan and is also covered by:

- Any primary payer besides this Plan.
- Any other group health care Plan or individual policy.
- Any other coverage or policy covering the participant or covered dependent.
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company.

- Medicare.
- Other government programs, such as: Medicaid, Tricare/CHAMPUS, a program of the U.S. Department of Veterans Affairs, or any coverage provided by a federal, state, or local government or agency; or
- Workers' Compensation.

NOTE: This Plan's prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. There will be no coverage for prescription drugs under this Plan if you have additional prescription drug coverage that is primary.
This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source (as described above), would allow you to recover more than 100% of allowable expenses you incur. In some instances, you may recover less than 100% of those allowable expenses from the duplicate sources of coverage. It is possible that you will incur out of pocket expenses, even with two payment sources.

When and How Coordination of Benefits (COB) Applies

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

Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan or policy, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

If the Low Deductible PPO Plan is secondary coverage, the participant will be required to pay their copayments and/or coinsurance as applicable.

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

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

Examples of what an allowable expense does NOT include:

- The difference between the cost of a semi-private room in the hospital and a private room.

- When both plans use usual and customary (U&C) fees, any amount in excess of the highest of the U&C fee for a specific benefit.
- When both plans use negotiated fees, any amount in excess of the highest negotiated fee is not an allowable expense (except for Medicare negotiated fees, which will always take precedence); and

- When one plan uses U&C fees and another plan uses negotiated fees, the secondary plan's payment arrangement is not the allowable expense.

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

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

When two (2) plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

These rules are:

Rule 1: Non-Dependent/Dependent

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

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

This rule applies when both spouses are employed and cover each other as dependents under their respective plans. The plan covering the person as an employee pays first, and the plan covering the same person as a dependent pay benefit second.

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

- The parents are married.
- The parents are not separated (whether they ever have been married); or
- A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- If both parents have the same birthday, the plan that has covered one of the parents for a longer period pays first, and the plan that has covered the other parent for the shorter period pays second.
- The word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

If the parents are not married, or are separated (whether they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

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

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

Rule 3: Active/Laid-Off or Retired Employee

The plan that covers a person, as an active employee (that is, an employee who is neither laid-off nor retired) or as an active employee's dependent pays first; the plan that covers the same person as a laid-off/retired employee or as a laid-off/retired employee's dependent pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member, or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member, or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period pays first; and the plan that covered the person for the shorter period pays second. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan.

Administration of COB

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

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

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

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

This Plan follows the customary Coordination of Benefits rule that the medical program coordinates with only other medical plans or programs (and not with any dental plan or program), and the dental program coordinates only with other dental plans or programs (and not with any other medical plan or program). Therefore, when this Plan is secondary, it will pay secondary

medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

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

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the participant may have against the other plan, and the participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Coordination with Medicare

Coordination with Medicare is not applicable to this Plan for retirees and their covered dependents who are entitled to Medicare Parts A and B and have completed the required transition to the Medicare Exchange. Refer to the *Enrollment and Eligibility MPD* for more information regarding enrollment in the Medicare Exchange.

Entitlement to Medicare Coverage (Retirees and their Covered Dependents)

When retirees and/or their covered dependent become entitled to premium-free Medicare Part A due to age or a qualified SSA disability, the Plan will require the retiree and/or his or her covered dependent to enroll in premium-free Medicare Part A and purchase Medicare Part B coverage. For more information, see the *PEBP Enrollment and Eligibility MPD* at *www.pebp.state.nv.us*.

Retirees Ineligible for Premium-Free Medicare Part A

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

have enrolled. This Plan will assume that Medicare will pay 80% of Medicare Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

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

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

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

How Much This Plan Pays When It Is Secondary to Medicare

When you are retired and covered by Medicare Parts A and B, this Plan is secondary to Medicare. This Plan pays as secondary with the Medicare negotiated allowable fee taking precedence. If a service is not covered under Medicare but is covered under this Plan, this Plan will pay as primary with the Plan's allowable fee for the service taking precedence.

When a retiree or a retiree's covered dependent is enrolled in Medicare Part B, this Plan will pay as secondary to Part B.

If a Part B eligible retiree or the dependent of a retiree is not enrolled in Part B coverage, the retiree and/or dependent will be responsible for any applicable copayments and this Plan will estimate the Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only pay the remaining 20% of the Medicare allowable Part B expenses. The Participant will be responsible for any amounts exceeding this Plan's benefit payment.

Note: A Medicare participant has the right to enter into a Medicare private contract with certain health care practitioners. Under Medicare private contracts, the participant agrees that no claim will be submitted to or paid by Medicare for health care services and or supplies furnished by that practitioner. If a PEBP Medicare participant enters 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 the private contract.

Coordination with Other Government Programs

Medicaid

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

Tricare

If a participant is covered by both this Plan and Tricare (the program that provides health care services to active or retired armed services personnel and their eligible dependents), this Plan 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 because of a military service-related illness or injury, Benefits are not payable by this Plan. If a participant receives services in a U.S. Department of Veterans Affairs hospital or facility because of any other condition that is not a military service-related illness or injury, benefits are payable by this 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 this Plan.

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

Disability

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

Prescription Drug Plan

This Plan does not coordinate prescription drug plan benefits.

Subrogation and Third-Party Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the manner in which they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). Any and all claims made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. Any and all payments made by the Plan relating in any way to the Injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury. Refer to the separate *Health and Welfare Benefits Wrap Plan* document for more information regarding third party liability and subrogation.

The Participant must cooperate fully, at all times, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

(1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation.
(2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
(3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate Health and Welfare Benefits Wrap Plan document available at *www.pebp.state.nv.us* for more information regarding third party liability and subrogation.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) 901 S. Stewart Street, Suite 1001 Carson City, NV 89701 Customer Service: (775) 684-7000 or (800) 326-5496 Fax: (775) 684-7028 *www.pebp.state.nv.us*	**Plan Administrator** • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
HealthSCOPE Benefits Claims Submission P O Box 91603 Lubbock, TX 79490-1603 Appeal of Claims P O Box 2860 Little Rock, AR 72203 Group Number: NVPEB Customer Service: (888) 763-8232 www.healthscopebenefits.com	**Claims Administrator/Third Party Administrator/Obesity Care Management Administrator** • Claim submission/claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • ID Cards • Healthcare Bluebook • Obesity Care Management Program • HSA, HRA and FSA Administrator
American Health Holdings, Inc. **Utilization Management Company** 7400 West Campus Road, F-510 New Albany, OH 43054 Customer Service: (888) 323-1461 Fax: (833)336-3986	• Precertification/Prior authorization • Utilization/Case Management
Aetna Signature Network Contact HealthSCOPE Benefits (888) 763-8232 *http://aetna.com/asa*	**PPO Network** • Network Providers/directory • Additions/Deletions of Providers
Express Scripts Pharmacy Benefit Administrator Customer Service and Prior Authorization (855) 889-7708 www.Express-Scripts.com	**Pharmacy Benefit Manager for the LD PPO** Prescription drug information • Retail network pharmacies • Prior authorization • Customer service • Formulary, forms, online ordering • Price a Medication tool

Participant Contact Guide

Express Scripts Home Delivery/Accredo Specialty Drug Services
PO Box 66566
St. Louis, MO 63166-6566
Customer Service: (855) 889-7708

- Home delivery service and Mail Order forms
- Preferred Mail Order for diabetic supplies

Express-Scripts Benefit Coverage Review Department
PO Box 66587, St. Louis, MO 63166-6587
Phone: 800-946-3979
Administrative Coverage Review and Appeals

Express-Scripts Clinical Appeals Department
PO Box 66588 St. Louis, MO 63166-6588
Phone: 800-753-2851
Fax: 877-852-4070

- Clinical Reviews

SaveonSP
1-800-683-1074

MCMC LLC Attn: Express-Scripts Appeal Program
300 Crown Colony Dr. Suite 203
Quincy, MA 02169-0929
Phone: 617-375-7700 ext. 28253
Fax: 617-375-7683
External Review Requests

Participant Contact Guide	
Diversified Dental Services PO Box 36100 Las Vegas, NV 89133-6100 Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538 *https://dds.go2dental.com/member/dental_search/provsel.cgi?cqtype=DIVPPD*	PPO Dental Network • Statewide PPO Dental Providers • National PPO Dental Providers • Dental Provider Directory
The Standard Insurance Company 900 SW Fifth Avenue Portland, OR 97204 (888) 288-1270 *https://www.standard.com/mybenefits/nevada/*	• Basic Life Insurance • Voluntary (Supplemental) Life Insurance • Voluntary Short-Term Disability • Travel Assistance • Beneficiary Designations
Core Stream - Voluntary Products/Services Customer Care Center: (855) 901-1100	Various Voluntary Products and Services
Office for Consumer Health Assistance 3320 W. Sahara Avenue, Suite 100 Las Vegas, NV 89102 Customer Service: (702) 486-3587 or (888) 333-1597 *http://dhhs.nv.gov/Programs/CHA/Contact_GovCHA/*	**Consumer Health Assistance** • Concerns and problems related to coverage • Provider billing issues • External review information
Nevada Secretary of State Office The Living Will Lockbox c/o Nevada Secretary of State Phone: (775) 684-5708 Fax: (775) 684-7177 *Nevada Lockbox | Nevada Secretary of State (nvsos.gov)*	**Living Will Information** • Declaration governing the withholding or withdrawal of life-sustaining treatment • Durable power of attorney for health care decisions • Do not resuscitate order

Key Terms and Definitions

The following terms or phrases are used throughout the MPD. These terms or phrases have the following meanings. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

Active Rehabilitation: Refers to therapy in which a patient, who can learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Actively Engaged: Means:

1. Participation in regular office visits with your provider. The frequency of the office visits will be determined by your provider who will in turn report this information to the claim's administrator for monitoring.
2. Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss provider including, but not limited to routine exercise, proper nutrition and diet and pharmacotherapy, if prescribed. Commitment to your weight loss treatment will be measured by the Claims Administrator who will review monthly progress reports submitted by the provider; and
3. Losing weight at a rate determined by the weight loss provider.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding, or eating, use of the toilet, ambulating and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

When benefits for the services of an acupuncturist are payable by this Plan, the acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, be certified by the National Certification Commission for Acupuncturists (NCCA).

Adverse Benefit Determination: An "Adverse Determination" means a determination by this Plan or UM company that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet this health Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated. Adverse Benefit Determination includes a rescission of coverage determination.

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

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

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

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

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated, and staffed primarily for performing surgical procedures and which fully meets one (1) of the following two (2) tests:

- It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements:
  - It is operated under the supervision of a licensed physician who is devoting full-time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one (1) hospital in the area.
  - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
  - It provides at least one (1) operating room and at least one (1) post-anesthesia recovery room.
  - It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It has immediate access to a blood bank or blood supplies.
  - It provides the full-time services of one or more registered graduate Nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
  - It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or x-rays), an operative report and a discharge summary.

An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.

Ancillary Services/Charges: Charges for services provided by a hospital or other facility other than room and board, including, but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

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

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

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

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Approved Clinical Trial: A phase I, II, III, or IV trial conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted. An approved clinical trial's study must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA), (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Assistant Surgeon: A medically qualified doctor who assists the surgeon of record perform a particular procedure.

Autism Spectrum Disorder: A condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association or the edition of the manual that was in effect at the time the condition was diagnosed or determined.

Autologous: Refers to transplants of organs, tissues, or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.

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

Bariatric Surgery Center of Excellence: This provider has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

1. Behavior modification program supervised by a qualified professional.
2. Consultation with a dietician or nutritionist.
3. 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.
4. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise therapist or other qualified professional.
5. Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
6. Reduced-calorie diet program supervised by dietician or nutritionist.

Behavioral Health Disorder: Any illness that is defined within the Mental Disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause.
Behavioral health disorders covered under this Plan may include, but are not limited to depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods and is provided by behavioral health practitioners as defined in this section. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the *Benefit Limitations and Exclusions* section.

Behavioral Health Practitioner: A Psychiatrist, Psychologist, or a mental health or substance abuse counselor or social worker who has a Masters' degree and who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders

under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

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

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

- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements: has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the direction of a full-time Registered Nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological, and social needs of the patient.

A behavioral health treatment facility that qualifies as a hospital is covered by this Plan as a hospital and not a behavioral health treatment facility. A transitional facility, group home, halfway house or temporary shelter is not a behavioral health treatment facility under this Plan unless it meets the requirements above in the definition of behavioral health treatment facility.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, after calculation of all deductibles, coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one (1) of the two (2) following tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements:
- It is operated and equipped in accordance with any applicable state law for providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.
- It is equipped to perform routine diagnostic and laboratory examinations, including (but not limited) to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
- It has available to handle foreseeable emergencies, trained personnel, and necessary equipment, including (but not limited to) oxygen, positive pressure mask, suction,

intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
- It provides at least two (2) beds or two (2) birthing rooms.
- It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.
- It has a written agreement with at least one (1) hospital in the area for immediate acceptance of patients who develop complications.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It has the capacity to administer local anesthetic and to perform minor surgery.
- It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
- It is expected to discharge or transfer patients within 48 hours following delivery.

A birth (or birthing) center that is part of a hospital, as defined in this section, will be considered a birth (or birthing) center for the purposes of this Plan.

Business Day: Refers to all weekdays, except Saturday or Sunday, or a state or federal holiday.

Case Management: A process administered by the UM company in which its medical professionals work with the patient, family, caregivers, providers, Claims Administrator and PEBP to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential providers.

Cardiac Rehabilitation: Cardiac rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

Certified Surgical Assistant: A person who does not hold a valid health care license as an RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon. Such individuals are payable by this Plan, including designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

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

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

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

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

Coinsurance: That portion of eligible medical expenses for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses in excess of the Plan's deductible. The coinsurance varies depending on whether in-network or out-of-network providers are used.

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

Compound Drugs: Any drug that has more than one (1) ingredient and at least one (1) of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Concierge Medicine: A relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of all medical or dental care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care and direct practice medicine. Most concierge medicine practices do not bill insurance.

Concurrent Review: A managed care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the UM 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.

Contraception or its Therapeutic Equivalent: 2017 Legislative Session (AB 249)

1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:

   a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent, which is lawfully prescribed or ordered, and which has been approved by the Food and Drug Administration.

   (b) Any type of device for contraception or its therapeutic equivalent, which is lawfully prescribed or ordered, and which has been approved by the Food and Drug Administration.

   (c) Insertion or removal of a device for contraception.

   (d) Education and counseling relating to contraception.

   (e) Management of side effects relating to contraception; and

   (f) Voluntary sterilization for men and women.

2. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the managed care organization.

3. A managed care organization that offers or issues a health care plan shall not:

   (a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit included in the health care plan pursuant to subsection 1.

   (b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefits.

   (c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefits.

   (d) Penalize a provider of health care who provides any such benefits to an insured, including, without limitation, reducing the reimbursement of the provider of health care.

   (e) Offer or pay any type of material inducement, bonus, or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefits to an insured; or

   (f) Impose any other restrictions or delays on the access of an insured to any such benefits, including, without limitation, a program of step therapy or prior authorization.

4. Coverage pursuant to this section for a covered spouse or the covered dependent of an insured must be the same as for the insured.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery, or renewed on or after January 1, 2020, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

Contraceptives – 2017 Session SB233

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

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

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how plan benefits are payable when a person is covered by two (2) or more health care plans. (See also the *Coordination of Benefits* section).

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

Coronavirus Aid, Relief, and Economic Security Act (CARES Act); Families First Coronavirus Response Act (HR 6201) ("CARES Act").
This Plan shall comply with the CARES Act to the extent it applies to the Plan. The Plan shall cover COVID-19 testing and certain COVID-19 testing related items and services without cost sharing (deductibles, coinsurance, copayments), prior authorization or other medical management requirements. This coverage includes COVID-19 diagnostic testing and COVID-19 diagnostic testing-related visit to order or administer the test. A testing related visit may occur in a physician's office, via telehealth, in an urgent care center or emergency room. In-network and Out-of-Network costing sharing will not apply to diagnostic testing. To the extent it applies, this Plan will cover qualifying items, services, or immunizations intended to prevent or mitigate COVID-19 (qualifying coronavirus preventive services) without imposing cost sharing. To be covered, the services must be either (i) an evidenced-based item or service that has a "A" or "B" rating in the current recommendations from the United States Preventive Services Task Force, or (ii) an immunization with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Expansion of Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), and Health Reimbursement Arrangements (HRAs): Effective January 1, 2020, individuals may use HSAs, FSAs, and HRAs to purchase over-the-counter medicines without a prescription, and to purchase menstrual care products. To the extent it applies, this Plan shall allow early prescription refills to ensure members have sufficient supply of medication on hand. The refill shall stay consistent with the standards' supply previously filled by the member as allowed by the Plan (e.g., 30- or 90-days' supply). To the extent it applies, the Plan shall allow HSA members to continue to contribute to their 2019 HSAs to July 15, 2020 in accordance with IRS Notice IR-2020-58) This Act is effective March 18, 2020 to apply retroactively.

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

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes (but is not limited to) removal of tattoos, breast augmentation, or other medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

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

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

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

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

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

Deductible: The amount of eligible medical, prescription drug and dental expenses you are responsible for paying before the plan begins to pay benefits. The deductibles are discussed in the *Medical Expense Coverage* section of this document. The dental deductibles are discussed in the separate *Dental Master Plan Document*.

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

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

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

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN
- child under age 19 years for whom you have legal guardianship under a court order, or
- Over age of 26 years if the adult child is deemed permanently disabled, has maintained continuous medical coverage, is incapable of self-sustaining employment and depends chiefly on the participant or the participant's spouse or domestic partner for support and maintenance, and claimed on the participant's previous year's tax return as a dependent. (NAC 287.312)

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

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

Drug: See the definition for Prescription Drug.

Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient's home. Durable Medical Equipment includes (but is not limited to) apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Elective Hospital Admission, Service or Procedure: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that they are medically necessary; and the charges for them are usual and customary; and coverage for the services or supplies is not excluded (as provided in the *Benefit Limitations and Exclusions* section); and the Plan year maximum benefits for those services or supplies has not been reached.

Emergency: See Medical Emergency.

Emergency Care: Medical and health services provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

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

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

Enteral Formulas for Inherited Metabolic Disease: Enteral Formulas for use at home that are prescribed or ordered by a physician as medically necessary treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth of amino acid, organic acid, carbohydrate, or fat. For the purposes of this section only, Enteral Formulas including, without limitation a formula that is ingested orally.

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

Experimental and/or Investigational Services: *NRS 695G.173* Required provision concerning coverage for treatment received as part of clinical trial or study.
Unless mandated by law, the Plan Administrator or its designee has the discretion and authority to determine if a service or supply is, or should be, classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources

available at the time the service was performed or the supply was provided, or the service or supply was considered for prior authorization under the Plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply.
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
- In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
- With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered experimental and/or investigational if it is:
- Approved by the FDA as an "investigational new drug for treatment use"; or
- Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease," as that term is defined in FDA regulations; or
- Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
- The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

In determining if a service or supply is or should be classified as experimental and/or investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for Prior authorization under the Plan's utilization management program:

- Medical records of the covered person.
- The consent document signed, or required to be signed, to receive the prescribed service or supply.
- Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply.

- Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including (but not limited to) "United States Pharmacopoeia Dispensing Information"; and "American Hospital Formulary Service".
- The published opinions of the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
- Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
- The latest edition of "The Medicare Coverage Issues Manual."
- Nevada Statutes mandate the following criteria be met in cases of Cancer and Chronic Fatigue Syndrome:

1. A policy of health insurance must provide coverage for medical treatment in a clinical study or trial if:
   a. Treatment is for either Phase I, II, III, IV cancer or Phase II, III, IV Chronic Fatigue Syndrome.
   b. Study is approved by:
      i. Agency of National Institute of Health.
      ii. A cooperative group (see bill for exact definition).
      iii. FDA for new investigational drug
      iv. US Dept. of Veteran Affairs.
      v. US Dept. of Defense.
   c. Health care provider and facility have authority to provide the care for Phase I cancer.
   d. Health care provider and facility have experience to provide the care for Phase II, III, IV cancer or chronic fatigue syndrome.
   e. No other treatment considered a more appropriate alternative.
   f. Reasonable expectation based on clinical data that treatment will be at least as effective as other treatments.
   g. Study is conducted in Nevada.
   h. Participant signs a statement of consent that he has been informed of:
      i. The procedure to be undertaken.
      ii. Alternative methods of treatment.
      iii. Associated risks of treatment.
2. Coverage for medical treatment is limited to:
   a. A drug or device approved for sale by the FDA.
   b. Reasonably necessary required services provided in treatment or as a result of complications to the extent that they would have otherwise been covered for Phase II, III, IV cancer or chronic fatigue syndrome.
   c. The cost of any routine health care services that otherwise would have been covered for an insured for Phase I cancer.
   d. Initial consultation; and
   e. Clinically appropriate monitoring.
3. Treatment is not required to be covered if provided free by sponsor.

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

NOTE: To determine how to obtain a precertification (prior authorization) of any procedure that might be deemed to be experimental and/or investigational, see the *Precertification (Prior Authorization) Process* section of the *Utilization Management* section.

Explanation of Benefits (EOB): When a claim is processed by the Claims Administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, if your out-of-pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

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

Expedited Appeal: If a participant appeals a decision regarding a denied request for precertification (pre-service claim) for an urgent care claim, the participant or participant's authorized representative can request an expedited appeal, either orally or in writing. Decisions regarding an expedited appeal are generally made within 72 hours from the Plan's receipt of the request.

External Review: An independent review of an adverse benefit determination conducted by an external review organization.

External Review Organization: An organization that 1) conducts an external review of a final Adverse Benefit Determination; and 2) is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.

Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Formulary: A list of generic and brand name drug products available for use by participants.

Free-Standing Laboratory Facility: Free-standing laboratory facilities are stand-along facilities that are not affiliated with a hospital system. Examples of preferred free-standing laboratory facilities include Labor Corp or Quest.

Gender Dysphoria/Gender Identity Disorder/Transsexualism/Gender Nonconforming: Gender Dysphoria is a condition in which the person has the desire to live as a member of the opposite sex and progressively take steps to live in the opposite sex role full-time.

Generic; Generic Drug: A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the Pharmacist as being generic.

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

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

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

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

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, Master's prepared audiologist, optometrist, optician for vision plan benefits, oriental medicine doctor for acupuncture or Christian Science practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care services under

the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

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

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency (as those terms are defined in this section).

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

- It is approved by Medicare; or
- It is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
    - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or registered nurse (RN) to the home.
    - It has a full-time administrator.
    - It is run according to rules established by a group of professional health care providers including physicians and registered nurses (RNs).
    - It maintains written clinical records of services provided to all patients.
    - Its staff includes at least one (1) registered nurse (RN), or it has nursing care by a registered nurse (RN) available.
    - Its employees are bonded.
    - It maintains malpractice insurance coverage.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." (See also the *Benefit Limitations and Exclusions* section of this document regarding homeopathic treatment and services.) When the services of homeopaths are payable by this Plan (e.g., an office visit), the homeopath must be properly licensed to practice Homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post-graduate courses or training in a program approved by the American Institute of Homeopathy.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a life expectancy of six (6) months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family. The agency must meet one of the following tests:

- It is approved by Medicare; or is licensed as a hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
    - It provides 24 hour-a-day, 7 day-a-week service.
    - It is under the direct supervision of a duly qualified physician.
    - It has a full-time administrator.
    - It has a nurse coordinator who is a registered nurse (RN) with four (4) years of full-time clinical experience. Two (2) of these years must involve caring for terminally ill patients.
    - The main purpose of the agency is to provide hospice services.
    - It maintains written records of services provided to the patient.
    - It maintains malpractice insurance coverage.
    - A hospice that is part of a hospital will be considered a hospice for the purposes of this Plan.

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

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

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

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician, and as compared to the person's previous condition. Pregnancy of

a covered employee or covered spouse will be considered an illness only for coverage under this Plan. However, infertility is not an illness for the purpose of coverage under this Plan.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates, or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue, or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an Inherited Metabolic Disorder under this Plan.

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

Injury to Sound and Natural Teeth (ISNT): An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to Sound and Natural Teeth are payable under the medical plan (see also the definition of Sound and Natural Teeth).

In-Network Provider: Means an in-network provider that the network or one of its rental networks have contracted with to provide health services to covered individuals. An in-network provider has agreed to charge participants a discounted rate. To determine if a provider is an in-network provider log onto www.healthscopebenefits.com and click the "Find a Provider" tab. You may also call the number of the back of your ID card and a customer service representative can locate an in-network provider for you.

In-Network Services: Services provided by a health care provider that is a member of the Plan's Exclusive Provider Organization (EPO), as distinguished from out-of-network services that are provided by a health care provider that is not a member of the EPO network.

In-Network Contracted Rate: The negotiated amount determined by the EPO network to be the maximum amount charged by the EPO provider for a covered service. In some cases, the in-network contracted amount may be applied to out-of-network provider charges.

Inpatient Services: Services provided in a hospital or other health care facility during the period when charges are made for room and board.

Intensive Care Unit: A section, ward, or wing within the hospital which:

- Is separated from other hospital facilities.
- Is operated exclusively for providing professional care and treatment for critically ill patients.
- Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use.
- Provides room and board; and
- Provides constant observation and care by registered nurses or other specially trained hospital personnel.

Intensive Outpatient Program: An intensive outpatient program (IOP) is a kind of treatment service and support program used primarily to treat eating disorders, depression, self-harm, and chemical dependency that does not rely on detoxification. IOP operates on a small scale and does not require the intensive residential or partial day services typically offered by the larger, more comprehensive treatment facilities.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance Rehabilitation: Refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. Maintenance rehabilitation is not covered by the Plan.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are costlier than others that can achieve the same result.

Maximum Amount; Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by PEBP considering and after having analyzed:

- The reasonable and appropriate amount.
- The terms of the Plan.
- Plan negotiated and contractual rates with provider(s).
- The actual billed charges for the covered services; and
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with a service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s).

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

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

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

- Is provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- Is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American Medical and Dental standards; and
- Is determined by the Plan Administrator or its designee to meet all the following requirements:
    - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
    - It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider or health care facility; and
    - It is an appropriate service or supply given the patient's circumstances and condition; and
    - It is a cost-efficient supply or level of service that can be safely provided to the patient; and
    - It is safe and effective for the illness or injury for which it is used. A medical or dental service or supply is 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 not costlier than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be considered 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 considered 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 to be medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

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

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Part A: Hospital insurance provided by the Federal Government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the Federal Government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the Federal Government but is offered only by private companies contracted with Medicare such as HMOs and EPOs/PPOs.

Medi-Span: A national drug pricing information database for drug pricing analysis and comparison.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a Midwife or certified as a Certified Nurse Midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

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

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

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

Non-Network: See Out-of-Network.

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

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

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

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

Occupational Therapist: A person legally licensed as a professional Occupational Therapist who acts within the scope of their license and acts under the direction of a Physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills to regain independence.

Office Visit: A direct personal contact between a Physician or other health care practitioner and a patient in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a Physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is an office visit for the purposes of this Plan.

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as prognathism, retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Orthotic (Appliance or Device): A type of corrective appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including (but not limited to) crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical plan, this definition does not include dental orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or device).

Other Prescription Drugs: Drugs that require a prescription under state law but not under federal law.

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

Out-of-Pocket Maximum: The maximum amount of coinsurance each covered person or family is responsible for paying during a Plan year before the coinsurance required by the Plan ceases to apply. When the out-of-pocket maximum is reached, the Plan will pay 100% of eligible covered expenses for the remainder of the Plan year. See the section on out-of-pocket maximum in the *Medical Expense Coverage* section for details about what expenses do not count toward the out-of-pocket maximum.

Outpatient Hospital Laboratory and Outpatient Hospital-Based Laboratory Draw Station: Outpatient hospital-based laboratory facilities include lab services performed in a hospital outpatient setting. Outpatient hospital-based laboratory draw stations are hospital affiliated whereby the draw station collects specimens and sends them to the central hospital for processing.

Outpatient Services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Partial Hospitalization Service: Also known as PHP, a type of program used to treat mental illness and substance abuse in which the patient continues to reside at home, but commutes to a treatment center up to seven (7) days a week. This service model focuses on the overall

treatment of the individual and is intended to avert or reduce in-patient hospitalization. Services are typically provided in either a hospital setting or by a free-standing community mental health center. Treatment during a typical day may include group therapy, psych-educational groups, skill building, individual therapy, and psychopharmacological assessments, and check-ins. Programs are available for the treatment of alcoholism and substance abuse, Alzheimer's disease, anorexia and bulimia, depression, bipolar disorder, anxiety disorders, schizophrenia, and other mental illnesses.

Participant: The employee, retiree, enrolled spouse or domestic partner, dependent child(ren), or a surviving spouse or dependent of a retiree. NAC 287.095

Participating Provider: A health care provider who participates in the Plan's Exclusive Provider Organization (EPO).

Passive Rehabilitation: Refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for Passive Rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until the patient can achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be considered medically necessary for the purposes of this Plan.

Pharmacy: A licensed establishment where covered prescription drugs are filled and dispensed by a Pharmacist licensed under the laws of the state where he or she practices.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery, or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician Assistant (PA): A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a Plan of patient care; prescribe and

dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; under the laws of the state or jurisdiction where the services are rendered.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this Plan and as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan year if necessary. PEBP has the authority to revise the benefits and rates if necessary, each Plan year. For medical, dental, vision and pharmacy benefits, all deductibles, out-of-pocket maximums, and Plan year maximum benefits are determined based on the Plan year.

Plan Year Deductible: The amount you must pay each Plan year before the Plan pays benefits.

Plan Year Maximum Benefits: The maximum amount of benefits payable each Plan year for certain medical expenses incurred by any covered Plan participant (or covered family member of the Plan participant).

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

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

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis, seven (7) days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury.

Prescribed for a Medically Necessary Indication: The term medically accepted indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

Prescription Drugs: For the purposes of this Plan, prescription drugs include:

1. Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug, and Cosmetic Act requires to be labeled, "Caution—Federal law prohibits dispensing without prescription".

2. Other Prescription Drugs: drugs that require a prescription under state law but not under federal law; or
3. Compound Drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prior Authorization: (pre-certification) is a review procedure performed by the UM company before services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and medically necessary.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: Means the Public Employees' Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

Prophylactic Surgery: A surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth are performed by a dentist or dental hygienist.

Prospective Payment System (PPS): This Plan follows CMS's Prospective Payment System (PPS) where the Plan's payment is based on a predetermined, fixed amount payable to a facility for inpatient or outpatient hospital services. The Plan will not allow separate reimbursement for specific HCPCS supplies, DME, orthotics, prosthetics, biological, and drugs billed on a HCFSA claim form by any physician or other qualified healthcare professional in the following facility POS (place of service) 19, 21, 22, 23, and 24, see the following POS descriptions:

- **POS 19 Off Campus – Outpatient Hospital:** A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **POS 21 Inpatient Hospital:** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

- **POS 22 On Campus – Outpatient Hospital:** A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision physicians to patients admitted for a variety of medical conditions.
- **POS 23 Emergency Room – Hospital:** A portion of a hospital where emergency diagnosis and treatment of illness and injury is provided.
- **POS 24 Ambulatory Surgery Center:** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis

Prosthetic Appliance (or Device): A type of corrective appliance or device designed to replace all or part of a missing body part, including (but not limited to) artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

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

Qualified Individual: A covered individual who is eligible, according to clinical trial protocol, to participate in an approved clinical trial and either: (i) the referring health care professional is an in-network provider and has concluded that the covered individual's participation in the clinical trial would be appropriate; or (ii) the covered individual provided medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

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

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

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

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

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

PEBP's determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and Organizations; (b) The Centers for Medicare and Medicaid Services (CMS); (c) Centers for Disease Control and Prevention; and (d) The Food and Drug Administration.

To be Reasonable, charges must follow generally accepted billing practices for unbundling or multiple procedures. PEBP retains discretionary authority to determine whether a charge is Reasonable. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charges that are not reasonable and therefore not eligible for payment by the Plan.

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease, or tumor, or for breast reconstruction following a total or partial mastectomy.

Reference Based Pricing/Reference Price: The maximum amount the Plan will pay for a specific covered healthcare service as determined by the Plan Administrator.

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

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

Rescission: A cancellation or discontinuance of coverage under the Plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the Plan if (a) The cancellation or discontinuance of coverage has only a prospective effect; or (b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or (c) Fraud.

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

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

Retrospective Review: Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges.

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

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

Sickle Cell Disease: An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable. (AB254 Effective October 1, 2019).

Significantly Inferior Coverage: The PEBP Board has defined Significantly Inferior Coverage as either:

1. A mini-med or other limited benefit plan; or
2. A catastrophic coverage plan with a deductible equal to or greater than $5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement.

Skilled Nursing Care: Services performed by a licensed Nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a Nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a Nurse. Examples of skilled nursing care services include but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility or Extended Care/Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, sick people or people with disabilities, and that meets all the following requirements:

- Is licensed pursuant to state and local laws.
- Is operated primarily for providing skilled nursing care and treatment for individuals convalescing from injury or illness.
- Is approved by and is a participating facility with Medicare.
- Has organized facilities for medical treatment.

- Provides 24-hour-a-day nursing service under the full-time supervision of a Physician or Registered Nurse.
- Maintains daily clinical records on each patient.
- Has available the services of a physician under an established agreement.
- Provides appropriate methods for dispensing and administering drugs and medicines.
- Has transfer arrangements with one or more hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one physician; and
- Is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.

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

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

Special Food Product: [NRS 689B.0353] A Special Food product means a food that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. Special Food Products to not include a food that is naturally low in protein or foods or formulas for persons who do not have an inherited metabolic disease as that term is defined in this document. This term does not include a food that is naturally low in protein.

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

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to restore normal speech or to correct dysphagic or swallowing defects and disorders lost due to illness, injury, or surgical procedure. Speech Therapy for functional purposes, including (but not limited to) a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays/disorders are excluded from coverage.

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

Spouse: The employee's lawful spouse (opposite sex or same sex) as determined by the laws of the State of Nevada**.** The Plan will require proof of the legal marital relationship. A legally

separated spouse or divorced former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

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

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

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

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of behavioral health disorders and chemical dependency.

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

Multiple Surgical Procedure Allowances:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: Usual and Customary Charge or negotiated fee.
- Secondary procedure in same operative area: limited to 50% of Usual and Customary Charge or negotiated fee.
- Bilateral secondary procedure in same operative area: limited to 50% of Usual and Customary Charge or negotiated fee.

- Add-on to secondary procedure in same operative area: limited to 100% of Usual and Customary Charge or negotiated fee.
- Separate (incidental) procedure in same operative area as any of the above: not covered.
- Separate operative area: limited to 50% of Usual and Customary Charge or negotiated fee.

Temporomandibular Joint (TMJ), Temporomandibular Joint, Dysfunction or Syndrome: The Temporomandibular (or craniomandibular) Joint connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

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

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. (See the *Schedule of Medical Benefits* and the *Benefit Limitations and Exclusions* section for additional information regarding transplants. See also the *Utilization Management* section of this document for information about precertification requirements for Transplantation services).

Xerographic: Refers to transplants of organs, tissues, or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xerographic transplants are not covered by this Plan, except heart valves.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate, even though health and life are not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include (but are not limited to) fever, sprains, bone, or joint injuries, continuing diarrhea, or vomiting, or bladder infections.

Urgent Care Claim: Means a claim for benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not Urgent Care Claims could seriously jeopardize the participant's life, health, or the ability to regain maximum function by waiting for a routine appeal decision. An Urgent Care Claim also means a claim for benefits

that, in the opinion of a Physician with knowledge of the participant's medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for precertification of an Urgent Care service was denied, the participant could request an expedited appeal for the Urgent Care Claim.

Urgent Care Facility: A public or private hospital-based or free-standing facility, that includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance when the facility is open.

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

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

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

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

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

Utilization Management (UM): A managed care process to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur

before, during or after the services are rendered and may include (but is not limited to): precertification and/or preauthorization; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM, utilization review services, UR services, utilization management, concurrent review, or retro review services) are provided by licensed health care professionals employed by the UM company operating under a contract with the Plan.

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

Visit: See the definition of office visit.

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

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