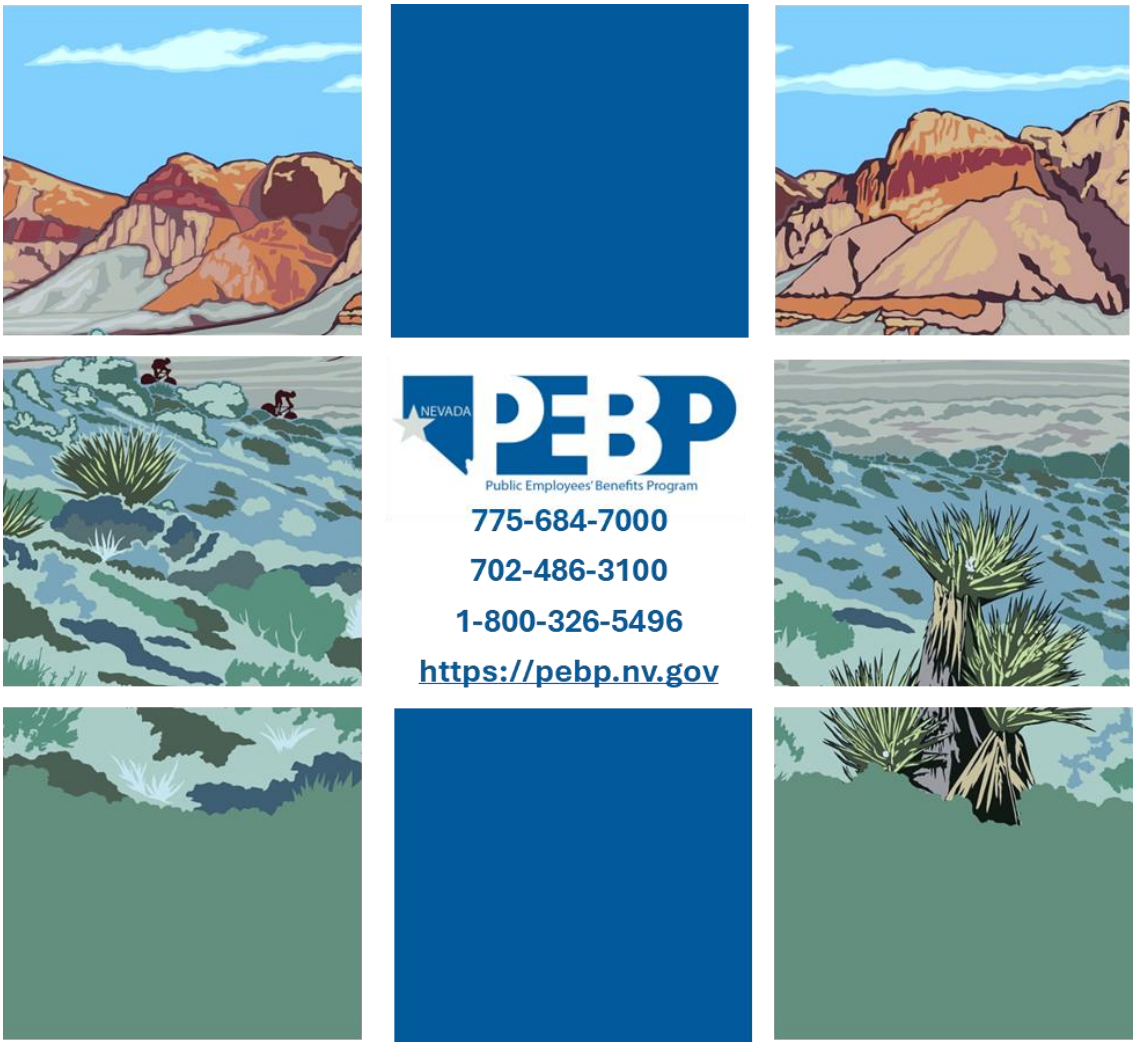
CONSUMER DRIVEN HEALTH PLAN

MASTER PLAN DOCUMENT

PLAN YEAR 2026

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



Public Employees' Benefits Program
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Contents

Amendment Log

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

1. April 28, 2025 – Amended the In-Network Out-of-Pocket Maximums on pages 10 and 11 from $8,300 to $4,000 for an individual, from $16,600 to $8,000 for a family, and from $8,300 to $6,850 for an individual family member; to reflect no changes made to the In-Network Out-of-Pocket Maximums for Plan Year 2026.
2. May 5, 2025 – Added HSA Contribution Limits on page 26 to $4,300 for an individual and $8,550 for a family.
3. May 16, 2025 – 1) Expanded, for clarification, HSA and HRA sections on pages 24 through 28. 2) Clarified gender dysphoria section to indicate that there are no parameters around age and that medical necessity is required on page 36. 3) Clarified vision therapy exclusions on page 99. 4) Corrected Doctor on Demand and Telehealth on page 62. 5) Clarified mammogram coverage for both men and women on page 77. 6) Clarified eligible medical expenses on page 20.
4. July 8, 2025 – 1) Added nutritional counseling to behavioral health services for eating disorders on pages 46-47. 2) Added, for clarification, Prediabetes/Type 2 Diabetes Screening and behavioral interventions under preventative services on page 76. 3) Added dollar limit for wigs on page 48.
5. September 30, 2025 - 1) Added prior authorization requirement for ketamine on page 38 and for circumcision for infants eight weeks and older on page 37, 2) clarified how condoms are covered on page 50, 3) clarified prior authorization requirement for hospice exceeding 6 months on pages 36 and 52, 4) added the plan adheres to NRS 695G.1714 regarding maternity services on page 55, 5) updated vision therapy coverage on page 65, 6) added genetic counseling provider information on page 71, 7) added provider information to Obesity Management Program on page 79, and 8) clarified that clarified that the Obesity Management Care Program does not cover preferred brand on page 77.

   Moved medications requiring prior authorization from Schedule of Prescription Drug Benefits to prior authorization section on pages 38.

   Added Schedule of Pharmacy Benefits Section back on page 80, and Participant Contact Guide on page 114.

6. January 1, 2026 – 1) Clarified language regarding claims processing on page 98, 2) corrected grammar for HSA on page 23, and 3) added *outpatient services with an observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement under this Plan* on page 33 for clarification.

Overview

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

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

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

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

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

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

Introduction

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

This Master Plan Document describes the Consumer Driven Health Plan (CDHP). The CDHP Plan offers In-Network and Out-of-Network benefits and is a self-funded plan. This plan offers medical, behavioral health, prescription drug, and vision benefits. Additional benefits include basic life insurance for active employees and eligible retirees. This document outlines medical, behavioral health, prescription drug and vision benefits.

The CDHP provides a Health Savings Account (HSA) for eligible employees or a Health Reimbursement Arrangement (HRA) for eligible retirees and active employees who are ineligible for the HSA.

The Plan and this document are intended to comply with Chapter 287 of the Nevada Revised Statutes (NRS), Chapter 287 of the Nevada Administrative Code (NAC), and all other applicable provisions of Nevada law. Additionally, PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which is a federal regulation affecting portability of coverage; electronic transmission of claims and other health information; and privacy and confidentiality of health information.

The Plan described in this document is effective **July 1, 2025**, and unless stated differently, replaces other CDHP medical and prescription drug benefit plan documents/summary plan descriptions previously provided to participants.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason.

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

Participant Rights

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

CDHP Components

The CDHP is a PEBP administered Preferred Provider Organization (PPO) High-Deductible Health Plan which provides In-Network and Out-of-Network benefits. As a member, participants receive coverage for many medically necessary services and supplies. This is an open-access PPO Plan and does not require a referral to see a specialist.

The Plan includes:

- Coverage statewide.
- Coverage nationwide.
- Coverage worldwide for those residing or traveling outside of the United States.
- In- and Out-of-Network benefits.
- Preventive Care/Wellness Services
- Health care resources and tools. For more information log in to the E-PEBP member portal account at https://pebp.nv.gov/.

The CDHP is coupled with either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA).

Plan Year Deductibles and Out-of-Pocket Maximums

	In-Network Deductible	In-Network Out-of-Pocket Maximum	Out-of-Network Deductible	Out-of-Network Out-of-Pocket Maximum
Individual (self-only coverage)	$1,650	$4,000	$1,650	$10,600
Family	$3,300	$8,000 Individual family member: $6,850	$3,300	$21,200

In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums are not interchangeable.

The Deductibles and Out-of-Pocket Maximums accumulate separately for In-Network and Out-of-Network provider expenses. See Family Deductible explanation below.

Deductibles

A deductible is an amount a participant may owe during a coverage period (usually one year) for covered health care services before the Plan begins to pay. An overall deductible applies to all or almost all covered items and services. In this Plan, there are both an individual deductible, a family deductible, and out of pocket maximums for both individual and family. Deductibles and out-of-pocket maximums apply to both in-network and out-of-network providers.

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

- **Individual Deductible**: Applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible**: Applies when two or more individuals are covered on the same Plan (e.g., Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductible may be met through a combination of *Eligible Medical Expenses* from covered family members.

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

Participants are responsible for paying Out-of-Pocket for eligible medical and prescription drug expenses that are subject to the Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for In-Network provider expenses and Out-of-Network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

In-Network Individual Deductible

The In-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible is **$1,650**.

Out-of-Network Individual Deductible

The Out-of-Network Individual Deductible applies when only one person is covered on the Plan. For this Plan Year, the Deductible for Eligible Medical Expenses received Out-of-Network is **$1,650**.

In-Network Family Deductible

The In-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **$3,300**. For a participant covered with one or more dependents, this Plan will pay benefits for eligible In-Network medical and prescription drug expenses for the entire family after the **$3,300** Family Deductible is met.

Out-of-Network Family Deductible

The Out-of-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is **$3,300**. For a participant covered with one or more dependents, this Plan will pay benefits for eligible Out-of-Network medical and vision (prescription drugs are not covered Out-of-Network) expenses for the entire family after the **$3,300** Family Deductible is met. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Coinsurance

Coinsurance is the participants share of the cost of a covered service.

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

Out-of-Network

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

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

Copayment, Copay

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

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

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

Cost-Share or Cost Sharing

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

Out-of-Pocket Maximums (OOPM)

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

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

Only Allowable medical expenses that are subject to cost-sharing (Deductible, Copayments, and Coinsurance) will apply to the OOPM. The OOPM does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges, preauthorization penalties, amounts exceeding the Plan's allowable charge for hip and knee

replacement and amounts billed by Out-of-Network providers that are payable and are greater than this Plan's Maximum Allowable Charge. This list is not all-inclusive and may not include certain services and supplies that are not listed here.

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

The accumulation of Eligible Medical Expenses toward the OOPM is based on the date the medical expense is received by the plan and not on the date of services.
The Family OOP Maximum (for Out-of-Network services only) can be met by one person or by a combination of Out-of-Pocket Eligible Medical Expenses from covered family members.
In- and Out-of-Network Maximums are not interchangeable and cannot be combined to reach the Plan Year OOP

In-Network Out-of-Pocket Maximums

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

- An Individual (covered as self-only) is **$4,000**
- Family coverage (participant plus one or more covered dependents) is **$8,000**
    - The Family OOP Maximum includes a **$6,850** embedded "Individual Family Member" OOP Maximum. An Individual Family Member OOP Maximum means one single family member will not pay more than **$6,850** in the Plan Year for Eligible Medical Expenses.

Out-of-Network Out-of-Pocket Maximum

The Out-of-Network Out-of-Pocket Maximum (OOPM) is the maximum amount participants will pay for Eligible Medical Expenses (excluding prescription drugs) during the Plan Year.

- Individual (covered as self-only) is **$10,600**.
- Family coverage (participant plus one or more covered dependents) is **$21,200**. (The Family coverage tier does not include an embedded Individual Family Member OOP Maximum.)

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

Medically Necessary

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

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

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

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

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

Usual and Customary

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

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

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

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

Reasonable

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

- The facts and circumstances give rise to the need for the service or supply.
- Industry standards and practices as they are related to similar scenarios; and
- The cause of the injury or illness is necessitating the service or charge.

The Plan Administrator’s determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities:

(a) The National Medical Associations, Societies, and Organizations.
(b) The Centers for Medicare and Medicaid Services (CMS).
(c) Centers for Disease Control and Prevention; and
(d) The Food and Drug Administration.

Provider of Health Care

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

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

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

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

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

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

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

Provider Types

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

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

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

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

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

Pursuant to NRS 695G.164, if a member is receiving medical treatment from a provider whose In-Network status changes during the course of treatment, the member may continue to receive treatment with that provider at In-Network rates under certain circumstances. The TPA shall evaluate on a case-by-case basis.

In-Network Provider Benefits

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

Out-of-Network Provider Benefits

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

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

Other Providers

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

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

Out-of-Network Benefit Exceptions

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

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

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

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

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

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

Directories of Network Providers

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

A list of In-Network providers is available to participants without charge by contacting the TPA. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

The online provider directory updates are made seven (7) days a week. The list of PPO providers is maintained and updated by the contracted network based on information supplied by Providers.

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

Eligible Medical Expenses

Eligible Medical Expenses are limited to those that 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 do not exceed this Plan's Maximum Allowable Charge.
- Not services or supplies that are excluded from coverage (as provided in the Exclusions section).
- Charges for services or supplies that do not exceed the limited overall or Plan Year maximum benefits as shown in the Schedule of Medical Benefits.

Generally, the Plan will not reimburse for all Eligible Medical Expenses. Participants are responsible for cost-sharing such as deductibles, copays, and coinsurance. Once the Out-of-Pocket maximum is reached, not further cost-sharing will apply.

There are also maximum benefits applicable to each participant.

The above is not all inclusive. For more information regarding Eligible Medical Expenses, see the Schedule of Medical Benefits.

Non-Eligible Medical Expenses

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

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

- Not determined to be medically necessary (unless otherwise stated in this Plan).
- Determined to exceed this Plan's Maximum Allowable Charge.
- Expenses for medical services or supplies that are not covered by the Plan, including, but not limited to, expenses that exceed the PPO provider contract rate, services listed in the *Exclusions* section of this document and dental expenses.
- Benefits exceeding those services or supplies subject to limited overall maximums for each covered individual for certain *Eligible Medical Expenses*.
- Additional amounts participants are required to pay because of a penalty for failure to comply with the Plan's utilization management requirements described in the *Utilization Management* section of this document. If participants fail to follow certain requirements of the Plan's utilization management program, the Plan may pay a smaller percentage of the cost of those services, and participants may have to pay a greater percentage of those costs. The additional amount participants may have to pay is in addition to their Deductibles or Out-of-Pocket Maximums described in the tables.
- *Preventive Care/Wellness Services* that are paid by the Plan at 100% do not accumulate towards the Out-of-Pocket Maximum.

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

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

With exception of services subject to the No Surprises Act, Out-of-Network providers may bill the participant their standard charges and any balance that may be due after the Plan payment. It is the participant's responsibility to verify the In-Network status of a chosen provider.

NOTE: In accordance with NRS 695G.164, a provider who leaves the network may be reimbursed as an in-network provider until the 120th day after the contract is terminated or if the medical condition is pregnancy, the 90th day after:

- The date of delivery; or
- If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Out-of-Country Medical, Prescription and Vision Purchases

This Plan provides coverage worldwide. Whether participants travel to a foreign country or live outside of the United States permanently or on a part-time basis, they are eligible for reimbursement of the cost of medical, prescription, and vision services.

Typically, providers in foreign countries do not accept payment directly from the Plan. Participants may be required to pay for medical and vision care services and submit receipts to the TYPA for possible reimbursement. Medical and vision services received outside of the United States are subject to Plan provisions, coverage, limitations, exclusions, clinical review if necessary, and determination of medical necessity. The review may include application of pertinent Food and Drug Administration (FDA), and federal government agency responsible for the approval of prescription drugs and other medical services, regulations Out-of-country medication purchases are only eligible for reimbursement while traveling outside of the United States.

The TPA may require a written notice explaining why the medical services from an out of country provider were provided outside of the United States. This provision applies to elective and emergency services.

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

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

The Plan administrator and the TPA reserve the right to request additional information. If the provider will accept payment directly from the TPA, there may be additional documents required.

Once payment is made, 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 participants or to the out-of-country provider if all requirements of these provisions are not satisfied.

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

This Plan may provide benefits for the purposes of emergency medical transportation only. For more information, contact this Plan's third-party claims administrator.

High-Deductible Health Plan (HDHP)

A HDHP is a health plan that combines a Health Saving Account (HSA) or a Health Reimbursement Arrangement (HRA) to help offset health care costs. The CDHP is an IRS qualified HDHP meaning it complies with federal requirements regarding Deductibles, Out-of-Pocket Maximums, and certain other features.

An HSA and an HRA are structured differently, specifically regarding ownership. An employee owns an HSA while an employer owns an HRA. Employees contribute to their HSA and never forfeit their funds. Employers contribute to an HRA, and funds are forfeited upon termination of the HRA for any reason.

Participants are required to have either an HSA or an HRA while on the CDHP. A selection must be made at enrollment. Participants may change their selection during open enrollment. Important notes:

- Participants who want to switch from an HRA to an HSA during open enrollment for the upcoming plan year will lose any remaining funds in their HRA. Any remaining funds in the HRA revert to PEBP.
- A participant may establish their own HSA even if they select an HRA. What's important is that the employer will only contribute to one, either an HSA or an HRA.

Health Savings Account (HSA) (Active Employees Only)

HSAs are employee-owned accounts, meaning the funds in the HSA remain with the employee and carry over from one year to the next (i.e., will not be forfeited unless there is no account activity for a 3-year period then the funds will be considered abandoned per NRS 120A.500.1(f) and subject to forfeiture by the State). Contributions to the HSA grow tax free and are portable. When an employee retires or terminates employment, the employee retains the funds in the HSA. The employee can continue to use the funds in the HSA for health care and other qualified medical expenses after employment ends until the funds are depleted.

There are limits on the amount participants can contribute to an HSA based on the employee's coverage tier. For example, "self-only" or "Family" coverage.

- Self-only coverage means an eligible individual (employee).
- Family coverage means an eligible employee covering at least one dependent (whether that dependent is an eligible individual (for example, if the dependent has Medicare) if that other person is claimed on the participant's tax return and not claimed as a tax dependent on someone else's return.

Participants must be eligible employees to qualify for an HSA. Employees may not establish or contribute to a Health Savings Account if any of the following apply:

- The employee is covered under other medical insurance coverage unless that medical insurance coverage: (1) is also a High-Deductible Health Plan as defined by the IRS; (2) covers a specific disease state (such as cancer insurance); or (3) only reimburses expenses after the Deductible is met.

- The employee is enrolled in Medicare.
- The employee is enrolled in Tricare.
- The employee is enrolled in Tribal coverage.
- The employee can be claimed as a dependent on someone else's tax return unless the employee is Married Filing Jointly.
- The employee or the employee's spouse has a Medical Flexible Spending Account (excludes Dependent Care or Limited Use Flexible Spending Accounts) that can reimburse the employee's medical expenses.
- The employee's spouse has an HRA that can be used to pay for the medical expenses of the employee.
- The employee is on COBRA; or
- The employee is retired.

If a participant loses eligibility to contribute to a Health Savings Account (HSA) for any reason, the participant is no longer eligible to contribute to an HSA, and PEBP contributions on the participants' behalf will discontinue. The participant retains all funds in their HSA at the time they lose eligibility.

Participants who wish to establish or contribute to an HSA should contact the HSA third-party claims administrator regarding eligibility requirements, consult with a tax professional or read the provisions described in IRS Publication 969.

Current CDHP participants who are eligible for the HSA will receive PEBP contributions during the first month of the new Plan Year. New hires receive a prorated contribution based on the effective coverage dates and the number of months remaining in the Plan Year. HSA funds may not be used for a person who does not meet the IRS definition of dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether the dependent is covered under this Plan. In general, HSA funds may not be used to pay premiums. There are certain exceptions for retirees or former employees enrolled in a Plan offered under COBRA provisions.

HSA funds may only be used to pay, or reimburse expenses incurred after the HSA is established and can only be reimbursed if there are available HSA funds in the account.

HSA Bank, a division of Webster Bank, N.A., is the third-party claims administrator and custodian for HSA. PEBP does not (i) endorse HSA Bank, a division of Webster Bank, N.A. as an HSA provider; (ii) limit an employee's ability to move funds to other HSA providers, (iii) impose conditions on how HSA funds are spent, (iv) make or influence investment decisions regarding HSA funds, or (v) receive any payment or compensation in connection with an HSA. PEBP HSA contributions and employee voluntary pre-tax payroll deductions will only be deposited to an HSA at HSA Bank, a division of Webster Bank, N.A. Employees may choose to establish an HSA with any HSA trustee or custodian and may transfer funds deposited into HSA Bank, a division of Webster Bank, N.A. account to another HSA account held by another trustee or custodian. However, PEBP will not pay any fees associated with any other HSA account including transfer fees.

The IRS requires any person with an HSA to submit form 8889 with their annual income tax return.

Health Savings Account Owner Identity Verification

Section 326 of the USA PATRIOT Act requires financial institutions to verify the identity of each employee who opens a Health Savings Account (HSA). If an employee's identity cannot be verified, the employee will be required to provide additional documentation to establish their identity. If additional verification is not provided within 90 days of the employee's HSA opening date, the HSA will be closed. Failure to comply with the identity verification requirement within the stated timeframe will result in the conversion from an HSA to a Health Reimbursement Arrangement (HRA) for the remainder of the Plan Year. The next opportunity to establish an HSA will be during the Open Enrollment Period for the subsequent Plan Year.

Contributions

Current CDHP participants who are eligible for and receiving the HSA will receive PEBP contributions during the first month of the new Plan Year.

HSA Contributions for Eligible Active Employees

Individual	**Family** (two or more HSA eligible family members)
$700	$200 each, up to three (3)

Participants and dependents who initially become eligible for PEBP coverage after July 1, 2025 will receive a prorated base contribution for the participant and their dependent(s) (up to a maximum of 3 dependents) based upon the coverage effective date and the months remaining in the plan year.

Participants who add a dependent mid plan year because of a qualifying life event may receive prorated HSA dependent contributions based on the effective coverage and the number of months remaining in the Plan Year.

Calendar Year 2025 HSA Contribution Limits

Individual	**Family** (two or more HSA eligible family members)
$4,300	$8,550

Total contributions (combined employee/employer) cannot exceed the **2025 calendar year limit**.

To contribute the family maximum, the employee and at least one tax dependent must be covered on the CDHP Plan. The Family maximum applies regardless of whether two employees are married and enrolled in the CDHP and eligible for the HSA. For example, if one employee is covering an HSA eligible dependent and the other employee is covered as self-only, the maximum for the entire family is $8,550. Employees aged 55 years and older at the end of the tax year may contribute an additional **$1,000** to the HSA.

Health Reimbursement Arrangement (HRA) (Active Employees and Retirees)

An HRA is a PEBP funded reimbursement account. The HRA works as follows:

- PEBP establishes an account for each Eligible Employee enrolled in the Consumer Driven Health Plan (CDHP) with effective coverage on or after July 1, 2025.
- Each Plan Year, PEBP has the discretion to set the HRA funding amount. HRA funding is not guaranteed from one Plan Year to the next Plan Year.
- HRAs are employer-funded accounts.
- Employees do not contribute to the HRA.
- Employees do not forfeit unused HRA dollars while covered under the CDHP.

Each eligible participant will receive an HRA account to keep a record of the amounts available for reimbursement of eligible health care expenses. Funds carry over from year to year as long as the participant is a current employee.

HRA's are available to active employees who are not eligible for an HSA, or who fail to establish an HSA. An HRA is also available to eligible retirees enrolled in the CDHP.

Each Plan Year, PEBP contributions will be available for use through a CDHP HRA account established in the participant's name. Funds in the CDHP HRA account may be used, tax-free, to pay for qualified medical expenses including payment of Deductibles, Coinsurance, and other Out-of-Pocket qualifying healthcare expenses not covered by this Plan. HRA funds may not be used to pay premiums.
Under no circumstances will a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing from the CDHP with an HSA to the CDHP with a HRA or vice versa. Reinstated employees who return to active employment within the same Plan Year and who re-enroll in the HRA shall have their remaining HRA fund balance reinstated. Reinstated employees who re-enroll in the HRA more than one year after termination are not eligible for reinstatement of HRA balance reinstatement.

HRA funds must be used prospectively from the date of funding. This means that reimbursements for medical expenses are only possible for expenses incurred after the HRA is in effect. Reimbursement of expenses incurred before the HRA's effective date or the employee's enrollment date is not permitted.

HRA funds may only be used to pay or reimburse qualifying health care expenses incurred by the participant, the participants spouse, or the participants dependents who can be claimed on their annual tax return. HRA funds may not be used for domestic partners, children of domestic partners, or older dependents who cannot be claimed on the participant's annual tax return, regardless of whether PEBP provides coverage for the dependent.

Examples of qualifying healthcare expenses include, but are not limited to, (a) insulin; (b) prescribed drugs and medications (whether or not the drug or medicine could be purchased without a prescription), (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental

expenses (e) dermatology; (f) physical therapy; and (g) contact lenses or gasses used to correct a vision impairment.
Any funds remaining in the HRA at the end of the Plan Year will carry over (i.e., will not be forfeited) and will be available for use in the following Plan Year. Unlike a Flexible Spending Account (FSA), participants cannot be reimbursed from funds that are not yet available in the HRA. Any reimbursement from the HRA will be the lesser of the available HRA balance or the claim amount paid to the provider.

HRA funds are not portable, meaning PEBP retains ownership of the funds. If a participant terminates their CDHP coverage, the remaining balance in the HRA account will revert to PEBP.

- Participants enrolled in the HRA who change plans during the Open Enrollment period, or a qualifying life event forfeit any remaining funds in their HRA account.
- Retirees who have a CDHP HRA balance and who transition to the Medicare Exchange will forfeit any remaining funds in the HRA on the last day of coverage under the CDHP.
- The death of an active employee or retiree will cause any remaining funds in the HRA to be forfeited on the first day following the date of death.

Note: Special funding of an HRA, if it occurs, remains with the participant and does not revert back to PEBP due to plan change. These funds will revert back to PEBP upon termination of employment or death of an active employee or retiree.

Contributions

Current CDHP participants who are eligible for and receiving the HRA will receive PEBP contributions during the first month of the new Plan Year.

HRA Contributions for Eligible Active Employees and Retirees

Individual	**Family** (two or more HRA eligible family members)
$700	$200 each, up to three (3)

Participants and dependents who initially become eligible for PEBP coverage after July 1, 2025, will receive a prorated base contribution for the participant and their dependent(s) (up to a maximum of 3 dependents) based upon the coverage effective date and the months remaining in the plan year.

Participants who add a dependent mid plan year because of a qualifying life event may receive prorated HRA dependent contributions based on the effective coverage and the number of months remaining in the Plan Year.

Direct deposit is required for HRA reimbursements.

The entire annual PEBP contribution will be available for use at the beginning of the Plan Year, and for new hires, the entire prorated contribution will be available the month after hire. Participants cannot contribute to

CDHP HRA. If the annual funds in the CDHP HRA are exhausted, neither PEBP nor the participant will contribute any additional funds.

Any funds remaining in the CDHP HRA at the end of the Plan Year will carry over (i.e., will not be forfeited) and will be available for use in the following Plan Year.
Active employees who retire and who are not Medicare age (typically at age 65 years) can maintain the balance of their CDHP HRA account at retirement if:

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

In the case of a retroactive coverage termination, any funds used from the CDHP HRA for expenses that are incurred after the date of coverage termination will be recovered by PEBP through the collection process.

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

Timely Filing of HRA Claims

In accordance with NAC 287.610, claim requests must be submitted to the TPA within one year (12 months) from the date of service that the claim is incurred. No plan benefits will be paid for any claim requests submitted after this period.

The one year (12 months) from the date of service that the claim is incurred is also required for participants who lose coverage or pass away.

Mid Plan Year Changes from HSA to HRA, or Vice Versa

Participants may change from an HSA to an HRA, and vice versa, mid plan year because of a qualifying life event, but under no circumstances will a participant who received contributions in either the HSA or HRA be eligible for additional contributions due to mid plan year changes.

Utilization Management

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

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

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

Utilization Management is conducted by an independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professionals, operating under a contract with the Plan to administer the Plan's utilization management services. Utilization management services (sometimes referred to as UM services, UM, utilization review services) include concurrent review, or retro review and case management.

The health care professionals at the UM company focus their review on the medical necessity of hospital stays including medical necessity and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM company has been given discretionary authority by the Plan administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of the Plan.

The UM program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document, PEBP's *Active Employee Health and Welfare Wrap Plan*, and *Retiree Health and Welfare Wrap Plan* documents. For example, benefits would not be payable if eligibility for coverage ended before the services were rendered, or if the services were not covered, either in whole or in part, by an exclusion in the Plan.

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

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

Delivery of Services

Participants are entitled to receive medically necessary medical care and services as specified in this Plan's *Schedule of Benefits*. These include medical, mental health, behavioral health, surgical, diagnostic, therapeutic, and preventive services. These services, although not all-inclusive are those that generally:

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

Concurrent Review

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

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

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

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

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

Retrospective Review

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

The Plan will pay benefits only for those days or treatment that would have been authorized under the utilization management program.

Case Management

Case management in healthcare is a coordinated and individualized approach to the management of a participant's health and social care needs. It is a voluntary process administered by the UM company. Its professionals work with the participant, their family, caregivers, providers, the TPA, and the Plan Administrator or its designee to coordinate a quality, timely and cost-effective treatment program. Case management services are particularly helpful when a participant needs complex, costly and/or high-technology services, or when assistance is needed to guide a participant through a maze of potential providers. Case management is available for sickle cell disease and its variants, see NRS 695G.174, as well as for a disability resulting from a mental health or substance use disorder diagnosis, among other conditions.

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

The case manager will be available at any time to answer questions, make suggestions or offer information.

Centers of Excellence (Voluntary)

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

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

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

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

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

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

Second Opinion

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

The UM company may authorize a second opinion upon request in accordance with this Plan. Examples of instances where a second opinion may be applicable include:

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

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

2nd.MD

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

Non-Emergency Hospital Admission

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

The physician or provider shall notify the UM company a minimum of 5 business days before the hospital admission. The UM company will review the physician/provider's recommendation and treatment plan to determine the level of care and place of service.

If the UM company denies the prior authorization for hospital admission as not covered or determines that the services do not meet the UM company's medical necessity criteria, the Plan's TPA will only pay benefits for inpatient that has been pre-certified, and/or benefits for the elective surgeries and inpatient hospital stays may be reduced by 50% of this Plan's Maximum Allowable Charge. This provision applies to both In-Network and Out-of-Network surgery expenses. Expenses related to the penalty will not be counted to meet the Out-of-Pocket Maximum, if applicable.

Participants are responsible for ensuring prior authorization is obtained.

Emergency and Urgent Hospital Admission

Emergency and Urgent Hospital Admissions include complications of pregnancy.

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

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

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

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

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

No Suprises Act

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

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

Other Exceptions

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

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

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

Due to cost variations for elective knee and hip joint replacement performed in Nevada, the third-party claims administrator has identified exclusive providers who meet the Plan's cost threshold for routine knee and hip replacement procedures. The exclusive provider list can be found on the PEBP website.

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

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

Inpatient or Outpatient Surgery

Participants are responsible for ensuring that the UM company is notified at least 5 (five) business days before elective inpatient or outpatient surgery is performed to ensure that it is covered.

A physician or other provider may notify the UM company, but it is the participants' 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.

Some surgeries may require parental consent or have other requirements for individuals under the age of 18.

Outpatient services with an observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement under this Plan.

Outpatient Infusion Services

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

Air Ambulance Services

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

Air/Flight Schedule Inter-Facility Transfer

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

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

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

Emergency Air Ambulance

This Plan provides coverage for emergency air ambulance transportation for participants whose medical condition at the time of pick-up requires immediate and rapid transport due to 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 *Ambulance* section for details on plan benefits and coverage.

Gender Dysphoria

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

There is no age limit for treatment for gender dysphoria. Surgery and treatment are subject to medical necessity and any additional requirements by physicians and/or facilities.

Reversal surgeries or additional surgeries are subject to medical necessity and any additional requirements by physicians and/or facilities.

Case management services are available for gender dysphoria.

Health Care Services and Supplies Review

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

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

Prior Authorization

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

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

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

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

- Failure to obtain prior authorization may result in benefits being reduced or denied. In some cases, a retroactive prior authorization may be obtained.
- Participants are ultimately responsible for ensuring prior authorization is obtained as necessary.
- Services received after a prior authorization denial are not covered unless overturned on appeal or external review.

Services Requiring Prior Authorization

Inpatient Admissions

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

Outpatient and Physician – Surgery

- Back Surgeries and hardware related to surgery
- Total and remaining Hip and Knee Surgeries
- Biopsies (excluding skin, colonoscopy and upper GI endoscopy biopsy, upper GI endoscopy diagnosis)
- Thyroidectomy, Partial or Complete
- Open Prostatectomy
- Frenectomy
- Oophorectomy, unilateral and bilateral
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Surgeries to treat Gender Dysphoria (Top surgery and bottom surgery)
- Bariatric/weight loss surgeries at Centers of Excellence and adjustments to lap bands after the first 12 months post-surgery
- Sleep apnea related surgeries, limited to:
    - Radiofrequency ablation (Coblation, Somnoplasty)
    - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
- Mastectomy (including gynecomastia and prophylactic) and reconstruction surgery
- Orthognathic procedures (e.g., Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
- Varicose vein surgery/sclerotherapy
- Any procedure deemed to be Experimental and/or Investigational (provider must indicate on the pre-certification request that the service/procedure is Experimental and/or Investigational and/or part of a clinical trial).
- Intraoperative Neuro Monitoring
- Prophylactic surgery
- Circumcisions for infants 8 weeks of age and older.

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

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

Outpatient and Physician – Diagnostic Services

- Advanced high-tech imaging services (for example, CT, PET, SPEC, MRI, etc.)
- Capsule endoscopy
- Genetic testing including:

- BRCA
- Biomarker testing for diagnosis, treatment, case management, and ongoing monitoring of cancer when such biomarker testing is supported by the medical and scientific evidence.
    - Requests for prior authorization for biomarker testing will be responded to within 72 hours after receipt, or within 24 hours if the provider indicates the request is urgent.

Outpatient and Physician – Continuing Care Services

- Applied Behavior Analysis (ABA) Therapy for Medical, Mental Health, and substance use disorder
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Chemotherapy including oral medications
- 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
    - prior authorization is based on overall cost to the plan and/or purchase price, not the amount billed for monthly rental. DME rental to purchase in accordance with Medicare guidelines.
- Non-Emergency Medical Transportation – scheduled air and ground facility to facility and interstate
- Injectables and infusions excluding services reviewed by the PBM
- Intensive Outpatient Programs, including partial hospitalization programs
- Sickle Cell Disease
- Vein Therapy
  Habilitative and rehabilitative therapy (physical, speech, occupational) exceeding a visit limit of 90 visits between the types of therapy per Plan Year.
- Outpatient Treatment for Mental Health and Substance Use Disorders (generally follows an inpatient stay). Visit limits will not apply to medically necessary treatment of mental health or substance use disorder.
- Ketamine administration.
    - Prior authorization is required under both the medical plan and the pharmacy benefit.
    - A treatment plan may be required as a component of the prior authorization process.
    - Available for FDA approved conditions only.
- Hormone replacement therapy medications
- Medications to treat opioid and substance abuse disorders
- Medications to treat sickle cell disease
- Other medications as required by the Pharmacy Benefit Manager

Services Not Requiring Prior Authorization

Prior authorization is not required for emergency services when a medical condition that manifests itself by symptoms of such severity (including severe pain) that a prudent layperson who possesses an average

knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

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

The TPA must be notified of an emergency hospital admission within one business day so the UM company can conduct a *concurrent review*. The physician or the hospital should call the UM company to initiate the concurrent review. Even though prior authorization may not be required for some services, the hospital or facility is still required to comply with the Plan's provisions regarding UM, such as concurrent review.

How to Request Prior Authorization

The physician must contact the UM company to request prior authorization. Calls for elective services should be made at least 15 (calendar) days before the expected date of service or may be subject to the benefit reduction listed in the *Utilization Management* section. The UM company will require the following information:

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

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

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

Participants are responsible for ensuring prior authorization is obtained.

Schedule of Benefits (Medical)

To determine the benefit limitations for any health care service or supply, review the Summary of Benefits listed in this section.

Covered services must be medically necessary and are subject to exclusions and limitations as described herein. Prior authorization is required for many services. Plan benefit limitations apply to certain benefit categories and out-of-network charges are not covered unless otherwise specified in this document.

The *Summary of Benefits* should be read in conjunction with the *Benefit Limitations and Exclusions*. The Explanations and Limitations may not include every limitation. Contact the Utilization Management company for additional information.

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

Benefit Description	In-Network	Out-of-Network
Acupuncture	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible
Explanations and Limitations Acupuncture and Acupressure 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. • Covered if performed by a licensed provider acting within the scope of their license. Where licensing is not required, must be certified by the National Certification Commission for Acupuncturists (NCCA). • Supporting documentation establishing medical necessity will be required after 20 visits in a Plan Year. • Maintenance services are not a covered benefit.		

Benefit Description	In-Network	Out-of-Network
Allergy Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible, or 110% of the Medi-Span Average Wholesale Price (AWP) after Plan Year Deductible
Explanations and Limitations Allergy Services • Covered when performed by a licensed provider acting within the scope of their license. • Allergy services include sensitivity testing (including skin patch or blood tests such as Rast or Mast); Desensitization and hypo-sensitization, allergy antigen solution, and allergy shots.		
Ground Ambulance	Plan pays 80% after Plan Year Deductible	Play pays 80% of Maximum Allowable Charge after Plan Year Deductible
Air Ambulance	Plan pays 80% after Deductible	Plan pays 80%, subject to the No Surprises Act.
Explanations and Limitations Ground and Air Ambulance Services		

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

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

Deductibles, coinsurance, and accrual of the Out-of-Pocket Maximum are the same for In-Network and Out-of-Network providers. However, benefits for Out-of-Network providers are subject to the Plan's Maximum Allowable Charge, which is 140% of the Medicare Allowable rate. Because Out-of-Network providers do not have a contract with this Plan's provider network, they may bill the member for any amount exceeding the benefits paid.

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

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

These amounts are for illustrative purposes only; the difference between what an out-of-network Provider bills for a ground ambulance ride and the Medicare Allowable rate for that ride varies. Please

Benefit Description	In-Network	Out-of-Network

direct questions about any balance billed by the Provider to the Provider.

Covered services:

- Life threatening emergency by or in conjunction with first responders. Does not require prior authorization. This includes an accident which is an unforeseen event that is not work related, resulting from an external or extrinsic source.
  Transfer to another facility if deemed necessary. Requires prior authorization.
  - As part of the prior authorization review, the Plan Administrator retains the discretionary authority to limit benefit availability to alternative providers of flight-based inter-facility patient transport if a provider fails to comply with the terms of the Plan, or the proposed charges exceed the maximum allowable charge in accordance with the terms of this Plan.
- Emergency air ambulance transportation when a medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness/injury.
  - The patient's destination is an acute care hospital, and
  - The Patient's condition is such that the ground ambulance (basic or advanced life support) would endanger the patient's life or health, or
  - Inaccessibility to ground transport or extended length of time required to transport the patient via ground ambulance transportation could endanger the patient.
- The Plan Administrator retains discretionary authority to limit benefit availability for air emergency ambulance and/or inter-facility patient transfer when a provider fails to comply with the terms of this Plan, except where provided by the No Surprises Act.

Benefit Description	In-Network	Out-of-Network
Autism Spectrum Disorders Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Autism Spectrum Disorders Services

Autism Spectrum Disorder is a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined.

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

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

Benefit Description	In-Network	Out-of-Network

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

Explanation and Limitations

Bariatric/Weight Loss Surgery

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

The third-party claims administrator will determine the In-Network Bariatric Surgery Center of Excellence facility. It is the participant's responsibility to ensure that bariatric surgery services providers are In-Network and facilities chosen to provide services are In-Network. Participants may verify the network status of any provider, including a facility, by calling the TPA.

Participants are limited to one obesity related surgical procedure of any type in an individual's lifetime while covered under any PEBP-sponsored self-funded plan.

If a participant has started any type of program to meet the pre-surgery criteria outlined below with an Out-of-Network provider (including a facility), those services will not meet the Plan's mandatory prior authorization requirements. For the Plan to consider bariatric surgery at the In-Network benefit level; participants will have to begin the pre-certification process again with the proper In-Network providers.

Lap band adjustments are covered for up to 12 months following surgery. The participants must be compliant with their post-surgical plan as verified by the UM company.

Lap band adjustments after 12 months require review by the UM company and prior authorization.

Clinical criteria for weight loss surgeries is managed by the UM Company.

Travel Expenses:

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

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

Benefit Description	In-Network	Out-of-Network
Behavioral Health Services (Mental Health and Substance Abuse)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Behavioral Health Services

A behavioral health condition 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.

A behavioral health practitioner is a psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a master's degree, licensed dietician, or other provider who is legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

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 services payable by this Plan include:

- Inpatient admission: Treatment in a hospital or mental health facility for intensive mental health care. Requires prior authorization.
- Partial hospitalization: This is an alternative to inpatient care. It is a structured outpatient program that provides intensive psychiatric care. Requires prior authorization.
- Intensive outpatient program: A structured treatment program for mental health and substance use disorders. Requires prior authorization.
- Psychological testing: A standard way to measure a person's mental and behavioral characteristics. Testing is used for diagnosis and developing treatment plans. May require prior authorization.
- Detoxification: Set interventions to manage acute intoxication and withdrawal. Requires prior authorization.
- Nutritional counseling by a licensed dietician

Benefit Description	In-Network	Out-of-Network
Behavioral Health Services (Mental Health and Substance Abuse)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Behavioral Health Services

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

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

Outpatient prescription drugs for behavioral health are payable under the prescription drug benefits. Note: Mental health office visits are not covered under this benefit or any specific benefit. They are like primary care office visits. They do not require prior authorization, there are no limitations, and they have the same copay requirement as a primary care physician.

Payments to out-of-network providers are paid pursuant to NRS 687.409.

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

Explanations and Limitations

Blood Transfusions

A blood transfusion is the use of donated blood for the purposes of surgeries, injuries, diseases, or bleeding disorders.

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

Services must be ordered by a physician and may be administered as a component of, or during surgery, or in a free-standing facility. Prior authorization may be required in certain circumstances.

Benefit Description	In-Network	Out-of-Network
Chemotherapy	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge or 110% of the Medi Span AWP, after Plan Year Deductible

Explanations and Limitations

Chemotherapy

Chemotherapy is the treatment of a disease or cancer using chemical substances.

Services include chemotherapy drugs and supplies administered under the direction of a physician in a hospital, health care facility, physician's office or at home. Must be prior authorized.

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

Participants undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year, up to $350, (excluding sales tax).

Benefit Description	In-Network	Out-of-Network
Chiropractic Services (Office visit and spinal manipulation services)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Chiropractic Services

Chiropractic services must be medically necessary by meeting the following:

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

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

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

Benefit Description	In-Network	Out-of-Network

Clinical Trials/Experimental or Investigative Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Clinical Trials/Experimental or Investigative Services

A clinical trial involves a test and one or more human subjects and is subject to the requirements of the Food and Drug Administration (FDA).

Experimental services refer to services, procedures, drugs, or equipment that is not considered standard medical care for a condition and have not been proven effective. A service, procedure, drug, or equipment may be approved for one condition but not another. General criteria for experimental or Investigative Services if at least one of the following is met.

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

Coverage for certain treatment received as part of a clinical trial or study for treatment of cancer or chronic fatigue syndrome will be provided subject to the requirements and limitations set forth in NRS 695G.173. The procedure to request external review of a denial of coverage based on a determination that a health care service or treatment is experimental or investigative is set forth in NRS 695G.275.

- Prior authorization is required.
- May require UM interventions.

Benefit Description	In-Network	Out-of-Network
Prosthetic & Orthotic Devices, other than dental	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Prosthetic & Orthotic Devices, other than dental

The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic).

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

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

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

Explanations and Limitations

Dialysis

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

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

Benefit Description	In-Network	Out-of-Network
Durable Medical Equipment (DME)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Durable Medical Equipment (DME)

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

- Durable medical equipment includes (but is not limited to) apnea monitors, augmentation devices, blood glucose monitors, blood pressure monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.
- All DME must be medically necessary and ordered by a physician.
- Prior authorization is required when cost is expected to exceed $1,000.
- Repair or maintenance of standard models at the option of the Plan to include equipment maintenance agreements. Repair, adjustment or servicing or medically necessary replacement of the DME due to a change in the covered person's physical condition, or if the equipment cannot be satisfactorily repaired.
- Certain DME may be rented, and rental of DME is subject to Medicare guidelines.

Certain blood glucose monitors are covered under this Plan. In-Network, the Plan pays 80% after the Plan Year Deductible.

Participants enrolled in the Diabetes Care Management Program are eligible to receive one glucose monitor each Plan Year at no cost in accordance with the DCM Program requirements, refer to the *Diabetes Care Management Disease Program section*.

Benefit Description	In-Network	Out-of-Network
Enteral Formula and Special Food Products	Plan pays 80% after Plan Year Deductible; with benefit limitations	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; with benefit limitations

Explanations and Limitations

Special Food Product and Enteral Formula

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

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

There is a $2,500 maximum benefit per Plan Year for special food products for the treatment of an inherited metabolic disease. The maximum does not apply to coverage of special food products prescribed or ordered in connection with a mental health diagnosis.
Documentation to substantiate the presence of an inherited metabolic disease, including documentation that the product purchased is a special food product or enteral formula, may be required before the Plan will reimburse costs associated with special food products or enteral formulas.

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

Explanations and Limitations

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

Only diagnostic procedures for fertility and infertility are payable for the employee and spouse/domestic partner. Diagnostic procedures for fertility and infertility are subject to the Plan Year Deductible.

The Plan does not cover the treatment of fertility or infertility. Please see the *Benefit Limitations and Exclusions* section, and in particular, the subsections for drugs, medicines, and nutrition; fertility and infertility; maternity services; and sexual dysfunction services, for more details.

Procedures related to sexual dysfunction may be covered. See the *Benefit Limitations and Exclusions* section of this document for more information.

Coverage is provided for vasectomies and tubal ligations. Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals are excluded.
Male surgical sterilization is subject to the Plan Year Deductible and Coinsurance.

Condoms (male and female) are covered under this plan for individuals aged 13 and above.

For a pharmacist to submit a medical claim for condoms on a member's behalf, the member must have a valid prescription. For condoms purchased over the counter, a receipt for reimbursement may be submitted to the TPA. Please see 'How to File a Claim' in the Claims Administration section.

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

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

Explanations and Limitations

Gender Dysphoria

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

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

Medically necessary means health care services or products that a prudent provider of health care would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

1. Provided in accordance with generally accepted standards of medical practice.
2. Clinically appropriate with regard to type, frequency, extent, location and duration.
3. Not provided primarily for the convenience of the patient or provider of health care.
4. Required to improve a specific health condition of a patient or to preserve the existing state of health of the patient.
5. The most clinically appropriate level of health care that may be safely provided to the patient.

The Plan does not cover cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary. "Cosmetic surgery" means a surgical procedure that does not meaningfully promote the proper function of the body, does not prevent or treat illness or disease, and is primarily directed at improving the appearance of a person.

Benefit Description	In-Network	Out-of-Network
Hearing Aids	Plan pays 80% after Plan Year Deductible (maximum benefit $1,500 per device, per each ear)	Plan pays 50% after Plan Year Deductible (maximum benefit $1,500 per device, per each ear)

Explanations and Limitations

Hearing Aids

When air conduction hearing aids are medically necessary, each air conduction hearing aid is subject to the deductible, then the Plan pays 80% up to a maximum benefit of $1,500 per device (one device per ear), every three years.

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

Over the Counter hearing aids are excluded from plan benefits.

Benefit Description	In-Network	Out-of-Network
Hinge Health	$0; not subject to Deductible or Coinsurance	Not Covered

Explanations and Limitations

Hinge Health Digital Musculoskeletal (MSK) Care Program

Hinge Health's Digital MSK Program is offered through the Pharmacy Benefit Manager (PBM) and is designed to help members with musculoskeletal care using digital technology. The program offers qualifying participants virtual physical therapy focusing on prevention, acute injury, chronic and surgical care programs via digital physical therapy plus additional physical and behavioral support through a full clinical-care team. Members will also have access to other services, such as pelvic floor therapy, advanced wearable technology for electrical nerve stimulation and pain relief, expert medical opinion consultation, health education, etc.

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

Benefit Description	In-Network	Out-of-Network

Home Health Care and Home Infusion Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible; or for infusion drug services 110% of the Medi-Span AWP after Plan Year Deductible

Explanations and Limitations

Home Health Care and Home Infusion Services

Home infusion services involve the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Participants must be assessed and determined to be a candidate for this service. It must be prior authorized.

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

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

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

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

Explanations and Limitations

Hospice

The following hospice care services are covered for members with a life expectancy of six months or less where the person lives.

- Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week. Hospice care requires preauthorization exceeding 6 months.

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

Hospice may be provided by a licensed hospice agency or a licensed home health care agency.

The Plan also covers outpatient bereavement counseling services provided by a licensed master's level clinician or a licensed pastoral care counselor for the patient's immediate family (covered spouse and or dependent children) provided as part of the hospice service. Bereavement counseling beyond that included as a part of the hospice program is payable under the Behavioral Health benefits of this Plan.

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

Explanations and Limitations

Pre-Planned Hospital Services (Inpatient)

Pre-planned hospitalization is subject to concurrent review by the UM Company.

Must be prior authorized.

Services include:

- Room, board, and facility fees in a semi-private room with general nursing services; Specialty Care Units (e.g., intensive care unit, cardiac care unit);
- Ancillary services such as lab, x-ray, and diagnostic services, prescriptions, and supplies.
- Newborn care and circumcision.

Private room is payable at the semi-private rate unless it is determined that a private room is medically necessary, or the facility does not provide semi-private rooms.

Outpatient services with an observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement under this Plan.

Under the following circumstances, the Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the UM company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services:

- Dental general anesthesia for an individual when services are rendered in a hospital or outpatient surgical facility, when the individual is being referred because in the opinion of the dentist, the individual:
- Is under age 18 and has a physical, mental, or medically compromising condition; or

- Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, anatomic anomaly, or an allergy; or
- Patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient.
- Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by the dentist.
- No payment is extended toward the dentist or the assistant dental provider under this Plan.

No coverage for non-emergency hospital admission: The Plan does not cover care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission.

Inpatient private duty nursing by a licensed nurse (RN, LVN or LPN) is covered only when care is medically necessary and not custodial, and the hospital's intensive care unit is filled, or the hospital has no intensive care unit.

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

Explanations and Limitations
Mastectomy and Breast Reconstruction

This Plan complies with the Women's Health and Cancer Rights Act of 1998. A mastectomy is the removal of a breast and breast reconstruction is to restore the shape of the breast. The following are covered:

- Implants and/or autologous tissue.
- 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
- Prostheses and treatment of physical complications of all states of mastectomy, including lymphedema.

If reconstructive surgery occurs within three years after a mastectomy, the amount of the benefits for that surgery will equal the amounts provided for in the Plan at the time of the mastectomy. If the surgery occurs more than three years after the mastectomy, the benefits provided are subject to the terms, conditions, and exclusions contained in the Plan at the time of reconstructive surgery. The treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy. The mastectomy and breast reconstruction may be performed together or separately and must be prior authorized.

Refer to gender dysphoria section if a mastectomy is related to treatment of gender dysphoria.

When the member has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days, consistent with NRS 689B.033.

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

Benefit Description	In-Network	Out-of-Network

Maternity and Newborn Services	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations
Maternity and Newborn Services

This Plan covers the following:

- Prenatal care and delivery for an employee or spouse/domestic partner only. Delivery is covered in either a hospital or a birthing center, which is a facility designed to provide a more homelike environment for low-risk deliveries with the assistance of midwives.
- Prenatal care for covered dependent children. Delivery is not covered unless it is related to a complication of pregnancy. Complications of pregnancy include gestational hypertension, pre-eclampsia, gestational diabetes, miscarriage, placental abruption, infections, low amniotic fluid, anemia, preterm labor, premature rupture of membranes, severe and persistent nausea and vomiting, and stillbirth.
- Elective termination of pregnancy in accordance with NRS 442.250.
- The plan adheres to NRS 695G.1714 regarding maternity services.

Some prenatal care may be covered under preventive services such as obstetrical office visits, breastfeeding support, screening for gestational diabetes, blood type and Rh lab services.

- Coverage for newborn and adopted children and children placed for adoption includes coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.
- Hospital length of stay for childbirth: This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the Plan or its UM Company for prescribing a length of stay not more than those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

Coverage includes gestational carriers.

Benefit Description	In-Network	Out-of-Network
Nondurable Supplies	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge or 110% of the Medi-Span AWP after Plan Year Deductible

Explanations and Limitations
Nondurable Supplies

Non-durable supplies or items 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.

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

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

- Diabetic supplies may be covered under this area or under the prescription drug benefit.

Benefit Description	In-Network	Out-of-Network
Oral Surgery, Dental Services, and Temporomandibular Joint Disorder	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible

Explanations and Limitations

Oral Surgery, Dental Services, and Temporomandibular Joint Disorder

- Expenses for dental services may be covered under the medical plan if the expenses are incurred for the repair or replacement of injury to teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the medical Plan, an accident does not include any injury caused by biting or chewing.
  - Treatment of injury to teeth must be provided by a dentist or physician and is limited to restoration of teeth or jaw to a functional level, as determined by the Plan Administrator or its designee.
- Coverage for dental services as the result of an injury to teeth will be extended under the medical plan to a maximum of two years following the date of injury, regardless of date enrolled in the plan. Restorations past the two-year time frame may be considered under the dental benefits described in the PEBP Self-funded Dental PPO Plan Master Plan Document available at https://pebp.nv.gov/.
- Oral or craniofacial surgery is limited to surgical procedures to remove tumors, cysts, abscess including dental abscesses and cellulitis, or for acute injury. Must be prior authorized.
- Frenectomy is based on medical necessity as determined by the UM company and must be prior authorized.
- *Temporomandibular Joint (TMJ) services are payable under the medical Plan when medically necessary but not if treatment is recognized as a dental procedure, involves extraction of teeth or application of orthodontic devices (e.g., braces) or splints. Must be prior authorized.

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

Benefit Description	In-Network	Out-of-Network

Provider of Health Care	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Provider of Health Care

This benefit includes licensed medical professional fees for services provided in a hospital, emergency room, urgent care center, laboratory, or surgical center. A provider of health care is defined in NRS 629.031.

Assistant surgeon and certified surgical assistant fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon.

Prophylactic surgery or treatment is not covered.

Homeopathic treatments, supplies, remedies, or substances are not covered.

Benefit Description	In-Network	Out-of-Network
Radiology & Radiation Therapy	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Radiology & Radiation Therapy

The Plan covers medically necessary outpatient radiology when ordered by a physician or health care practitioner acting with the scope of their license.

- Prior authorization required for outpatient radiology.
- The Plan covers technical and professional fees associated with outpatient radiology that is performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to a sickness or injury for which admission or surgery is planned.
- Medically necessary professional services related to radiation therapy are covered.

Benefit Description	In-Network	Out-of-Network
Real Appeal	No cost to Participants	Not Covered

Explanations and Limitations

Real Appeal

Real Appeal provides eligible members who are at least 18 years old a benefit for virtual weight loss and weight management coaching sessions, with no cost to the member.

This support includes one-on-one coaching and online group sessions with supporting video content delivered by a virtual coach.

A qualified enrolled member will receive:

- Access to a coach who will guide participants through the program and develop a custom plan that fits their needs, preferences, and goals;
- 24/7 access to digital tools and dashboards;
- A Real Appeal kit containing health weight management tools that may include fitness guides, recipes, digital food and weight scales; and

- Support from online group classes with a coach and other members who share what has helped them achieve success.

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

Benefit Description	In-Network	Out-of-Network
Rehabilitation Services (Physical, Occupational, and Speech Therapy)	Inpatient or Outpatient: Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Rehabilitation Services (Physical, Occupational, and Speech Therapy)

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, surgery, or medically necessary treatment of a behavioral health condition and that is performed by a licensed therapist acting within the scope of his or her license. Also, cardiac therapy.

- Rehabilitation services are covered only when ordered by a physician or other provider acting within the scope of their license.
- Inpatient rehabilitation admission requires prior authorization.
- Prior authorization for outpatient rehabilitative and habilitative therapy (occupational, physical, or speech) exceeding 90 combined visits per Plan Year. Visit limits do not apply to Medically Necessary treatment of mental health or substance use disorder. Visit limits do not apply to speech therapy for children under the age of 18.
- Cardiac Rehabilitation is included under this header. Cardiac rehabilitation is a program that helps people with heart disease improve their cardiovascular health. It can include exercise, education, and support. There is no limit to cardiac rehabilitation.
- Benefits for rehabilitation therapy are limited to services given for acute or recently acquired conditions that, in the judgement of the member's physician, are subject to significant improvement through short-term therapy.
- Short term active, progressive rehabilitation services for occupational, physical, or speech therapy must be performed by a licensed or duly qualified therapist/provider acting within the scope of their license.
- Inpatient rehabilitation services in an acute hospital, rehabilitation unit or facility or skilled nursing facility for short term, active, progressive rehabilitation services that cannot be provided in an outpatient or home setting.
- Maintenance Rehabilitation and coma stimulation services are not covered. Once an individual meets their function goal, no additional therapy sessions will be covered.

Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagia, swallowing defects, to correct speech disorders due to childhood developmental delays and disorders due to illness, injury, or a surgical procedure. Speech therapy is payable following surgery to correct the congenital condition of the oral cavity, throat, or nasal

complex (other than a frenectomy), an injury, or sickness that is other than a learning disorder. Maintenance Rehabilitation and coma stimulation are not covered.

Benefit Description	In-Network	Out-of-Network
Second Opinion Services	Plan pays 100% after Plan Year Deductible	Not Covered

Explanations and Limitations

Second Physician Opinion

For a second opinion, participants may choose any In-Network, licensed specialist who is not an associate of the diagnosing physician.

Limit to one officer visit per opinion.

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

Benefit Description	In-Network	Out-of-Network
Doctor on Demand	Listed prices are before deductible has been met. The plan pays 80% after Plan Year Deductible is met.	Not Covered
Medical Visit	$49	Not Covered
Psychology Visit (25-minute visit)	$79	Not Covered
Psychology Visit (50-minute visit)	$129	Not Covered
Psychiatry Visit (initial 45-minute visit)	$229	Not Covered
Psychiatry Visit (15-minute follow-up visit)	$99	Not Covered
Telehealth (other telemedicine providers)	Plan pays 80% after Plan Year Deductible	Not Covered

Explanations and Limitations

Telemedicine and Telehealth

Telemedicine (vendor/virtual visit) is the practice of medicine using technology to deliver care at a distance via electronic communications through a vendor. Telehealth/telemedicine is covered on the same basis as in-person services.

Doctor on Demand telemedicine services is PEBP's contracted telehealth provider and are considered In-Network. To learn more, visit http://www.doctorondemand.com/pebp.

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

Benefit Description	In-Network	Out-of-Network
Skilled Nursing Facility (SNF) and Subacute Care Facility	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Skilled Nursing Facility (SNF) and Subacute Care Facility

- Admission to a skilled nursing facility or subacute care facility must be ordered by a physician and requires prior authorization (see the *Utilization Management* section of this document).

Medically necessary care at a skilled nursing facility (limited to 60 days per Plan Year) is covered. A skilled nursing facility is a facility that is duly licensed by the state and/or federal government and that provides inpatient skilled nursing care, rehabilitation services, or other related health services that are not custodial or convenient in nature. Skilled nursing care includes medically necessary services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse. This Plan does not cover skilled nursing care that is not covered by CMS. Prior care in a hospital is not required before being eligible for coverage for care in a skilled nursing facility.

Benefit Description	In-Network	Out-of-Network
Transplant (Organ and Tissue)	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Transplants (Organ and Tissue)

A transplant is 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.

- Transplantation-related services require prior authorization. (see the *Utilization Management* section of this document for details). Coverage is provided only for eligible services related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.
- See the *Exclusions* section related to experimental and investigational services and transplants.
- To receive maximum Plan benefits, members must use a Center of Excellence for single organ or combined organs and tissue transplants. Transplant Center of Excellence facilities will be identified by the claim's administrator. For information regarding transplant benefits and Centers of Excellence facilities, contact the third-party claims administrator at 888-763-8232.
- This Plan provides for reimbursement of certain costs associated with travel and lodging accommodation for the patient and one additional person (spouse/domestic partner, family member or friend) when associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. For travel expense benefits, refer to the *Travel Expenses* section.
- Expenses incurred for travel and lodging accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.
- PEBP does not provide advance payment for travel expenses related to organ or tissue transplants.

Benefit Description	In-Network and Out of Network
Travel Services	Not Subject to Deductible and Out-of-Pocket Maximum

Explanations and Limitations

Travel Services

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

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

- Transplant or bariatric surgery.
  - This includes pre-surgery appointments such as evaluations, testing, counseling, etc.
- Hip and knee total joint replacement surgery performed at an approved exclusive Nevada hospital/ ambulatory surgery facility when prior authorized by the utilization management company
  - This includes pre-surgery evaluations, and
  - For one year after surgery for follow-up visits as required by the patient's surgeon; and
- Travel expenses related to an organ or tissue transplant, or bariatric surgery scheduled or performed at a facility or other provider type that is not a Center of Excellence as determined by the Plan Administrator or its designee will not be covered.
  - Travel expenses related to an inpatient or outpatient surgery that is not determined to be a preferred hospital/ambulatory surgical facility by the UM company will not be covered. There are no exceptions.
- Travel for a participant located in a State with more restrictive access to abortion than Nevada, to the nearest care center for abortion services covered under this Plan pursuant to NRS 442.250.

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

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

PEBP does not provide advance payment for travel expenses.

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

Pre-approval for travel expenses:

- Travel expenses must be pre-approved by PEBP. Pre-approval requests shall be sent to PEPBs Quality Control Unit.
  - If the member is unable to obtain pre-approval because the organ or tissue transplant required immediate travel, the member may submit travel costs to PEBPs Quality Control Unit after the transplant surgery.

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

Submitting Travel Reimbursement form and receipts:

- Requests for travel expense reimbursement must be submitted to PEBPs Quality Control Unit using the Travel Reimbursement form available at pebp.nv.gov.
- Travel Reimbursement forms and receipts (hotel, toll roads, parking) must be submitted within 12 months of the date of the service.
    - The form must be completed, including the start and end times, destination, and purpose of trip
    - Must include original itemized receipts identifying the name(s) of the person(s) incurring the expense. If the travel includes a commercial airline flight, an itinerary must be attached for meal justification.

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

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

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

Mileage, if driving, will be reimbursed in accordance with Nevada current mileage non-medical reimbursement rate.

Eligible Travel Expenses include:

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

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

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

Excluded travel expenses:

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

- Alcoholic beverages.

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

Transplants (Organ and Tissues)

- Travel expenses related to an organ or tissue transplant, or bariatric surgery scheduled or performed at a facility or other provider type that is not a Center of Excellence as determined by the Plan Administrator or its designee will not be covered.
    - Travel expenses related to an inpatient or outpatient surgery that is not determined to be a preferred hospital/ambulatory surgical facility by the UM company will not be covered. There are no exceptions.
- Travel for a participant located in a State with more restrictive access to abortion than Nevada, to the nearest care center for abortion services covered under this Plan pursuant to NRS 442.250.

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

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

PEBP does not provide advance payment for travel expenses.

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

Pre-approval for travel expenses:

- Travel expenses must be pre-approved by PEBP. Pre-approval requests shall be sent to PEPBs Quality Control Unit.
    - If the member is unable to obtain pre-approval because the organ or tissue transplant required immediate travel, the member may submit travel costs to PEBPs Quality Control Unit after the transplant surgery.

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

Submitting Travel Reimbursement form and receipts:

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

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

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

Mileage, if driving, will be reimbursed in accordance with Nevada current mileage non-medical reimbursement rate.

Eligible Travel Expenses include:

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

- Methods of transportation including personal car, airline, rental car, bus, taxi, etc. The least expensive method of transportation must be used.
    - Flight expenses for commercial air (regular coach rate).
    - Mileage reimbursement for personal vehicle (GSA non-medical mileage rate).
- Travel meals (for patient and travel companion only).
    - Reimbursement for meals while traveling will apply the GSA rate for the travel day for the first and last day of travel.

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

Excluded travel expenses:

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

- Alcoholic beverages.
- Car maintenance.
- Vehicle insurance.
- Flight insurance.
- Travel insurance.
- Room service fees.
- 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.

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

Explanations and Limitations
Vision Services

- Limited to one vision screening, may or may not include refraction, every 24 months. Vision screening is subject to deductible; plan pays 80% after deductible. There is no limit on the number of visions screenings for children 18 and younger.
- Hardware such as, but not limited to, contact lenses, lenses and frames are not covered.
- When refraction is conducted in conjunction with an examination with a medical diagnosis, such as cataracts, it will be paid under the medical benefit, subject to Deductible and Coinsurance.
- Some FDA-approved vision therapy is covered at 80% after deductible for certain conditions, including lazy eye, convergency insufficiency, and stroke recovery. Requires prior authorization.

Benefit Description	In-Network	Out-of-Network
Diabetes Care Management Disease Program (DCM) (Enhanced Benefits)	Two office visits covered at 100% per Plan Year, not subject to Deductible (In Network)	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible (Out of Network)
Laboratory Test (must be performed using a free-standing non-hospital-based laboratory)	Two routine lab tests covered at 100% per Plan Year, not subject to Deductible (In Network)	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible (Out of Network)

	Preferred Retail Network Retail 30-Day Supply	**Smart90 Retail or ESI Home Delivery** 90-Day Supply	
Preferred Generic	$5 Copay	$15 Copay	Not covered Out of Network
Preferred Brand	$25 Copay	$75 Copay	

Non-Preferred Brand	100% copay	
Diabetic Supplies (test strips, insulin syringes, alcohol pads, and lancets)	**ESI Home Delivery Pharmacy**: 90-Day Supply $50 Copay per supply item or the lessor of actual cost	
Blood Glucose Monitor	**ESI Home Delivery**: $0 Copay (limited to one per Plan Year)	

Explanations and Limitations

Diabetes Care Management Disease program (enhanced benefits)

The Diabetes Care Management (DCM) program is a voluntary opt-in disease management program that provides enhanced benefits to participants diagnosed with diabetes, and who are enrolled in and meeting the goals of the program. Benefits provided under the DCM program are not subject to deductible if determined to be preventive under the ACA and IRS guidelines. To enroll:

- Obtain the DCM form by logging into the E-PEBP Portal at https://pebp.nv.gov/, or contact the third-party claims administrator to request the DCM enrollment form. Complete the required information and have a physician sign the form. Send the form to the third-party claims' administrator for processing.
- The effective date of the DCM program will begin on the first day of the month following the third-party claims administrator's receipt and processing of the DCM enrollment request.
- To continue receiving the DCM enhanced benefits, a new DCM form must be completed annually, at the start of, or prior to, the new plan year. This form must be signed by both participants and a physician and submitted to the third-party claims' administrator for processing.

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

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

Enhanced In-Network benefits in the DCM Program include:

- Two physician office visits per Plan Year are paid at the 100% benefit level when billed with a primary diagnosis of diabetes (additional office visits are subject to deductible and coinsurance).
- Two routine laboratory hemoglobin (A1c) blood tests are paid at the 100% benefit level per Plan Year (additional lab services are subject to deductible and coinsurance).
- Diabetes-related medications, such as insulin and Metformin, are eligible for copayments listed in the DCM Pharmacy Benefits and not be subject to the Plan Year Deductible.
- One glucose monitor, per Plan Year at $0 copayment available through the Pharmacy Benefit Manager.
- Diabetic supplies including test strips, lancets, insulin syringes and alcohol pads are eligible for purchase for the lessor of a $50 copay per 90-day supply item, or the cost of the item, when coordinated through the Pharmacy Benefit Manager's Home Delivery program.

- Copayments for Tier 1 (Generic) and Tier 2 (Preferred Brand) drugs apply to the Plan Year Deductible and Out-of-Pocket Maximum.
- Copayments made while enrolled in the DCM program apply to the Plan Year Deductible and Out of Pocket Maximum.

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

Other limitations:

- Diabetes Medications: Preferred Retail Network Pharmacies, Smart90 Retail, and the Home Delivery Program requirements apply. Refer to the *Schedule of Prescription Drug Benefits* for coverage limitations, cost implications and details regarding these programs.
- Participants who are not enrolled or non-compliant in the DCM Program receive the standard CDHP benefits. The effective date of the return to the standard CDHP benefits will be the first day of the month following the non-compliance determination by the third-party claims administrator.
- Specialty medications are not eligible for enhanced benefits under this program and are subject to the standard CDHP benefits.
- This Plan does not coordinate prescription drug benefits.
- Medications purchased at Out-of-Network pharmacies are not covered under this Plan.

Benefit Description	In-Network	Out-of-Network
Diabetes Education Services	This Plan pays 80% after Plan Year Deductible	Not Covered

Explanations and Limitations
Diabetes Education Services

- Diabetes training and education services are payable when requested by a physician and are medically necessary for the self-care and self-management of a person with diabetes. Services must be provided by a certified diabetes educator or a health care practitioner. Included in this benefit is retraining due to new techniques for the treatment of diabetes or when there has been a significant change in the person's clinical condition or symptoms that require modification of self-management techniques.

- Some diabetic supplies are payable under the *Prescription Drug* section of this document. Please contact the prescription drug Plan Administrator for more information.

- This Plan pays enhanced benefits for participants enrolled in Diabetes Care Management (DCM). For information regarding the DCM program and the enhanced benefits, refer to the Disease Management section and to the *Schedule of Benefits* for the Diabetes Care Management Program.

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

Explanations and Limitations

Emergent and Urgent Care Services

Emergency Services means immediate medical attention for a medical or mental health condition in the following manner:

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

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

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

Urgent care is the middle ground between a primary care physician and an emergency room and is for medical conditions that require prompt attention but not serious enough to meet the definition of an emergency. No prior authorization is needed, and providers will be reimbursed at the in-network rate. Deductibles, coinsurance, and out of pockets maximums apply. Participants must contact the UM Company within 24 hours of admission.

This Plan complies with the federal No Surprises Act, which provides patients who receive emergency services at hospitals, independent freestanding emergency departments, and air ambulances with certain protections against surprise medical bills. In addition, the law protects patients who receive emergency services from out-of-network providers at in-network facilities. Members receiving such services will only be responsible for paying their in-network cost sharing and cannot be balance billed by the provider or facility for emergency services.

Post Stabilization Services

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

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

Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by an out-of-network provider at an in-network facility, the items or services are covered by the plan:

With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider;

By calculating the cost-sharing requirements consistent with the federal No Surprises Act; and

By counting any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an in-network provider.

Non-emergency items or services performed by an out-of-network provider at an in-network facility will be covered based on out-of-network coverage if:

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

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

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider,
- With cost-sharing requirements calculated consistent with the federal No Suprises Act.

- With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by an in-network provider.

The cost sharing amount for Non-emergency Services at in-network facilities by out-of-network providers will be based on the lessor of billed charges from the provider or the Qualifying Payment Amount.

Payments to Out-of-Network Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for emergency services, non-emergency services at in-network facilities by out-of-network providers, or air ambulance services within 30 calendar days of either receiving a clean claim from the out-of-network provider or the date the plan receives the information necessary to decide the claim.
If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing required under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

External Review

An adverse benefit determination related to an emergency service, non-emergency service provided by an out-of-network provider at an in-network facility, or air ambulances services covered under the No Surprises Act is eligible for External Review. Please see the *External Review* section further information.

Continuity of Care

Continuity of Care is a process that allows a participant to continue using the same provider for a period of time after enrolling in a new plan. This is for participants who have complex medical conditions, which are conditions that affect multiple body systems or has multiple systems.

If this occurs:

- Participants will be notified in a timely manner of the contract termination and of their right to elect continued transitional care from the provider or facility; and
- Participants will be allowed up to ninety (90) days of continued coverage at in-network cost sharing to allow for a transition of care to an in-network provider.

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

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

Incorrect Provider Information

A list of in-network providers is available on PEBP's website or by calling the phone number on the participant ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice. If participants obtain and rely upon incorrect information about whether a provider is an in-network provider from the Plan or its administrators, the Plan will apply in-network cost-sharing to the claim, even if the provider was out-of-network.

Benefit Description	In-Network	Out-of-Network
Preventive Care/Wellness Benefits	Plan pays 100%, not subject to Deductible	Not Covered
Colorectal Cancer Screening (Colonoscopy/bowel prep or Cologuard)	Plan pays 100%, not subject to Deductible	Not Covered
Women's Preventive Services	Plan pays 100%, not subject to Deductible	Not Covered
BRCA Risk Assessment and Genetic Counseling/Testing	Plan pays 100%; not subject to Deductible	Not Covered

- BRCA risk assessment for women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations.
- Genetic Counseling following a positive result on risk assessment and, if indicated after counseling, genetic testing.
- Genetic counseling must be provided by a licensed health care provider acting within the scope of his or her license.
- BRCA testing requires prior authorization.

Breastfeeding Support/Equipment	Plan pays 100%, Not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible

Coverage for comprehensive lactation support and counseling must be provided from trained providers for women during the prenatal and postpartum period and up to one year following delivery. Coverage for breastfeeding equipment and supplies in conjunction with each live birth. The Plan covers one manual or standard electric breast pump per live birth.

Contact the third-party claims administrator regarding the purchase of covered breast pumps. Rental for heavy duty electrical (hospital grade) breast pump covered only when the UM company determines it is medically necessary and only during the newborn's inpatient hospital stay.

Contraceptives / Family Planning	Plan pays 100%, not subject to Deductible	Plan pays 50% of the Maximum Allowable Charge after Deductible; pharmacy not covered

- Up to 12-month supply, per prescription, of a drug for contraception or its therapeutic equivalent;
- Devices for contraception, and insertion and removal of such devices;
- Self-administered hormonal contraceptives;
- Education and counseling relating to the initiation of the use of contraception and any necessary follow-up;
- Management of side effects of contraception; and
- Voluntary sterilization for women. Includes contraceptive injection or the insertion of contraceptive device at a hospital immediately after an insured gives birth.

Methods of Covered Contraception

- Elective sterilization for women
- Surgical sterilization implants for women
- Implantable rods
- Copper-based intrauterine devices
- Progesterone-based intrauterine devices
- Injections
- Combined estrogen- and progestin-based drugs
- Progestin-based drugs
- Extended- or continuous-regimen drugs
- Estrogen- and progestin-based patches
- Vaginal contraceptive rings
- Diaphragms w/spermicide
- Sponges w/spermicide
- Cervical caps w/spermicide
- Female condoms
- Male condoms
- Spermicide
- Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception
- Ulipristal acetate for emergency contraception

Explanations and Limitations

Preventive Care/Wellness Benefits

This Plan complies with the Patient Protection and Affordable Care Act; IRS rules and regulations for HSAs, and in particular, Section 223 of the Internal Revenue Code; and applicable Nevada law regarding covered preventive care.

Recommended preventive care services are covered with no cost sharing when provided by in-network providers. Preventive care services are not subject to and will not apply to the Plan Year Deductible or Out-of-Pocket Maximum. Some preventive care services have service quantity limitations.

Preventive care focuses on detecting and preventing medical problems before they become more serious. Preventive care services include:

- Recommendations of the U.S. Preventive Services Task Force with a current rating of "A" or "B," including:
  - Screening for various conditions, including depression, diabetes, obesity, hypertension, sexually transmitted infections, prenatal conditions, and various cancers;
  - Medications intended to prevent conditions, including those intended to prevent HIV, breast cancer, and heart disease; and
  - Counseling for various medical concerns, including addressing drug use, tobacco use, healthy diet, and physical activity.
  - Immunizations recommended by the federal Advisory Committee on Immunization Practices (ACIP), including influenza, COVID-19, hepatitis A, hepatitis B, HPV, measles/mumps/rubella, meningitis, RSV, shingles, and Tdap.
  - Prediabetes and type 2 diabetes screening for individuals 35-70 years of age who are overweight or obese.
  - Participants and covered dependents who have a body mass index of 30 or higher, cardiovascular disease (CVD) risk factors, or prediabetes may be referred for behavioral interventions by their primary care physician, consistent with recommendations of the US

Preventive Services Task Force. Such behavioral interventions are covered under the Wellness/Preventive Care Benefit provided by an in-network provider.

- Recommendations by the Women's Preventive Services Initiative, including well-woman visits, pelvic examinations, Pap smears, breast exams, and prenatal visits.

Recommendations by the Health Resources and Services Administration's with respect to the health of infants, children, and adolescents, including well-child visits, behavioral and developmental assessments, and screening for autism, certain genetic diseases, lipid disorders, tuberculosis, and vision impairment.

Annual check-ups, including related screening lab and x-rays.

- Note: routine lab services from independent labs may not be recognized as preventive care unless there is a corresponding wellness office visit within a reasonable number of days prior to or after lab date

A physician may recommend a preventive service that is not listed in this document. For additional information regarding preventive benefit information, contact the third-party claims administrator listed in the *Participant Contact Guide*.

Note: Once an individual becomes symptomatic, or has been diagnosed with a serious health condition, all diagnostic testing and blood testing no longer fall under preventive care/wellness. An example of this would be the removal of a polyp during a colorectal cancer screening.

Guidelines for common preventive services:
Mammogram: Preventive mammograms are covered at 100% for women aged 40 years and older, one per year, when performed in-network. Mammograms for both men and women may begin at age 20 if there are BRCA mutations present, or age 30 with a high-risk (20% or greater chance of developing breast cancer), when performed in-network. Additional diagnostic needs are subject to cost sharing.

Colorectal cancer screening: Once every 10 years for adults aged 45 years and older who are at average risk of colorectal cancer or beginning at age 40 for members with a high-risk of colorectal cancer.

Healthy Diet and Physical Activity for Cardiovascular Disease Prevention: For Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions for adults aged 18 years and older are covered under the Wellness/Preventive Benefit when referred by a primary care practitioner for those who have a basal metabolic index (BMI) of 30 or greater and have additional cardiovascular disease (CVD) risk factors. This wellness/preventive benefit is limited to twelve (12) Healthy Diet/Physical Activity Counseling or Obesity Screening/Counseling visits per Plan Year. Additional visits are subject to a specialist visit copay, deductible, or coinsurance where applicable.

Smoking/Tobacco Cessation:

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

- Over-the-counter smoking/tobacco cessation products may be obtained by presenting a physician's written prescription to an in-network pharmacy, or participants can submit a purchase receipt for the product with the physician's written prescription attached to the Prescription Drug Reimbursement Claim Form (this form is located at https://pebp.nv.gov/).
- Second-line therapies such as clonidine hydrochloride and nortriptyline hydrochloride are sometimes used in the management of smoking/tobacco-cessation are not FDA approved and are not covered.
- The Plan does not cover electronic cigarettes.

Additional services covered as preventive as a component of the Affordable Care Act (ACA).

- One-time screening for abdominal aortic aneurysm with ultrasonography in men aged 65 – 75 who have smoked.
- Anxiety screening for adults 64 years of age and younger (including pregnancy and postpartum)
- Anxiety screening for children aged 8 – 18.

For more information, please visit or contact the third-party claims administrator.

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

Explanations and Limitations

Laboratory Outpatient Services

- Outpatient lab services are covered when medically necessary, when ordered by a physician or health care practitioner, and when services are performed in accordance with the Laboratory Outpatient Services benefit described in this section.

Free-standing, non-hospital -based laboratory facility: The Plan covers outpatient routine and preventive lab services performed at free-standing, non-hospital-based lab facilities. Although there may be other in-network free-standing, non-hospital-based lab facilities in the network, the Plan's preferred facilities include Lab Corp and Quest. Routine and preventive lab services include:

- Medically necessary routine labs when ordered by a physician or other licensed provider acting within the scope of his/her license as part of comprehensive medical care. To be covered at 100%, the lab must be used to proactively screen for protentional diseases for which a participant has no symptoms of. This includes, but not limited to, cholesterol to screen for heart disease.
  - Labs used to diagnose or rule out conditions are diagnostic and subject to cost sharing.

- **Outpatient hospital-based lab facilities and hospital-based lab draw stations:** The Plan covers outpatient lab services for pre-admission testing when performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to sickness or injury for which admission or surgery is planned.
- If a free-standing, non-hospital-based outpatient laboratory facility is not available within 50 miles of a participant's residence, participants may use a hospital-based laboratory facility or hospital-based draw station.

The following screening is covered as preventive as a component of the Affordable Care Act (ACA):

- One-time screening for Abdominal Aortic Aneurysm with ultrasound in men aged 65 – 75.
- Screening for anxiety disorders in children aged 8 – 18, pregnant women, and adults aged 64 and older.
- Screening for asymptomatic bacteriuria in pregnant women.
- Chlamydia and Gonorrhea screening in sexually active women under 24 and women aged 25 years and older at increased risk.
- Screening for syphilis in pregnant women and those at increased risk.
- Depression and suicide risk in children aged 12 – 18 and adult aged 65 years and older.
- Screening for gestational diabetes in pregnant women 24 weeks and over.
- Screening for HEP B in pregnant women and those at increased risk.
- Screening for HEP C in adults aged 18 to 79.
- HIV Screening in pregnant women and adults aged 15 – 65.
- Tuberculosis screening in adults at increased risk.
- Lung cancer screening in adults aged 50 – 80 who smoke more than 20 packs per year.
- Screening for diabetes for adults aged 35 – 70 who are overweight/obese.
- Rh(D) blooding typing and antibody testing for pregnant women.

Benefit Description	In-Network	Out-of-Network
Genetic Counseling/Testing	Plan pays 80% after Plan Year Deductible	Plan pays 50% of the Maximum Allowable Charge after Plan Year Deductible

Explanations and Limitations

Genetic Testing and Counseling

Genetics is the study of how genes and how traits are passed down from one generation to the next.

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

Covered services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic

conditions and how they are inherited, explain inheritance patterns, assess risk, and review testing options, where available.

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

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.

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

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.

Benefits include amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), alpha-fetoprotein (AFP), BRCA1 and BRCA2, apo E.

This list is not all-inclusive for what genetic tests may be covered.

Contact the UM company for coverage details and prior authorization requirements for covered genetic testing.

Benefit Description	In-Network		Out-of-Network
Obesity Care Disease Management Program (Enhanced Benefits)			
Office Visits	Plan pays 100%; not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Deductible
Laboratory Test (must be performed using a free-standing, non-hospital-based laboratory)	Plan pays 100%; not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Deductible
Nutritional Counseling Services	Plan pays 100%; not subject to Deductible		Plan pays 50% of the Maximum Allowable Charge after Deductible
Weight loss medications	Preferred Retail 30-Day Supply	Smart90 Retail or ESI Home Delivery	

		90-Day Supply	
Preferred Generic	*$5 Copay	$15 Copay	Not covered
Preferred Brand	Not covered		Not covered
Non-Preferred Brand	Not covered		Not covered

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

Explanations and Limitations

Obesity Care Disease Management Program (Enhanced Benefits)

The Obesity Care Management (OCM) Program is a disease management program that provides enhanced benefits to participants who have been diagnosed as obese by their physician, who have met the BMI criteria as indicated below, and have enrolled in the OCM Program.

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

How to enroll in the OCM Program:

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

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

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

The patient's BMI must be greater than 30 kg/m2, with or without any co-morbid conditions present, or greater than 25 kg/m2 (or waist circumference greater than 35 inches in women, 40 inches in men) if one or more of the following co-morbid conditions are present:

- Coronary artery disease.
- Diabetes mellitus type 2.
- Hypertension (Systolic Blood Pressure greater than or equal to 140 mm Hg or Diastolic Blood Pressure greater than or equal to 90 mm Hg on more than one occasion).
- Obesity-hypoventilation syndrome.
- Obstructive sleep apnea.
- Cholesterol and fat levels measured (Dyslipidemia):

- HDL cholesterol less than 35 mg/dL.
- LDL cholesterol greater than or equal to 160 mg/dL; or
- Serum triglyceride levels greater than or equal to 400 mg/dL.

For children ages two to 18 years:

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

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

Monitoring Engagement in the OCM Program:
Your OCM provider must submit monthly reports to include your weight loss (weight, BMI, and waist circumference) and your compliance with the treatment plan. Submission of these reports will be a requirement for payment under the OCM Program's enhanced benefits. If your monthly weight loss reports are not received by the third-party claim's administrator, your benefits under this program will end, and your coverage will return to the standard CDHP benefits where other Plan limitations will apply. The effective date of the return to the standard CDHP benefits will be the first day of the month following the non-compliance notification received from the third-party claim's administrator.

You and your weight loss provider will determine your final weight loss goal when you initially start participating in the OCM Program. Once you have met your final weight loss goal, the OCM Program's enhanced benefits will return to the standard CDHP benefits on the first day of the following month. The OCM Program does not provide enhanced benefits for ongoing maintenance care. Ongoing maintenance care will be subject to the standard CDHP benefits.

Laboratory Services:
Routine wellness laboratory testing must be performed at an In-Network free-standing laboratory facility, for example Lab Corp or Quest. A hospital-based outpatient laboratory/draw station is not a free-standing laboratory.

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

Weight Loss Medications:

- The Plan covers certain only short-term use obesity/weight loss generic medications as identified by the Plan's pharmacy benefits manager. Contact the pharmacy benefit manager or refer to the Plan's prescription drug formulary to determine what weight loss medications are covered by the enhanced benefit.
- Copayment for a 31-90-day supply is subject to three times the listed 30-day retail copayment.
- This Plan does not coordinate prescription drug plan benefits.
- Medications purchased at non-participating pharmacies are not covered under this Plan.

Other limitations:

- Weight loss medications: Preferred Retail Network Pharmacies, Smart90 Retail, and Express Scripts Home Delivery Program requirements apply. Refer to the *Schedule of Prescription Drug Benefits* for coverage limitations, cost implications and details regarding these programs.

A provider for obesity management is a health care professional who has received specialized training and certification in the diagnosis, treatment, and management of obesity. Providers may include physicians, nurses, nurse practitioners, physician assistants, registered dietitians, and other types of health care professionals. Certifications are accepted from the American Board of Obesity Medicine or other equivalent organizations specializing in obesity management.

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

Schedule of Prescription Drug Benefits

This Plan does not coordinate prescription drug plan benefits.

Benefits for prescription drugs are provided through the prescription drug plan administered by the Pharmacy Benefit Manager (PBM), Express Scripts (ESI). Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the U.S. Food and Drug Administration (FDA) as requiring a prescription and FDA approval for the condition, dose, route, duration, and frequency, if prescribed by a physician or other practitioner.

A Formulary, which is a list of generic and brand name drug products available for use by participants, is maintained by the Pharmacy Benefit Manager and may be subject to change according to the Pharmacy Benefit Manager.

A generic drug is a prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. The Plan considers 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

Certain OTC female contraception and over the counter (OTC) products are covered when presented with a prescription from a physician to a pharmacy. Female contraception products include the female condom, sponges, and spermicides. OTC products include, but are not limited to, aspirin, folic acid, and smoking cessation products.

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

The pharmacy benefit also includes a variety of testing including, but not limited to, HPV, HIV, HEP C, syphilis, and a variety of sexually transmitted diseases. Some testing may be covered at 100% and some may require cost sharing.

Anti-obesity branded products are excluded from this benefit. Only generic products are covered. Refer to the Obesity Care Management Program.

This plan allows for step therapy, which is a cost-savings measure that requires participants to try a less expensive medication before trying a more expensive one. Some classes of medications are excluded from step therapy including medications to treat mental health disorders, opioid disorders, substance abuse disorders, and certain types of cancer.

Quantities and limits may apply to medical supplies obtained through the pharmacy benefits such as diabetic supplies including lancets, syringes, test strips, insulin pumps, and insulin pump supplies.

All prescription drugs under this plan must be FDA approved for the condition which is prescribed. For helpful tools such as "Price a Medication" see the *Participant Contact Guide* section or go to the PEBP website at *https://pebp.nv.gov/*.

Prior authorization may be required from some classes of medications.

Copay, coinsurance and deductibles apply to all medications, supplies, testing, and vaccinations that are not considered preventive. The Preventive Drug Benefit Program provides participants access to certain preventive drugs subject only to Coinsurance. Coinsurance paid under the benefit will not apply to the Deductible but will apply to Out-of-Pocket Maximum costs. The medications covered under this benefit include categories of prescription drugs that are used for preventive purposes for conditions such as hypertension, asthma, and high cholesterol. A list of eligible preventive drugs covered under this benefit can be found by logging on to https://pebp.nv.gov/ or by contacting the Pharmacy Benefit Manager (PBM).

Preventive Drug Benefit Program

The Preventive Drug Benefit Program provides participants access to certain preventive drugs without having to meet a Deductible and will instead only be subject to Coinsurance. Coinsurance paid under the benefit will not apply to the Deductible but will apply to Out-of-Pocket Maximum costs. The medications covered under this benefit are limited to those preventive drugs identified by the PBM. Preventive drugs include categories of prescription drugs that are used for preventive purposes for conditions such as hypertension, asthma, and high cholesterol. A list of eligible preventive drugs covered under this benefit can be found by logging on to https://pebp.nv.gov/ or by contacting the PBM The Pharmacy Benefit Manager (PBM).

Specialty Drugs

Specialty drugs are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, rheumatoid arthritis, etc. Specialty drugs and prescriptions are limited to a 30-day supply. Specialty drugs must be filled through Accredo, an Express Scripts Specialty Pharmacy (see the *Participant Contact Guide)*. Plan participants are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. Contact the PBM to determine if the prescription is considered specialty.

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

- Limited access.
- Treat complex medical conditions.
- Complicated treatment regimens.

- Compliance issues.
- Special storage requirements; or
- Manufacturer reporting requirements.

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

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

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

Preferred Retail Pharmacy Network

For short-term prescriptions, such as antibiotics, use a Preferred Retail Pharmacy (for lower copays) or a Non-Preferred Retail Pharmacy (where participants will pay $10 extra for each short-term prescription). To find a preferred pharmacy near you, register or log in to *express-scripts.com/findapharmacy* or call Express Scripts' Member Services at 855-889-7708.

Smart90 Retail and Home Delivery Program

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

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

Smart90 Retail Pharmacy

To locate a participating Smart90 Retail Pharmacy or a Preferred Retail Network Pharmacy, log in to the E-PEBP Portal located at https://pebp.nv.gov/ and select *the identified PBM*. Participants can also get pharmacy information by contacting the PBM. Participants can transfer medications easily in-store, by phone or online.

Home Delivery

Participants may use home delivery through the PBM Home Delivery Pharmacy to receive a 90-day supply of maintenance medications and have them mailed to participants with free standard

shipping. Not all drugs are available via mail order. Check with the PBM for further information on the availability of prescription medication. Enrolling in home delivery is easy! First, log in to *express-scripts.com.*

If participants are enrolling a new prescription in home delivery:

- **Contact the doctor** and ask them to e-prescribe a 90-day prescription directly to the PBM
- **OR send a request** by selecting "Forms" or "Forms & Cards" from the "Benefits" menu,print and mail-order form and follow the mailing instructions
- **OR call** the PBM and they will contact the doctor for participants.

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

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

Generics Preferred Program

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

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

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

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

Example:

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

SaveonSP Program

As part of the prescription drug plan, PEBP has partnered with an Express Scripts' copay assistance program, SaveonSP, to help save money on certain specialty medications. Through the SaveonSP Program, manufacturer-funded assistance is available to help participants with the cost of the Program drug(s). The cost is reimbursed by the manufacturer at no cost to the participant.

The medications included in the SaveonSP Program are classified as Non-Essential Health Benefits under the Affordable Care Act. The cost of these drugs will not be applied towards satisfying the deductible or out-of-pocket maximum.

Participants currently taking a medication or those who will be taking a medication that is on the Non-Essential Benefit Specialty Drug List, are eligible to participate in the program.

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

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

Diabetes Care Value

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

Extended Absence Benefit

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

Out-of-Country Emergency Medication Purchases

This Plan may cover emergency prescription drugs purchased if participants reside in the United States and travel to a foreign country. Participants will need to pay for the drug at the time of purchase and later submit for reimbursement from the PBM. Prescription drug purchases made outside of the United States are subject to Plan provisions, *Benefit Limitations and Exclusions,* clinical review, and determination of medical necessity. The review may include application of pertinent Food and Drug Administration (FDA) regulations. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the United States.

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

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

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

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

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

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

Out-of-Network Pharmacy Benefit

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

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

Other Limitations

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

Emergency Refills

This plan allows for three (3) emergency refills per plan year, including in a declared disaster area.

Benefit Limitations and Exclusions

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

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

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

Abortion: Abortions are covered in accordance with NRS 442.250.

Alternative/Complimentary Health Care Exclusions:

- Chelation therapy (except as may be medically necessary for treatment of mental health, acute arsenic, gold, mercury, or lead poisoning) and for diseases due to excess of copper or iron.
- Prayer, religious healing, or spiritual healing.
- Naprapathy services or treatment/supplies.
- Homeopathic treatments/supplies that are not FDA approved.

Autopsy: Autopsies are not covered.

Bariatric and Overweight Surgery: The Plan's individual limit is one (1) bariatric surgery while covered under any current or previous PEBP self-funded health plan. Must be performed at a Center of Excellence. Surgeries provided out of network are excluded. PEBP or its designee will determine the In-Network Center of Excellence facility.

Behavioral Health Care Exclusions: The following behavioral health services are not covered.

- adoption counseling;
- court-ordered behavioral health care services (except pursuant to involuntary confinement under a state's civil commitment laws);
- custody counseling;
- dance therapy,
- 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 and/or couples counseling;
- intellectual disability;
- pregnancy counseling;
- vocational disabilities, or
- organic and non-organic therapies
  - including (but not limited to) crystal healing, EST, primal therapy, L-Tryptophan, vitamin therapy, religious/spiritual, etc.

- Expenses for tests to determine the presence of or degree of a person's dyslexia or learning disorder unless the visit meets the criteria for benefits payable for the diagnosis or treatment of Autism Spectrum Disorders.

Complications of a non-covered service: Treatment for complications of non-covered services is excluded.

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

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

- orthotic devices or orthotic braces that straighten or change the shape of a body part,
- prosthetic appliances, or
- air purifiers,
- humidifiers,
- electric heating units,
- swimming pools,
- spas,
- saunas,
- escalators,
- lifts,
- motorized modes of transportation determined to be not medically necessary,
- pillows,
- orthopedic mattresses,
- water beds, and
- air conditioners are excluded.

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

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

Cosmetic Services and Surgery: The Plan excludes expenses for cosmetic services, cosmetic surgery, and any drugs used for cosmetic purposes, including but not limited to health and beauty aids.

Complications resulting from cosmetic services or cosmetic surgery are not covered. This exclusion does not apply to breast reconstructive surgery or certain related treatments for members who have undergone mastectomies or other treatment for breast cancer.

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

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

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

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.

Dental Services: Dental prosthetics and orthodontia not covered.

The following services are covered under the dental plan.

- extraction of teeth;
- repair of injured teeth;
- general dental services;
- treatment of dental abscesses or granulomas;
- treatment of gingival tissues (other than for tumors);
- dental examinations;
- restoration of the mouth, teeth, or jaws because of injuries from
    - biting,
    - chewing, or
    - accidents;
- artificial implanted devices;
- braces;
- periodontal care or surgery;
- teeth prosthetics and bone grafts regardless of etiology of the disease process; and
- repairs and restorations except for:
    - appliances that are medically necessary to stabilize or repair sound and natural teeth after an injury;

- dental and or medical care including mandibular or maxillary surgery,
- orthodontia treatment,
- oral surgery,
- pre-prosthetic surgery,
- any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth in the Schedule of Benefits.

Coverage for dental services as the result of an injury to sound and natural teeth may be extended under the medical Plan to a maximum of two (2) years following the date of the injury. Restorations past the two-year time frame will be considered under the dental benefits described in the PEBP Self-Funded Dental PPO Plan Master Plan Document available at https://pebp.nv.gov/.

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

Drugs, Medicines, Nutrition or Devices:

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been prescribed for a medically necessary indication or are Experimental and/or Investigational.
- Non-prescribed, non-Legend and over the counter (OTC) drugs or medicines (except as preventive care medications required by the Affordable Care Act).
- Foods and nutritional supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs, and minerals (regardless of whether they can be purchased OTC or whether they require a prescription), except when provided during hospitalization; prenatal vitamins or minerals requiring a prescription;
- Special Food Product except for the benefit described as covered under Special Food Product in the *Schedule of Benefits* section or elsewhere in this document under the section titled *Obesity Care Management Program*;
- Naturopathic, Naprapathy, or homeopathic treatments/substances.
- Weight control or anorexiants, except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy or where otherwise noted in this document under the section titled *Obesity Care Management Program*;
- Compounded Prescriptions in which there is not at least one ingredient that is a Legend Drug requiring a Prescription, as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, or other health care facility.
- Vaccinations, immunizations, inoculations, or preventive injections that are not covered under the Summary of Benefits section.
- Marijuana and any derivative, including CBD, THC, edibles, etc. are not a covered benefit under this Plan.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the prescription drug program.

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

Durable Medical Equipment: See Corrective Appliances.

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

Electronic cigarettes: The Plan does not cover electronic cigarettes.

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

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

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

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

Fertility and Infertility Treatment: Except as otherwise specified in the Schedule of Benefits section, all other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) are excluded. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy; the promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility;

reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the participant's ability to become pregnant or to carry a pregnancy to term; and any payment made by or on behalf of a participant who is contemplating or has entered into a contract for surrogacy to a provider or individual related to any services potentially included in the scope of surrogacy services; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are also excluded.

Foot/Hand Care: Expenses for non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain; and expenses for routine foot care (including but not limited to: trimming of toenails, removal of corns and callouses, preventive care with assessment of pulses, skin condition and sensation) or hand care, (including manicure and skin conditioning), unless the Plan Administrator or its designee determines such care to be medically necessary.

Routine foot care from a podiatrist for treatment of foot problems such as corns, calluses and toenails are payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

Genetic Testing and Counseling: Coverage is not available for tests solely for research, or for the benefit of individuals not covered under this Plan.

Genetic testing and counseling not covered, unless otherwise specified in this Plan's Schedule of Benefits.

Growth Hormone: Off-labeled growth hormone is not covered.

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

Hair: Expenses for or related to hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Eflornithine; or for hair replacement devices, including (but not limited to) wigs, toupees and/or hairpieces or hair analysis. Patients undergoing chemotherapy may be able to receive benefits for some hair replacement devices, as set forth in the "Chemotherapy" section in the *Schedule of Benefits*.

Hearing Education: Special education and associated costs related to sign language a patient or family members.

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

Home Birth/Delivery: Home births are not covered by this Plan.

Home Health Care:

- Expenses for any home health care services that are not medically necessary, other than part-time, intermittent skilled nursing services and supplies.
- Expenses for a homemaker, custodial care, childcare, adult care, or personal care attendant, except as provided under the Plan's hospice coverage.
- Expenses for any home health care services that is not provided by an organization or professional licensed by the state to render home health services.
- Over-the-counter medical equipment supplies or any prescription drugs, except otherwise provided in the Summary of Benefits and Schedule of Benefits.

Expenses for any services provided substantially or primarily for the participant's convenience or the convenience of a caregiver.

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

Hypnosis and Hypnotherapy: An artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility is not covered.

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

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

Maternity/Family Planning: The following are not covered under the Plan.

- Expenses related to delivery associated with a pregnant dependent child, except for expenses related to complications of pregnancy.
- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs.
- For nondurable supplies.
- Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.

Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary.

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required because of an injury, illness, or disability of a covered individual, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc.) is not covered.

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

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 are not covered.

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

Orthodontia: Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an injury or illness are not covered.

Personal Comfort Items: Expenses for patient convenience, including (but not limited to) care of family members while the covered individual is confined to a hospital (or other health care facility, or to bed at home), guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

Private Room in a Hospital or Health Care Facility: The use of a private room in a hospital or other health care facility, unless the facility has only private room accommodation, or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

Prophylactic Surgery or Treatment: Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery, when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for:

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

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

Prophylactic drugs are excluded.

Rehabilitation Therapy (Inpatient or Outpatient):

- Expenses for education, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing, and related services.
- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
- Expenses for maintenance rehabilitation.

- Expenses for speech therapy for functional purposes including (but not limited to) stuttering, and stammering.
- Expenses for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for daily living or for Medically Necessary treatment of a mental health or substance use disorder diagnosis.
- Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability.
- Treatment that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency.

Service Animals: Purchase, training, or maintenance of any type of service animal is not covered.

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

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

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

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.

Transplant (Organ and Tissue) Experimental and/or Investigational: Human organ and/or tissue transplants that are experimental and/or Investigational, including (but not limited to) donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post-operative services and drugs or medicines, and all complications thereof.

Non-human (Engrafted) organ and/or tissue transplants or implants, except heart valves.

- Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this Plan

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

Vision Services: Some vision therapy is considered medically necessary and is covered under the medical plan such as recovery from stroke or brain injury, amblyopia, and strabismus.

The following are excluded from the Plan:

- Costs to fit visual aids,
- Vision therapy for dyslexia, reading issues, and learning disabilities,
- Experimental or non-FDA approved vision therapy or surgery,

- 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.

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

Weight Management and Physical Fitness:

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

Other Benefit Exclusions

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

Claims Administration

How Benefits are Paid

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

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

How to File a Claim

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 TPA; however, for providers who do not bill the Plan directly, participants may be sent a bill. In that case, follow these steps:

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

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

To ensure that medical, pharmacy or dental expenses participants incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For

example, the Plan has the right to deny Deductible and Out-of-Pocket Maximum credit or payment to a provider if the provider's bill does not include necessary information such as:

- Itemization of services;
- Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10;
- Date(s) of service;
- Place of service;
- Provider's Tax Identification Number;
- Provider's signature;
- Operative report;
- Patient ledger; or
- Emergency room notes, if applicable.

Providers such as hospitals and facilities that bill for single or bulk items such as orthopedic devices/implants or other types of biomaterials shall provide a copy of the manufacturer's/organization's invoice (that directly supplied the device/implant/biomaterial to the healthcare provider) to the TPA. This Plan will deny payment for such medical devices until a copy of the invoice is provided to the TPA.

Claims are processed by the TPA in the order that they are received.

Within 30 days of receipt of a clean claim, PEBP members will be notified if the claim is approved or denied. The claim cannot be adjudicated until completed correctly with all required documentation submitted for review.

Steps in claims processing	Pass	Fail
Was the claim sent on the correct claims form? Is there a date of service? Is there a provider ID? Is there a primary diagnosis code? Is there a procedure code? Is there a cost for the service?	Move to the next step.	Claim denies. The provider must resubmit it in the correct claim form.
Is the claim for a covered individual?	Move to the next step.	Claim denies.
Is the medical service date within 12 months of the claim submission.	Move to the next step.	Claim denies.
Was the provider in-network.	Apply negotiated price/rate.	Apply out of network coverage. In some cases, the claim denies if out-of-network is not allowed for the services.
Is the service covered by the plan?	Move to the next step.	Claim denies.
Does the service meet medical necessity?	Move to the next step.	Claim denies.

If required, was there a prior authorization for the service?	Move to the next step.	Claim denies.

The last component of claims processing is verification of the participant's coinsurance status; whether the member has met their deductible and determining what portion in the member's responsibility.

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

It is participants responsibility to maintain copies of EOBs. They cannot be reproduced.

Where to Send the Claim Form

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

Appeals (Medical)

Participants have the right to appeal any claim or a Adverse Benefit Determination resulting in a denial, reduction, termination, failure to provide or make payments (in whole or in part) for a service or treatment, rescission of coverage (retroactive cancellation), or HRA claim.

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

Level 1 Claim Appeal (NRS 287.670):

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

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

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

The TPA will review a participants claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process the request for appeal, it will be requested promptly.

The TPA will issue a Level 1 Claim Appeal decision in writing within 20 days after receipt of the request for appeal. The Appeal Decision shall include an explanation of the appeal determination and references to Plan rules, Master Plan Documents, or other relevant documentation.

The Appeal Decision will explain the steps necessary to proceed to a Level 2 Appeal if participants are not satisfied with the response of the Level 1 Claim Appeal.

Level 2 Claim Appeal (NRS 287. 880):

Level 2 Claim Appeals must be sent to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request form*s are available at https://pebp.nv.gov/ or by contacting PEBP Customer Service.

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

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

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

A Level 2 Appeal Decision will be provided to participants, in writing, by certified mail within 30 days of receipt by the Executive Officer or designee.

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

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

External Review

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

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

The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim. The independent review organization will use medical necessity as a component of their review which means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a 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.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. The OCHA will assign an independent external review organization within five 5 days after receiving the request.

A Request for External Claim Review must include:

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

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

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance

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

Discretionary Authority of PEBP and Designee

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

Utilization Management Appeal (NRS Chapter 695G)

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

Requests for an appeal must be made within 180 days of the date of the denial/non-certification. Appeals must be sent to PEBP's TPA. Appeals for pre-service denials will be reviewed by a physician within 15 days of the UM company's receipt of the request. Appeals for post-service treatment will be completed within 20 days of receipt of the request. The results of the determination of a standard appeal will be provided in writing to the participant, managing physician, facility, and third-party claim's administrator.

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

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

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

Standard Internal UM Appeal Review

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

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

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

External UM Appeal Review

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

Expedited Request for External Review (Pre-Service Urgent UM Appeal) NRS 287.04335

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

Expedited external review is available only if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination and the patient's treating provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered individual or would jeopardize the covered individual's ability to regain maximum function. Pursuant to NRS 695G.271, the Office for Consumer Health Assistance (OCHA) will approve or deny a request for an external review of an adverse determination not later than 72 hours after receipt from the provider. If OCHA determines the request qualifies for expedited review, a final of the external review will made by the external review organization within 72 hours of receipt and the provider and participant will be notified within 24 hours.

A participant may file a request for an expedited external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. An expedited external review request form, which includes a certification of treating provider for expedited consideration can be found on the PEBP website at https://pebp.nv.gov/.

The request must be submitted to:

Office for Consumer Health Assistance
7150 Pollock Dr
Las Vegas, NV 89119
Phone: (702) 486-3587, (888) 333-1597

Web:
https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/

Standard Request for External UM Review

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

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

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

Experimental and/or Investigational Claim/UM External Review

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

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

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

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

Prescription Drug Appeals

All prescription drug appeals are handled by the Pharmacy Benefit Manager (PBM). The PBM offers four levels of review: 1) Review, 2) Level I Appeal, 3) Level II Appeal, and External Review.

Review

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

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

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

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

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

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

Level 1 Appeal or Urgent Appeal

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

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

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health

of the patient or the patient's ability to regain maximum function or would subject the patient to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

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

Level 1 Appeal Decisions and Notifications
The PBM will render Level 1 Appeal determinations within the following timeframes:

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

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the participant and the health care professional together with an opportunity to respond prior to the 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, participants must request by mail or fax to the correct Clinical Coverage or Administrative Coverage Review Request department.

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

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

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

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

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

External Reviews (Pharmacy)

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

The pharmacy benefit manager will review the external review request within 5 (five) business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and the participant will be notified within 1 (one) business day of the decision.

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

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

Urgent External Review

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

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

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

Coordination of Benefits (COB)

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

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

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

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

Plan Type

- A participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such a fully insured plan and the rules and procedures described in such fully insured plan's applicable Summary of Insurance.
- A participant in a self-insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures set forth herein. PEBP delegates to the third-party administrator of such self-insured plan the duty to administer and interpret the COB provisions of this document and to adopt, document and communicate any rules and procedures necessary to implement the COB procedures, as set forth below.

COB Determination Rules

PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), to determine the primary plan and the secondary plan. Any plan that does not use these same rules will always be the primary plan.

The order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.
These rules are:

Rule 1: Non-Dependent/Dependent

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

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

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

Rule 2: Dependent Child Covered Under More Than One Plan

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

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

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

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

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

Rule 3: Retired Employee

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

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

Rule 4: Continuation Coverage

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

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

Rule 5: Longer/Shorter Length of Coverage

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

In order to make a COB determination, PEBP reserves the right to:

- Exchange information with other plans involved in paying claims;
- Require that participants or participants' health care provider(s) furnish any necessary information;
- Reimburse any plan that made payments this Plan should have made; or
- Recover any overpayment from a Participant's hospital, physician, dentist, other health care provider, other insurance company, or a Participant.

Once a payment is made, this Plan will be fully discharged from any liability it may have to the extent of such payment.

This Plan follows the customary COB rule that the medical program coordinates with only other medical plans and the dental program coordinates only with other dental plans or programs. There is no cross coordination of a medical plan to a dental plan.

When PEBP is the primary plan, it will consider the reasonable value of each service to be both the allowable expense, and the benefits paid. The reasonable value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

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

When PEBP is determined to be secondary, it will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to rights the participant may have against the other plan, and the participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

This Plan does not coordinate pharmacy benefits when PEBP is the secondary or tertiary payor.

Coordination with Medicare

Coordination with Medicare is not applicable for retirees and their dependents who are eligible for Medicare Part A and Medicare Part B and who are required to transition to the Medicare Exchange.

Entitlement to Medicare Coverage

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

Anyone under age 65 years who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

When the Participant Is Not Eligible for Premium Free Medicare Part A

This Plan will pay Part A services as primary. The Participant must enroll in Medicare Part B and PEBP will be the secondary payer for Medicare Part B services. This Plan will always be secondary to Medicare Part B, whether a Participant has enrolled.

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

How Much This Plan Pays When It Is Secondary to Medicare

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

When the Retiree or the Retiree's covered Spouse or Domestic Partner is enrolled in Medicare Part B, this Plan will pay secondary to Medicare Part B.

If eligible Retirees or their covered Spouses or Domestic Partners are not enrolled in Part B, this Plan will estimate Medicare's Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

End-Stage Renal Disease (ESRD)

A participant becomes entitled to Medicare when diagnosed with end-stage renal disease (ESRD). In this case, this Plan is the primary for:

- the first 30 months of Medicare ESRD coverage begins, or
- the first month in which the individual receives a kidney transplant.

This plan becomes secondary:

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

If a Participant is under age 65 years and receiving Medicare ESRD benefits the Participant will not be required to transition to PEBP's Medicare Exchange program. When a Participant reaches age 65 years, the Participant will be transitioned to the Medicare Exchange.

When the Participant Enters into a Medicare Private Contract

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

Coordination with Other Government Programs

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

Subrogation and Third-Party Recovery

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

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

Participant Contact Guide

Public Employees' Benefits Program (PEBP) 3427 Goni Road, Ste 109 Carson City, NV 89706 Customer Service: (775) 684-7000, (702) 486-3100, or (800) 326-5496 Fax: (775) 684-7028 https://pebp.nv.gov/	**Plan Administrator** • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
UMR Claims Submission P O Box 30541 Salt Lake City, UT 84130-0541 EDI #39026 Appeal of Claims P O Box 30546 Salt Lake City, UT 84130-0546 Customer Service (888) 763-8232 www.UMR.com Diabetes Care Management form submission UMR 27 Corporate Hill Drive Little Rock, AR 77205 Fax: 800-458-0701 Email: diabetes@UMR.com	**Third-party Claims Administrator/Third-party Administrator/PPO Network/ Disease Management Administrator** • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • Obesity Care Management Program • Disease Care Management Program • Sierra Health-Care Options (SHO) – Southern Nevada PPO Network • UnitedHealthcare Choice Plus – Outside of Southern Nevada PPO Network • Behavioral Health-Care Options (BHO) – Behavioral Health Network in Nevada
Sierra Health-Care Options, Inc PO BOX 15645 Las Vegas, NV 89144-5648 Customer Service : 888-323-1461 Fax : 800-288-2264	**Utilization Management and Case Management Company** • Pre-Certification/Prior Authorization • Utilization Management • Case Management • Transplants

Express Scripts Pharmacy Customer Service (855) 889-7708 www.Express-Scripts.com Accredo Patient Customer Service: (800) 803-2523 Accredo Physician Service Line (800) 987-4904 option 5 Express Scripts / Accredo Prior Authorization (800) 753-2851 Electronic option: express-scripts.com/PA Specialty Medication SaveonSP copay assistance (800) 683-1074 www.saveonsp.com/pebp	**Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and EPO Plan** • Prescription drug information • Retail network pharmacies • Prior authorization • Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies • Accredo Specialty Drug Services • Coverage and Clinical reviews • Appeals • External Review Requests • Copay/Deductible/Coinsurance assistance
HSA Bank HRA Claim Submission PO Box 2744 Fargo, ND 58108-2744 hsaforms@hsabank.com Fax: 855-764-5689 www.hsabank.com Customer Service: 833-228-9364 askus@hsabank.com myaccounts.hsabank.com	**HSA and HRA Claims Administrator** • HSA/HRA Claims and claim appeals
Diversified Dental Services 5470 Kietzke Lane, Ste 300 Reno, NV 89511 ProviderRelations@ddsppo.com 1-866-270-8326 diversifieddental.com	**PPO Dental Network** • Statewide PPO Dental Providers • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 www.myhpnstateofnevada.com/	**Southern Nevada Health Maintenance Organization (HMO)** • Medical claims/provider network
VIA Benefits 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888)598-7545 https://my.viabenefits.com/pebp Phone: (888) 598-7545 Fax: (402) 231-4310	**Medicare Exchange and Medicare HRA administrator** • Medigap (Supplemental) plans • Medicare Advantage Plans (HMO and PPO) • HRA claims administrator
United Healthcare Specialty Benefits Group Number: 370074 Customer Service: 1-888-763-8232	• Basic Life Insurance for eligible active and retirees

UnitedHealthcare Specialty Benefits P.O. Box 7149 Portland, ME 04112-7149	• Member Assistance Program • Global Travel Assistance
Office for Consumer Health Assistance 7150 Pollock Dr Las Vegas, NV 89119 Customer Service: (702) 486-3587 or (888) 333-1597 https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/	**Consumer Health Assistance** • Concerns and problems related to coverage • Provider billing issues • External review information
Corestream PEBP+ Customer Care: (775) 249-0716 E-mail: pebpcustomercare@corestream.com www.corestream.com Voluntary Life, Critical Illness, Accident, and Hospital Indemnity Insurance The Standard Insurance Company (888) 288-1270 www.standard.com/mybenefits/nevada	**PEBP+ Voluntary Benefits Administrator** • Accident Insurance • Auto Insurance • Critical Illness • Disability Insurance (Long-term and Short-term) • Home Insurance • Hospital Indemnity • Identity Theft • Legal Services • Life Insurance (Supplemental) • Pet Insurance • Vision Care