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

Welcome to the State of Nevada Public Employees’ Benefits Program (PEBP). PEBP provides a variety of benefits such as medical, dental, life insurance, long-term disability, flexible spending accounts, and other voluntary insurance benefits for eligible state and local government employees, retirees, and their eligible dependents.

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

All PEBP participants choosing the Consumer Driven Health Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD) which includes a Summary of Benefits for Life and Long-Term Disability (LTD) insurance, the Health and Welfare Wrap Plan Document, the Section 125 Document, and the PEBP Enrollment and Eligibility Master Plan Document. These documents are available at www.pebp.state.nv.us.

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

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

Sincerely,
Public Employees’ Benefits Program
Introduction

This Master Plan Document describes the Consumer Driven Health Plan (also referred to as the CDHP). This Plan is available to eligible employees, retirees and their dependents participating in the Public Employees’ Benefits Program (PEBP).

The CDHP is a self-funded plan administered by PEBP. The benefits offered with the CDHP includes medical, prescription drug, vision and dental coverage. The CDHP provides a Health Savings Account (HSA) for eligible employees and a Health Reimbursement Arrangement (HRA) for eligible retirees and active employees who are ineligible for the HSA. Additional benefits include long term disability insurance and basic life insurance for active employees and basic life insurance for eligible retirees. The medical, prescription drug and vision benefits are described in this document. An independent third-party claims administrator pays the claims for the medical, dental and vision benefits. An independent pharmacy benefit manager pays the claims for prescription drug benefits.

This PEBP Consumer Driven Health Plan is governed by the State of Nevada.

This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code 287 as amended and certain provisions of NRS 695G and NRS 689B.

The Plan described in this document is effective July 1, 2018, and unless stated differently, replaces all other CDHP medical and prescription drug benefit plan documents/summary plan descriptions previously provided to you.

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

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

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Per NRS 287.0485 no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.
Suggestions for Using this Document:

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

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

Accessing Other Benefit Information:

You will also want to access the following documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA and Privacy and Security and mandatory notices. These documents are available at www.pebp.state.nv.us.

- State of Nevada PEBP Health and Welfare Wrap Plan
- Consumer Driven Health Plan (CDHP) Master Plan Document
- CDHP Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life and Long-Term Disability Insurance Master Plan Document
- Premier Plan Master Plan Document
- Premier Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description
Participant Rights and Responsibilities

You have the right to:

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

You have the responsibility to:

- Establish a patient relationship with a participating primary care physician and a participating dental care provider. (Note: This Plan does not require you to designate a primary care physician.)
- Take personal responsibility for your overall health by adhering to healthy lifestyle choices. Understand that you are solely responsible for the consequences of unhealthy lifestyle choices.
  - If you use tobacco products, seek advice regarding how to quit.
  - Maintain a healthy weight through diet and exercise.
  - Take medications as prescribed by your health care provider.
  - Talk to your health care provider about preventive medical care.
  - Understand the wellness/preventive benefits offered by the Plan.
  - Visit your health care provider(s) as recommended.
- Choose in-network participating provider(s) to provide your medical care.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your health care providers.
- Read all materials concerning your health benefits or ask for assistance if you need it.
- Supply information PEBP and/or your health care professionals need to provide care.
- Follow your physician’s recommended treatment plan and ask questions if you do not fully understand your treatment plan and what is expected of you.
- Follow the Plan’s guidelines, provisions, policies and procedures.
- Inform PEBP if you experience any life changes such as a name change, change of address or changes to your coverage status because of marriage, divorce, domestic partnership, birth of a child(ren) or adoption of a child(ren).
• Provide PEBP with accurate and complete information needed to administer your health benefit plan, including if you or a covered dependent has other health benefit coverage.
• Retain copies of the documents provided to you from PEBP and PEBP’s vendors. These documents include but are not limited to copies of:
  o The Explanation of Benefits (EOB) from PEBP’s claims administrator. Duplicates of your EOB’s may not be available to you. It is important that you store these documents with your other important paperwork.
  o Your enrollment forms and/or other eligibility documents submitted to PEBP.
  o Your medical, vision and dental bills.
  o Copies of your HSA contributions, distributions and tax forms.

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

Summary of the CDHP Components
The CDHP is a PEBP administered Preferred Provider Organization High Deductible Health Plan which provides both in-network and out-of-network benefits. As a member, you receive coverage for many medically necessary services and supplies, subject to any Benefit Limitations and Exclusions of the Plan.

Highlights of the Plan
• Provides coverage for participants residing in and outside of Nevada. The Plan provides reimbursement for eligible medical expenses described in this document (and as determined by the Plan Administrator) for participants residing permanently, part time or while traveling outside of the United States. For more information, refer to the Out-of-Country Medical and Vision Purchases section.
• Provides coverage for eligible preventive care services at 100% when using in-network providers. Refer to the Preventive Care Services section for more information.
• Provides useful health care resources and tools to assist you in making informed decisions about your and your family’s health care services. For more information log in to your E-PEBP member portal account at www.pebp.state.nv.us.
• Provides access to in-network and out-of-network medical care (out-of-network coverage is not provided for preventive care or prescription drugs unless otherwise specified in this document).
• This Plan is an open access PPO plan and does not require a referral to see a specialist.
Deductibles
The Plan Year Deductibles (combined medical and prescription drug) includes two tiers:

- **Individual Deductible**: Applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible**: Applies when two or more individuals are covered on the same Plan (e.g. Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductible may be met through a combination of eligible covered expenses from all covered family members. The Family Deductible includes a “Single Member” embedded Deductible. This means one single member of the family is only required to meet the Single Member Deductible before the Plan starts to pay Coinsurance for that member.

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

During the Plan Year, you are responsible for paying for your eligible medical and prescription drug expenses (except eligible Preventive Services provided in-network) out of pocket until you have met your Deductible. Deductible credit is only applied for eligible medical and prescription drug expenses and in the order in which the claims are received by the Plan. Non-eligible medical and prescription drug expenses do not count toward the Deductible.

**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 $1,500. Participants are responsible for paying Out-of-Pocket for eligible medical and prescription drug expenses up to the Plan Year Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for in-network provider expenses and out-of-network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

**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 $1,500. Participants are responsible for paying Out-of-Pocket for eligible medical (prescription drugs are not covered out-of-network) expenses up to the Plan Year Deductible. Once the Individual Deductible is met, the Plan will pay its cost-share of eligible benefits. (In-Network and Out-of-Network Deductibles are not interchangeable, meaning the Deductibles accumulate separately for in-network provider expenses and out-of-network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

**In-Network Family Deductible**
The In-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is $3,000 (with a $2,700 “embedded” Single Member Deductible). For a participant covered with one or more dependents, this Plan...
will pay benefits for eligible in-network medical and prescription drug expenses for the entire family after the $3,000 Family Deductible is met; or the Plan will pay benefits for one single member of the family who has met the $2,700 Single Member “embedded” Deductible (under no circumstances will one single member of the family be required to pay more than the $2,700 toward the $3,000 Family Deductible.) The $3,000 In-Network Family Deductible may be met by any combination of eligible medical and prescription drug expenses from two or more covered individuals in the family. The Family Deductible (including Single Member Embedded Deductible) accumulates separately for in-network provider and out-of-network provider expenses. Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Out-of-Network Family Deductible
The Out-of-Network Family Deductible applies when two or more individuals are covered on the same Plan. For this Plan Year, the Family Deductible is $3,000 (with a $2,700 “embedded” Single Member Deductible). For a participant covered with one or more dependents, this Plan will pay benefits for eligible out-of-network medical (prescription drugs are not covered out-of-network) expenses for the entire family after the $3,000 Family Deductible is met; or the Plan will pay benefits for one single member of the family who has met the $2,700 Single Member “embedded” Deductible (under no circumstances will one single member of the family be required to pay more than the $2,700 toward the $3,000 Out-of-Network Family Deductible.) The $3,000 Family Deductible may be met by any combination of eligible medical expenses from two or more covered individuals in the family. The Family Deductible (including Single Member “embedded” Deductible) accumulates separately for in-network provider and out-of-network provider expenses.) Deductible credit is based on the date the medical or prescription drug expense is received by the Plan and not on the date of service.

Coinsurance
Coinsurance is the percentage of costs that generally, you and the Plan pay for eligible medical expenses after your Deductible is met. If you receive covered health care services using a health care provider who is a participating provider of this Plan’s PPO network, you will be pay less money of your pocket. This Plan generally pays 80% of the in-network provider’s contract rate and you are responsible for paying the remaining 20%. If you use an out-of-network provider (a non-participating provider, meaning the provider is not contracted with the PPO network), the Plan benefit may be reduced to 50% of usual and customary (U&C) charges, and you are responsible for paying the remaining 50%. Out-of-network providers can also bill you directly for any difference between their billed charges and the U&C charges allowed by this Plan.

Out-of-Pocket Maximums
In-Network Out-of-Pocket Maximums
The In-Network Out-of-Pocket Maximum (OOP Maximum) is the maximum amount you will pay for in-network eligible medical and prescription drug expenses during the Plan Year. The Out-of-Pocket costs you pay toward your Deductible and Coinsurance for eligible medical expenses accumulate toward your OOP Maximum. The OOP Maximum for:

- An Individual (covered as self-only) is $3,900
- Family coverage (participant plus one or more covered dependents) is $7,800.
o The Family OOP Maximum includes an “embedded” $6,850 Single Member OOP Maximum. A Single Member OOP Maximum means one single person covered under the CDHP’s Family coverage will not pay more than $6,850 in the Plan Year for eligible medical expenses.

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

Only eligible medical expenses that apply to the Deductible and Coinsurance will apply to the OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges and amounts that out-of-network providers bill and are payable that are greater than this Plan’s maximum allowable charge. This list is not all inclusive and may not include certain services and supplies that are not listed here.

For this section only, all references to the OOP Maximum, eligible medical expenses, Deductible and Coinsurance are specific to in-network benefits.

**Out-of-Network Out-of-Pocket Maximum**

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

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

Once an Individual or Family satisfies the OOP Maximum, the Plan will pay 100% of all covered medical (excluding out-of-network prescription drug expenses) for the remainder of the Plan Year. The OOP Maximum accumulates on a Plan Year basis and resets to zero at the start of a new Plan Year.

The accumulation of eligible medical expenses toward the OOP Maximum is based on the date the medical 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 expense from all covered family members.

Only eligible medical expenses that apply to the Deductible and Coinsurance will apply to the OOP Maximum. The OOP Maximum does not include premiums, cost-sharing for non-covered supplies and services, expenses associated with denied claims, ancillary charges and amounts that out-of-network providers bill and are payable that are greater than this Plan’s maximum allowable charge. This list is not all inclusive and may not include certain services and supplies that are not listed here.
Out-of-Network Out-of-Pocket Maximum, all references to the OOP Maximum, eligible medical expenses, Deductible and Coinsurance are specific to out-of-network benefits.

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

A PERSON WHOSE STATUS CHANGES FROM EMPLOYEE/RETIREE TO DEPENDENT OR FROM DEPENDENT TO EMPLOYEE

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

FAILURE TO COMPLY WITH UTILIZATION MANAGEMENT PROGRAMS

If you fail to follow certain requirements of the Plan’s utilization management program (as described in the Utilization Management section of this document), the Plan may pay a smaller percentage of the cost of those services and you will have to pay a greater percentage of those costs. The additional amount you will have to pay is in addition to your Deductibles or Out-of-Pocket Maximums described in the following tables.

**Expenses that Do Not Accumulate Towards Your Deductible and Out-of-Pocket Maximum.**

This Plan will never pay benefits equal to all the medical expenses you may incur. You are always responsible for paying for certain expenses for medical services and supplies. The following services **do not** accumulate toward the Deductible or Out-of-Pocket Maximum and you will be responsible for paying these expenses out of your own pocket:

- All 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 Benefit Limitations and Exclusions section of this document and dental expenses (unless deemed medical as described in this document).
- All charges exceeding the usual and customary charge determined by the Plan.
- Any additional amounts you are required to pay because you failed to comply with the utilization management program described in the Utilization Management section of this document.
- Benefits exceeding those services or supplies subject to limited overall maximums for each covered individual for certain eligible medical expenses. The services or supplies that are subject to limited overall maximum Plan benefits and the amounts of the limited overall maximum Plan benefits are identified in the Schedule of Medical Benefits.
- Certain Preventive 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 not include certain services and supplies that are not listed above.
## Individual and Family Deductibles and Out-of-Pocket Maximums

### Consumer Driven Health Plan (CDHP)

<table>
<thead>
<tr>
<th>Plan Deductibles and Out-of-Pocket Maximums</th>
<th>Individual (self-only coverage)</th>
<th>Family Participant plus one or more dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Deductibles</td>
<td>Individual: $1,500</td>
<td>Family: $3,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Single Member: $2,700</td>
</tr>
<tr>
<td>In-Network Out-of-Pocket Maximum</td>
<td>Individual: $3,900</td>
<td>Family: $7,800</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Single Member: $6,850</td>
</tr>
</tbody>
</table>

In-Network Deductibles and Out-of-Pocket Maximums – Combined medical and prescription drugs. For more information, refer to the In-Network Individual and Family Deductibles and In-Network Individual and Family Out-of-Pocket Maximum sections.

| Out-of-Network Deductibles                  | Individual: $1,500              | Family: $3,000                                 |
|                                            |                                 | Single Member: $2,700                          |

| Out-of-Network Out-of-Pocket Maximum       | Individual: $10,600             | Family: $21,200                                |

Out-of-Network Deductibles and Out-of-Pocket Maximums

 Prescription drugs purchased out-of-network are not a covered under this Plan and do not apply to the Out-of-Network Out-of-Pocket Maximum. For more information, refer to the Out-of-Network Individual and Family Deductibles and Out-of-Network Out-of-Pocket Individual and Family Maximums sections.
Eligible Medical Expenses
You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called eligible medical expenses, and they 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 are Usual and Customary (U&C) or do not exceed this Plan’s Maximum Allowable Charge (as those terms are defined in the Key Terms and Definitions section); and
- Not services or supplies that are excluded from coverage (as provided in the Benefit Limitations and Exclusions section); and
- The charges for services or supplies 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 you for all eligible medical expenses. Usually you will have to pay some Coinsurance toward the amounts you incur that are eligible medical expenses. However, once you have incurred the Plan Year Out-of-Pocket Maximum cost, no further Coinsurance will be applied for the balance of the Plan Year. There are also maximum benefits applicable to each participant.

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

- Not determined to be medically necessary (unless otherwise stated in this Plan);
- Determined to exceed this Plan’s Usual and Customary Charges (U&C) or Maximum Allowable Charge;
- Not covered by the Plan;
- Amounts exceeding the Plan’s maximum benefit; or,
- Payable because of a penalty for failure to comply with the Plan’s utilization management requirements.

Non-eligible benefits do not contribute to the Plan Year Deductibles or Out-of-Pocket Maximums as determined by the Plan Administrator for your specific coverage tier.

For more information regarding Non-Eligible Medical Expenses, see the Benefit Limitations and Exclusions section.

PPO Network Health Care Provider Services
If you receive medical services or supplies from an in-network PPO provider, you will be responsible for paying less money out-of-your pocket. Health care providers who are participating providers of the PPO network have agreed to accept the PPO network negotiated amounts in place of their standard charges for covered services. You are responsible for any applicable Plan Deductible and or Coinsurance requirements as outlined in this document and are described in more detail in the Schedule of Medical Benefits. 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, if you are seeing a provider that is in-network and that provider leaves the network, and you are actively undergoing a medically necessary course of treatment, and you and your provider agree that a disruption to your current care may not be in your best interest or if continuity of care is not possible immediately with another in-network provider, PEBP will pay that provider at the same level they were being paid while contracted with PEBP’s PPO network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

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

**Out-of-Country Medical and Vision Purchases**

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

Please contact this Plan’s claims administrator before traveling or moving to another country to discuss any criteria that may apply to a medical or vision service reimbursement request.

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

PEBP may require a written notice from you or your designated representative explaining why you received the medical services from an out of country provider and why you were unable to travel to the United States for these services. This provision applies to elective and emergency services. For emergency services, this Plan provides certain benefits for transportation back to the United States.

- If you are a state of Nevada active employee or a dependent of an active employee, this benefit is provided by United Healthcare Global, a subcontractor for Standard Insurance. For more information about this program please refer to the website and telephone number for Standard Insurance provided in the Participant Contact Guide.
- If you are a retiree or a dependent of a retiree with life insurance through Standard Life Insurance Company, this benefit is available through United Healthcare Global, a subcontractor for Standard Insurance. For more information about this program please...
refer to the website and telephone number for Standard Insurance provided in the Participant Contact Guide.

- If you are not eligible for transportation services provided by United Healthcare Global or if you do not utilize United Healthcare Global for transportation, this Plan may provide benefits for the purposes of medical transportation. This Plan typically will pay for commercial transportation. For more information, contact this Plan’s claims administrator listed in the Participant Contact Guide.

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

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

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

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

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

**Medical Provider (PPO) Networks**

The Plan’s Preferred Provider Organizations (PPO) are networks of hospitals, physicians, medical laboratories and other health care providers located within a service area who have agreed to provide health care services and supplies at negotiated discount fees to participants. When a participant uses the services of a PPO network (in-network) health care provider, the participant is responsible for paying the applicable Deductible and Coinsurance on the discounted fees for medically necessary services or supplies, subject to the Plan’s Benefit
Limitations and Exclusions. If you receive medically necessary services or supplies from an in-network provider, you will pay a lower Coinsurance than if you received those services or supplies from a health care provider who is not in the PPO network. In-network providers have agreed to accept the Plan’s payment (plus any applicable Coinsurance you are responsible for paying) as payment in full. The in-network health care provider generally deals with the Plan directly for any additional amount due.

Out-of-network (non-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 reimburse the participant for the Usual and Customary Charge (as defined in this document) for medically necessary services or supplies, subject to the Plan’s Deductibles, Coinsurance (on non-discounted services), Benefit Limitations and Exclusions. Non-network health care providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing). You can avoid potential balance billing by always using in-network providers.

Participants may obtain health care services from in-network or non-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 seeking services by contacting the PPO network. The PPO network’s telephone number and website are listed in the Participant Contact Guide section of this document and are available on the PEBP website at www.pebp.state.nv.us.

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

- In the event of a life-threatening emergency in which a participant uses a non-network provider, benefits will be paid at the in-network benefit level.
- For medically necessary services or supplies from non-network providers when such services or supplies are not available from in-network providers within 50 driving miles of the participant’s residence. This includes services provided for wellness/preventive, or a second opinion. (This exception only applies to those individuals who live in a service area covered by an eligible PPO network.)
- If a participant travels to an area not serviced by an eligible PPO network, benefits for a non-network provider will be paid at the Plan’s in-network level.
- If a participant travels to an area serviced by one of the Plan’s eligible PPO networks, the participant must use an in-network provider to receive benefits at the in-network benefit level.
- If a participant traveling to an area serviced by an eligible PPO network experiences an urgent but not life-threatening situation and cannot access an in-network provider, benefits may be paid as in-network for use of an out-of-network urgent care facility.
- If there is a specialty not available inside the participant’s eligible PPO network, benefits may be paid as in-network.

When a participant uses the services of a non-network provider in the circumstances defined above, charges by the non-network provider will be subject to the Plan’s Usual and Customary Charge (as defined in the Key Terms and Definitions section). Non-network
health care providers may bill the participant for any balance that may be due in addition to the amount paid by the Plan (called balance billing).

**In-State Preferred Provider Organizations (PPO Network)**
You should access the in-state PPO network:
- If you reside in the State of Nevada; or,
- If you reside outside the State of Nevada and travel into Nevada for medical services.

Information regarding the in-state PPO network is in the *Participant Contact Guide* section of this document and is available on the PEBP website www.pebp.state.nv.us.

**Out-of-State Preferred Provider Organizations (PPO Network)**
You should access the out-of-state PPO network:
- If you reside outside of Nevada and require medical services outside of Nevada (within the United States); or,
- If you reside in the State of Nevada and require medical services available in another state.

Information regarding the out-of-state PPO network is in the *Participant Contact Guide* section of this document and is available on the PEBP website www.pebp.state.nv.us.

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

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

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

**Healthcare Bluebook In-Network Pricing Tool**
Healthcare Bluebook is a resource that enables participants to find and compare high-quality, low-cost providers for various healthcare procedures. This service may be accessed by logging into the E-PEBP Portal and selecting Healthcare Bluebook. To encourage you to be an informed healthcare consumer, this service may offer a monetary reward when you use reasonably priced healthcare facilities for certain procedures.
Utilization Management

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

The Plan’s UM program is administered by an independent professional UM company operating under a contract with the Plan. The name, address and telephone number of UM company appears in the Participant Contact Guide section. The healthcare professionals at the UM company focus their review on the medical necessity of hospital stays and the medical necessity, appropriateness and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is medically necessary with respect to the patient’s condition and within the terms and provisions of this Plan.

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

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

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

- The UM company does not authorize a proposed surgery or other proposed medical treatment as medically necessary; or
- The Plan will not pay regular benefits for a hospitalization or confinement in a skilled nursing or sub-acute facility because the UM company does not authorize a proposed confinement.

PEBP, HealthSCOPE Benefits (claims administrator), and Hometown Health (UM company) are not engaged in the practice of medicine and are not responsible for the outcomes of health care
services actually provided (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.

The Plan’s UM program consists of:

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

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

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

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

Case Management
Case Management is a voluntary process administered by the UM company. Its medical professionals work with the patient, the patient’s family, caregivers, providers, the claims administrator, and the Plan Administrator or its designee to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly and/or high-technology services, or when assistance is needed to guide the patient through a maze of potential providers.
The case manager will work directly with your physician, hospital and/or other provider to review proposed treatment plans and to assist in coordinating services and obtaining discounts from providers as needed. From time to time, the case manager may confer with your physician or other providers and may contact you or your family to assist in making plans for continued health care services or obtaining information to facilitate those services.

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

Note: There are some services for which case management services are mandatory for those who are seeking treatment of gender reassignment procedures. The Plan Administrator requires case management to help the participant, provider and other PEBP vendors to work together for successful outcomes.

Prior Authorization
Prior Authorization or pre-authorization review is a procedure administered by the UM company to assure health care services meet or exceed accepted standards of care. It also includes the determination of whether the admission and length of stay in a hospital or skilled nursing or sub-acute facility, surgery or other health care services are medically necessary and if the location of service is high quality and lowest cost.

The services for which you are required to seek prior authorization are:

- All inpatient admissions, including observation admissions and same day surgeries with observation requests, services in any facility type, including acute and skilled care, mental health care, drug or alcohol detoxification, or rehabilitation (including partial or full day hospitalization service stays). This includes planned use of a hospital for a dental purpose. (Exception: a pregnant mother does not need to notify the utilization management company about the admission for delivery unless the stay will exceed 48 hours for a vaginal delivery or 96 hours for a C-section);
- All outpatient surgeries performed in a surgery center or outpatient hospital setting;
- All inpatient services, outpatient partial hospitalization programs, and partial residential treatment programs for behavioral health services;
- All admissions to a skilled nursing facility or sub-acute facility;
- All admissions to any hospital or rehab facility for rehabilitation therapy;
- All organ/tissue pre-transplantation related expenses, including the admission for transplantation services;
- All outpatient non-emergent cardiac surgeries including cardiac ablations, automated implantable cardioverter-defibrillator (AICD), catheterization, angioplasty;
- Air ambulance for scheduled inter-facility patient transport (refer to the Air/Flight Ambulance section of this document for inter-facility patient transport benefits);
- Infusion therapy including outpatient and home infusion services;
• Any jaw/face/TMJ procedures and orthognathic surgical procedures or prosthetics including but not limited to stabilization or bite splints;
• Ear devices, including but not limited to cochlear implants and cochlear BAHA systems;
• Oral pharynx procedures performed for sleep apnea or potential airway compromise to include mandibular splints or mandibular advancement splints;
• Foot surgeries such as bunionectomy, correction of hammer toes, or corrective procedures on metatarsals, phalanges (toes); metatarsophalangeal joint, and interphalanageal joint;
• Carpal tunnel surgery;
• Gender dysphoria: Any services related to the diagnosis of or treatment of gender dysphoria;
• Genetic testing and/or counseling for:
  o Amniocentesis;
  o Non-invasive pre-natal testing for fetal aneuploidy;
  o Chorionic villus sampling (CVS),
  o Alpha-fetoprotein (AFP);
  o BRCA1 and BRCA2; or
  Apo E.
  o For other types of genetic testing and/or counseling, contact the claims administrator;
• Bariatric surgery (see more Plan restrictions for this service in the section below);
• All spinal surgeries, inpatient and outpatient, to include but not limited to laminotomy, discectomy, stereotaxis and neurostimulators;
• Dialysis: Inpatient and outpatient;
• Cardiac pace makers;
• Illnesses requiring chemotherapy or infusion therapy;
• Allergy testing services;
• Any procedure that might be deemed to be Experimental and or Investigational; and
• Durable medical equipment when the cost is expected to exceed $1,000.

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

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

The UM company must be notified of the emergency hospital admission within one business day so that the UM company conduct a concurrent review. Your physician or the hospital should call the UM company to initiate the concurrent review. Even though a prior authorization may not be required for some services, like those listed above, the hospital or facility is still required to comply with the Plan’s provisions regarding UM, such as concurrent review.
How to Request Prior Authorization

It is your responsibility to ensure that prior authorization occurs when it is required by the Plan. Any penalty for failure to obtain prior authorization is your responsibility, not the provider’s. You or your physician must call the UM company at the telephone number shown in the Participant Contact Guide to request prior authorization. Calls for elective services should be made at least 14 calendar days before the expected date of service or may be subject to the benefit reduction listed in the Elective Inpatient and Outpatient Surgeries section. The UM company will require the following information:

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

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

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

Elective Inpatient and Out-Patient Surgeries

You are required to obtain a prior authorization before you obtain services for inpatient and outpatient elective surgeries. If you do not follow the required UM process, benefits for the elective surgeries may be reduced by 50% of this Plan’s Maximum Allowable Charge. This provision applies to both in-network and out-of-network surgery expenses (if an out-of-network surgery is allowed as an exception). Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum.

Out-Patient Infusion Services Performed at Exclusive Hospitals and Infusion Centers

Prior authorization is required for all outpatient infusion services. The UM company will review the request based on covered benefits, medical necessity, provider quality, cost, and location. If you choose to receive your infusion at a non-exclusive hospital or infusion center, you will be responsible for any amount that exceeds this Plan’s reference-based pricing. Note: Amounts exceeding this Plan’s reference-based pricing will not apply to your annual Deductible or Out-of-Pocket Maximum.
Emergency Hospitalization
You are not required to obtain a prior authorization before you obtain services for a medical emergency. Further, if a medical emergency occurs, there may be no time to contact the UM company before you are admitted to the hospital. However, the UM company must still be notified of the hospital admission within one business day so that the UM company can conduct a concurrent review. You, your physician, the hospital, a family member or friend can call the UM company. If you do not follow the required UM process, benefits payable for the services may be reduced by 50% of this Plan’s Maximum Allowable Charge. This provision applies to both in-network and out-of-network medical expenses. Expenses related to the penalty will not be counted to meet your Out-of-Pocket Maximum.

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

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

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

Inpatient and Out-Patient Surgery Performed at Exclusive Hospitals and Out-Patient Surgery Centers
If you are planning to have an elective inpatient or out-patient surgery, it is your responsibility to request prior authorization through the UM company. The UM company will make a prior authorization determination based on the type of surgery, covered benefits, medical necessity, provider quality, cost, and location. If you choose to receive health care services from a non-exclusive provider or facility your benefits will be limited to the reference-based pricing for the services. This provision applies to health care services received from both in-network and out-of-network Providers. For this section only, you may be balanced billed for amounts exceeding this Plan’s reference-based price. Amounts exceeding this Plan’s reference-based price will not apply to your Deductible or Out-of-Pocket Maximum.

Failure to Follow Required UM Procedures
If you do not follow the required prior authorization review process described in this section, benefits payable for the services you failed to receive a prior authorization will be reduced by 50% of the Plan’s Maximum Allowable Charge. This provision applies to both in-network and
out-of-network (when allowed due to exception) covered expenses. Expenses related to the penalty will not apply to your Plan Year Deductible or Out-of-Pocket Maximum.

If you do not follow the required concurrent review process which requires notification to the UM company within one (1) business day of an emergency hospital admission so the UM company can conduct a concurrent (continued stay) review, the benefits payable for the services may be reduced by 50% of the Maximum Allowable Charge. This provision applies to both in-network and out-of-network (when allowed due to exception) covered expenses. Expenses related to the penalty will not apply to your Plan Year Deductible or Out-of-Pocket Maximum.

If you wish to appeal a decision made by the UM company, refer to the Appealing a UM Determination section.

What Is Covered Under the Plan

This Plan covers many medically necessary services and supplies, subject to any limits or exclusions in the Plan. However, this Plan only covers care provided by professionals or facilities licensed, certified or otherwise qualified under state law to provide health care services.

Preventive Care Services

The Plan provides coverage for preventive care services in accordance with the Affordable Care Act and other services that are recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC), and as mandated by NRS 287.0433.

Preventive care services received from in-network providers, are paid at 100% under this Plan. The participant is not responsible for Deductible or Coinsurance. Please note, any costs paid by this Plan for preventive care services will not apply toward the participant’s Deductible or Out-of-Pocket Maximum.

Highlights of the preventive care covered services are listed below:

Well-Child Care
Benefits are payable in any Plan Year for infants, children and adolescents for preventive care services and screenings provided for in guidelines supported by the HRSA if such guideline is issued at least one year prior to the beginning of such Plan Year.

Well-Adult Care
Well-adult care includes one routine office visit and examination each Plan Year after age 18 years and one OB/GYN office visit and examination after age 18 years of age each Plan Year.

Immunizations
Benefits are payable in any Plan Year for immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practice for Disease Control and Prevention if such recommendation went into effect at least one year prior to the beginning of such Plan Year.
Women’s Preventive Care

Covered health services include:

- One annual routine gynecological exam which includes a physician pelvic and breast exam. Covered health services for a PAP smear will be payable according to USPSTF recommendations;
- Screening for cervical cancer in women ages 21 to 65 years with cytology (PAP smear) every three years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every five years; and
- All FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The FDA requires the services to be “prescribed” by a physician even for over the counter methods. The following is a list of the FDA approved female contraceptive methods:
  1. Voluntary sterilization for women;
  2. Surgical sterilization implants for women;
  3. Implantable rods;
  4. Copper-based intrauterine devices;
  5. Progesterone-based intrauterine devices;
  6. Injections;
  7. Combined estrogen- and progestin-based drugs;
  8. Progestin-based drugs;
  9. Extended- or continuous-regimen drugs;
 10. Estrogen- and progestin-based patches;
 11. Vaginal contraceptive rings;
 12. Diaphragms with spermicide;
 13. Cervical caps with spermicide;
 14. Sponges with spermicide;
 15. Spermicide;
 16. Female condoms;
 17. Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
 18. Ulipristal acetate for emergency contraception (morning after pill)

For more information, please visit:

- **Preventive Services for Adults and Families**: Visit the U.S. Preventive Task Force at [https://www.uspreventiveservicestaskforce.org/Page/Name/uspsf-a-and-b-recommendations/](https://www.uspreventiveservicestaskforce.org/Page/Name/uspsf-a-and-b-recommendations/)
- Vaccines & Immunizations: Visit the Centers for Disease Control and Prevention at [https://www.cdc.gov/vaccines/index.html](https://www.cdc.gov/vaccines/index.html)

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

**This Plan covers preventive care services as recommended by the United States Preventive Services Task Force (USPSTF) A&B Recommendations and the Health Resources and Services Administration (HRSA) for Women and Children.** This Plan’s coverage may change if the recommendations of the USPSTF or HRSA change.

Note: This Plan complies with SB233, Sections 54-57 and AB249, Section 25 [2017 Legislative Session] as related to contraceptive methods, utilization management, step therapy, prior authorization, categorization of prescription drugs (meaning Preferred Generic, Preferred Brand and Non-Preferred Brands), and cost-sharing. For more information, refer to SB233 or AB249 at [https://www.leg.state.nv.us/Session/79th2017/Reports/](https://www.leg.state.nv.us/Session/79th2017/Reports/)

**Ambulance Services**

**Ground Ambulance**
This Plan covers transportation by a professional ground ambulance, including approved available train transportation to a local hospital or transfer to the nearest facility having the capability to treat the condition, if the transportation relates to an inpatient confinement.

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. Any amount exceeding the Plan’s maximum allowable charge. The maximum allowable charge for all air ambulance services is limited to 250% of the applicable Medicare allowable rate. Amounts exceeding the maximum allowable charge shall be the participant’s responsibility and will not be applied to the annual Out-of-Pocket Maximum. See the Utilization Management section for air ambulance prior authorization requirements.

**Air/Flight Scheduled Inter-Facility Transfer**
This Plan provides coverage for inter-facility patient air transport if there is a life-threatening situation or the service is deemed medically necessary by the UM company.
The following conditions apply to scheduled inter-facility air transport benefits:

- Prior authorization is required before inter-facility transport of the participant by air transport via any form of flight to another hospital or facility;
- Failure to obtain a prior authorization may, at the discretion of the Plan Administrator or its designee, result in a reduction or denial of benefits for charges arising from or related to inter-facility patient transport via air/flight. Non-compliance penalties imposed for failure to obtain prior authorization will not apply to the Plan Year Deductible or Out-of-Pocket Maximum; and
- As part of prior authorization review, the Plan Administrator retains the discretionary authority to limit benefit availability to alternative providers of flight-based inter-facility patient transport when a provider fails to comply with the terms of the Plan, or if the proposed charges exceed the Maximum Allowable Charge in accordance with the terms of this Plan.

For this section only, the Maximum Allowable Charge shall mean 250% of the applicable Medicare rate.

**Air/Flight Emergency Transport**

This Plan provides coverage for emergency air ambulance transportation for participants and their covered dependent(s) whose medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness or 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.

The Plan Administrator retains discretionary authority to limit benefit availability when a provider fails to comply with the terms of the Plan, or the charges exceed the Maximum Allowable Charge in accordance with the terms of the Plan. For this section only, the Maximum Allowable Charge shall mean 250% of the applicable Medicare rate.

**Skilled Nursing Facility**

The Plan benefit for an inpatient stay in a skilled nursing facility (SNF) is limited to 60 days per Plan Year for all confinements related to the same cause. Services must be ordered by a physician.

An inpatient admission to a skilled nursing facility or subacute facility requires prior authorization from the UM company.
Home Health Care
The Plan pays for part-time intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion services, subject to the maximum Plan benefits. Home services other than skilled nursing care are not covered by this Plan.

Home health care and home infusion services are only covered when ordered by a physician or health care practitioner. The maximum benefit for skilled home health care and home infusion services is 60 visits per Plan Year per covered per participant. A home health care visit will be considered a periodic visit by a nurse or therapist, or (4) four hours of home health services.

Charges are covered for private duty nursing by a licensed nurse (RN, LVN or LPN) only when the care is medically necessary and not custodial in nature. Outpatient private duty nursing care on a 24-hour shift basis is not covered by this Plan.

Enteral formulas for use at home (including parental nutrition and nutritional supplements) are payable for use as mandated by law.

Hospice Care
The hospice care program administers palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill patients with a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice) with an emphasis on keeping the patient as comfortable and free from pain as possible. This Plan covers home hospice and inpatient hospice care.

Bereavement counseling services provided by a licenses social worker or a licenses pastoral care counselor for the patient’s immediate family (covered spouse and or dependent children) as provided by the hospice service. Bereavement counseling beyond that included as part of the hospice program is payable under the Behavioral Health Benefits of this Plan.

For more information, see Hospice Care in the Key Terms and Definitions section.

Emergency Care
If you need emergency care and cannot arrange for care from an in-network provider, the Plan will pay your claims at the in-network level, regardless of the provider’s network status.

You are not required to obtain a prior authorization before receiving care; however, you must notify the UM company of an inpatient hospital admission within one (1) business day so the UM company can conduct a concurrent review. Refer to the Failure to Follow UM Procedures in the Utilization Management section of this document for penalties associated with emergency inpatient admissions.
Disease Management

Diabetes Care Management
The Diabetes Care Management (DCM) program is a disease management program open to participants diagnosed with diabetes.

The DCM program is voluntary and considered an “opt-in” program. To join the DCM program, contact the claims administrator listed in the Participant Contact Guide. Your effective date will be the 1st day of the month following the completion of your enrollment.

The information described in this section provides a summary of the program’s functions. For more detailed information, please contact the claims administrator.

Plan participants will be required to adhere to the following requirements:

- Submit a completed DCM form signed by both the DCM plan participant and their provider on or before June 30, 2019. Completed forms must be mailed (postmarked on or before June 30, 2019), or faxed on or before June 30, 2019 to the claims administrator;
- At least two visits with their primary care physician or endocrinologist each Plan Year;
- Adherence to the diabetes medications prescribed by their physician. This will be monitored by the claims administrator; and
- Adherence to appropriate laboratory testing as prescribed by their physician.
- Participants diagnosed with diabetes who are actively engaged in the diabetes care management program will receive the following benefits:
  - Two physician office visits indicating a primary diagnosis of diabetes will be paid for under the wellness/preventive benefit annually;
  - Two routine laboratory blood services such as the hemoglobin (A1c) test will be paid for under the wellness/preventive benefit annually;
  - Diabetes-related medications, such as insulin and Metformin, will be eligible for copayments and not be subject to the Plan Year Deductible; and
  - Diabetic supplies coordinated through the Pharmacy Benefit Manager’s mail order service are eligible for purchase for a flat copay for each 90-day supply item and are not subject to the Plan Year Deductible. If the diabetic supply is less than the copayment, the participant will be charged the actual cost of the item and not the copay.

Copays paid under this benefit will apply annual Out-of-Pocket Maximum.

If, at any time, the claims administrator deems a participant to be non-compliant or no longer engaged, the participant will return to the standard CDHP benefits where the cost sharing amounts will apply to the medical services listed in this section. The effective date of the return to the CDHP benefits will be the first day of the month following the non-compliance notification from the claims administrator.
### Schedule of Medical Benefits

**Diabetes Care Management Program (DCM)**

(All benefits are subject to the wellness benefit except where noted)

See also the *Explanations and Limitations* and *Key Terms and Definitions* sections of this document for important information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine office visits and routine laboratory testing</td>
<td>100% of PPO contracted rate No Deductible Limit of two visits per year</td>
<td>Not covered under wellness or preventive benefits Subject to 50% Coinsurance and Annual Deductible</td>
</tr>
</tbody>
</table>

#### Explanations and Limitations

- Enrollment in the DCM program, including compliance with the DCM program provisions is required to receive the DCM enhanced benefits.
- Must be for physician office visits indicating a diagnosis of diabetes.
- Must be actively engaged in the Diabetes Care Management program.
- Limit of two routine office visits per year.
- Limit of two routine laboratory blood services such as the hemoglobin (A1c) test will be paid for under the wellness/preventive benefit annually.
- **If a participant exceeds two routine office visits per year and two routine laboratory blood services per year, the annual Deductible and Coinsurance will apply to these services.**

#### Explanations and Limitations

To enroll in this benefit, contact the claims administrator at the number listed in the *Participant Contact Guide*.

- Enrollment in the DCM program, including compliance with the DCM program provisions is required to receive the DCM enhanced benefits.
<table>
<thead>
<tr>
<th>Benefit Description:</th>
<th>Diabetes related medications (such as insulin and Metformin)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Retail</td>
</tr>
<tr>
<td><strong>Retail 30-Day Supply</strong></td>
<td></td>
</tr>
<tr>
<td>Tier 1 Generic:</td>
<td>$5 Copay</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand:</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Brand:</td>
<td>100% of the cost of the medication. Deductible Credit is not applied.</td>
</tr>
<tr>
<td><strong>Mail Order – 90-Day Supply</strong></td>
<td></td>
</tr>
<tr>
<td>Tier 1 Generic:</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand:</td>
<td>$75 Copay</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Brand:</td>
<td>100% of the cost of the medication. Deductible Credit is not applied.</td>
</tr>
<tr>
<td><strong>Diabetic Supplies – 90-Day Mail Order Supply</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetic Supplies (test strips, insulin syringes, alcohol pads, and lancets)</td>
<td>$50 Copay / each supply item. If the cost is less than $50, you will pay the actual cost of the item.</td>
</tr>
<tr>
<td>Blood Glucose Monitor:</td>
<td>$0 Copay (limited to one per Plan Year)</td>
</tr>
</tbody>
</table>

**Explanations and Limitations**

- **Specialty medications are not covered under this program** and are subject to the standard Plan benefits. **Diabetes related medications will be identified by PEBP’s prescription drug administrator.**
- Copayments for Tier 1 (Generic) and Tier 2 (Preferred Brand) drugs apply to the Plan Year Deductible and Out-of-Pocket Maximum.
- **Must be actively engaged in the Diabetes Care Management program.**
- 90-day **retail** supply of diabetes medications is subject to three times the listed 30-day supply copayment. Diabetic supplies must be coordinated through the Pharmacy Benefit Manager’s mail order service to receive the DCM program’s enhanced benefit.
Obesity and Overweight Care Management

The Obesity and Overweight Care Management program is open to all CDHP participants who have been diagnosed as obese or overweight by their physician and who meet the criteria set out in this section.

For enrollment information, please contact the claims administrator listed in the *Participant Contact Guide*. When you enroll in the program, your effective date will typically be the 1st of the month following your enrollment. The effective date is determined by the Plan Administrator.

The information described in this section provides a summary of the program’s functions. For more detailed information, please contact the claims administrator.

The Obesity and Overweight Care Management program is optional and considered an “opt-in” program. To be eligible for this program’s enhanced benefits, participants must meet certain criteria and adhere to certain participation requirements.

You and your weight loss provider will determine your final weight loss goal when you initially start participating in a medically supervised weight loss program with your provider. Once you have met your final weight loss goal, benefits under the *Obesity and Overweight Care Management* program will end.

This Plan does not provide benefits for ongoing maintenance care. If you choose to receive ongoing maintenance care, you will be responsible for the cost of receiving the services.

This Plan’s claims administrator, HealthSCOPE Benefits, provides an Obesity Care Management participant program navigation guide available through the PEBP Member Portal, see the *Participant Contact Guide* for more information.

Criteria for Obesity/Overweight weight loss benefits for adults 18 years and older:

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

2. The patient’s BMI must be greater than 30 kg/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:
a. Coronary artery disease;

b. Diabetes mellitus type 2;

c. Hypertension (Systolic Blood Pressure greater than or equal to 140 mm Hg or Diastolic Blood Pressure greater than or equal to 90 mm Hg on more than one occasion);

d. Obesity-hypoventilation syndrome;

e. Obstructive sleep apnea;

f. Cholesterol and fat levels measured (Dyslipidemia):

g. HDL cholesterol less than 35 mg/dL;

h. LDL cholesterol greater than or equal to 160 mg/dL; or

i. Serum triglyceride levels greater than or equal to 400 mg/dL.

For Children two to 18 years:

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

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

Engagement in the Program

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

Monitoring Engagement

The claims administrator will assist your weight loss provider with completing monthly progress reports. The initial report should include your weight and BMI or waist circumferences, and a description of your treatment plan to include weekly weight loss goals, final weight loss goal, exercise regimen, diet and nutrition instructions. Subsequent monthly reports should provide information regarding your weight loss progress and adherence to the treatment plan. Submission of these reports will be a requirement for payment under the enhanced wellness benefits. If your monthly weight loss reports are not received by the claims administrator, your benefits under this program will end, and your coverage will return to the standard 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 claims administrator.

How to Enroll in the Obesity and Overweight Care Management Program

1. Contact the claims administrator for a list of in-network weight loss providers. This information is located on claims administrator website by logging into the E-PEBP Portal;

2. Make an appointment with an in-network weight loss provider. You may consider the physical location of the provider when considering which provider may work best with you. the claims administrator can also help you identify which in-network provider may best meet your needs, based on geography or other specialized needs you may have;
3. When you make an appointment with your in-network weight loss provider, before your visit, be sure to take an Obesity and Overweight Care Management Program Enrollment form with you. This form is located on HealthSCOPE Benefits’ website under forms;
4. Have your in-network weight loss provider complete the enrollment form and submit (by mail or fax) the completed form to HealthSCOPE Benefits. Their name, address and fax number are provided on the enrollment form;
5. HealthSCOPE Benefits will review the information submitted by your provider and if the information indicates that you meet the criteria for the weight loss program benefits, HealthSCOPE Benefits will enroll you in the program. HealthSCOPE Benefits will notify PEBP and Express-Scripts of your enrollment. If you do not meet the criteria for weight loss benefits, HealthSCOPE Benefits will notify you of the denial of benefits; and
6. Engagement in the program.

**Benefits under the Obesity and Overweight Care Management Program**
The following benefits are included, many at no cost to you, when provided under the obesity and overweight care program subject to the limits set out in the *Schedule of Medical Benefits*:

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

See the chart beginning on the next page for the Schedule of Benefits for Obesity Care and Overweight Care Management Program.
### Schedule of Medical Benefits

#### Obesity and Overweight Care Management Program

*(All benefits are subject to the wellness benefit except where noted)*

See also the *Explanations and Limitations* and *Key Terms and Definitions* sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description:</th>
<th>Weight loss medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Retail 30-Day Supply</strong></td>
<td></td>
</tr>
<tr>
<td>Tier 1 Generic:</td>
<td>$5 Copay</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand:</td>
<td>$25 Copay</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Brand:</td>
<td>Participant pays 100% of the cost of the drug; Does not apply to Deductible or Out-of-Pocket Maximum</td>
</tr>
<tr>
<td><strong>Mail Order 90-Day Supply</strong></td>
<td></td>
</tr>
<tr>
<td>Tier 1 Generic:</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Tier 2 Preferred Brand:</td>
<td>$75 Copay</td>
</tr>
<tr>
<td>Tier 3 Non-Preferred Brand:</td>
<td>Participant pays 100% of the cost of the drug; Does not apply to the Deductible Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

### Explanations and Limitations

Medications related to the treatment of overweight or obesity will be identified by PEBP’s pharmacy benefits manager. Before you begin your medication weight loss treatment, please contact PEBP’s pharmacy benefits manager to make sure the medication your provider has prescribed is covered under the current formulary.

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

### Other Limitations

This Plan does not coordinate prescription drug plan benefits.

Participant or covered dependent must be actively engaged in the Obesity and Overweight Care Management program.

- Copayment at 90-day supply retail is subject to three times the listed 30-day retail copayment.
- Medications purchased at non-participating pharmacies are not covered under this Plan.
- This Benefit does not include products such as HCG whether prescribed or obtained over the counter.
### Schedule of Medical Benefits

#### Obesity and Overweight Care Management Program

(All benefits are subject to the wellness benefit except where noted)

See also the *Explanations and Limitations* and *Key Terms and Definitions* sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits:</strong></td>
<td>Covered 100%; not subject to Deductible</td>
<td>Plan pays 50% Coinsurance after Deductible U&amp;C allowable applies.</td>
</tr>
<tr>
<td><strong>Laboratory Test:</strong></td>
<td>Covered 100%; not subject to Deductible</td>
<td>Plan pays 50% Coinsurance; after Deductible U&amp;C allowable applies.</td>
</tr>
<tr>
<td><strong>Nutritional Counseling Services:</strong></td>
<td>Covered 100%; not subject to Deductible</td>
<td>Plan pays 50% Coinsurance; after Deductible U&amp;C allowable applies.</td>
</tr>
</tbody>
</table>

#### Explanations and Limitations

- Office visits must be provided by an in-network provider who specializes in weight loss services according to the Plan’s PPO Provider network; or an in-network provider who is certified by the American Board of Bariatric Medicine (ABBM); or an in-network provider who is in training to become certified by the ABBM; or if no provider as described above is available within 50 miles of a participant’s residence, services may be provided by any in-network provider.

- Laboratory test must be provided by an in-network provider. Participant/dependent must meet criteria stated in the *Obesity and Overweight Care Management* section; and must be actively engaged in a medically supervised weight loss program to receive this benefit.

- Please refer to the *Obesity and Overweight Care Management* section of this document for more information about this program.

- The frequency of nutritional counseling services will be determined by the claims administrator and will be based on medical necessity.
### Schedule of Medical Benefits

#### Obesity and Overweight Care Management Program

(All benefits are subject to the wellness / preventive benefits except where noted)

See also the *Explanations and Limitations* and *Key Terms and Definitions* sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network Benefit</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meal Replacement Therapy</td>
<td>Plan pays 50% of the cost, up to a maximum benefit of $50 per month; not subject to Deductible.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Gym Membership and Exercise Equipment</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Bariatric Weight Loss Surgery</td>
<td>Not covered under this benefit. See <em>Bariatric Weight Loss Surgery</em> in <em>What is Covered Under This Plan</em> section.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Explanations and Limitations

Benefit is for individuals who are diagnosed as morbidly obese only.

- Meal replacements must be prescribed and dispensed by the weight loss medical provider.
- Participant or covered dependent is required to pay for their meal replacements and request reimbursement from the Plan.
- **Reimbursement will only be approved if the patient is considered actively engaged in each of the three months following the month the expense was incurred.**
- Does not include Weight Watchers, Lean Cuisine, Nutri-System, Atkins or other similar prepared meals or meal replacements.
- Meal replacement costs do not apply to the Plan Year Deductible or Out-of-Pocket Maximum.

Morbid obesity means that a person is more than 100 pounds over normal weight or has a BMI of 40 or higher. This must be confirmed by your weight loss medical provider.

Participants cannot use their Health Savings Account or Health Reimbursement Arrangement to pay for expenses related to meal replacements that are reimbursed by the Plan. Even if an expense is not reimbursed by the Plan (i.e., the participant fails to remain actively engaged), the IRS may still not allow reimbursement. For more details, see the Weight-Loss Program section in IRS Publication 502 or refer to your tax consultant.
Tobacco/Smoking Cessation

You may obtain OTC tobacco/smoking cessation products through the prescription drug benefit by presenting your physician’s written prescription to your local in-network pharmacy, or you can submit your purchase receipt for the product with your physician’s written prescription attached to the Prescription Drug Reimbursement Claim Form (this form is located at www.pebp.state.nv.us).

To access this benefit, submit the form, written prescription and your receipt to the pharmacy benefits manager whose name and address is in the Participant Contact Guide section.

Some examples of cessation products eligible to be paid at 100% at in-network pharmacies 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 Plan and your physician.

Talk to your physician about second-line therapies such as clonidine hydrochloride and nortriptyline hydrochloride that are sometimes used in the management of tobacco/smoking-cessation; however, the lack of an FDA-approved indication for smoking cessation, as well as undesirable side effect profiles, currently prohibit these agents from achieving first-line classification.

The Plan does not pay benefits for the use of electronic cigarettes.

Other Covered Expenses

Certain special services such as podiatric and chiropractic care and organ and tissue transplants are covered up to the Plan limits specified below or in the Schedule of Medical Benefits.

Bariatric Surgery

Weight loss surgeries must be performed at an in-network outpatient or inpatient Center of Excellence facility. There is no payment if services are provided at an out-of-network facility or out-of-network surgeon or other ancillary providers are used. PEBP or its designee will determine the in-network Center of Excellence facility.

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

For lap band adjustments, the Plan will consider any adjustments made in the 12 months following surgery if the participant remains compliant with their post-surgical agreement as verified by UM company. Any adjustments to the lap band after the first 12 months post-surgery will be subject to prior authorization.
It is the responsibility of the participant to ensure that their providers and facilities chosen to provide these services are in-network for benefits to be paid. Participants can verify the network status of any provider (including a facility) by calling HealthSCOPE Benefits. The participant must receive treatment in a Bariatric Surgery Center of Excellence. A Bariatric Surgery Center of Excellence has met the requirements outlined by the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The accreditation of a Bariatric Surgery Center of Excellence helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These MBSAQIP accredited providers adhere to a multidisciplinary surgical preparatory regimen to include but not limited to the following:

1. Behavior modification program supervised by a qualified professional;
2. Consultation with a dietician or nutritionist;
3. Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen;
4. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise Therapist or other qualified professional;
5. Program must have a substantial face-to-face component (must not be entirely delivered remotely); and
6. Reduced-calorie diet program supervised by dietician or nutritionist.

If a participant has started any type of program to meet the pre-surgery criteria outlined below with an out-of-network provider (including a facility), those services will NOT be a part of the Plan’s mandatory prior authorization requirements. For the Plan to consider your bariatric surgery at the in-network benefit level; you will have to begin the prior authorization process again with the appropriate providers.
All services, pre- and post-surgery must be at an in-network facility, with in-network providers AND be at a certified Center of Excellence for bariatric weight loss.

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

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

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

• Patient has a BMI exceeding $40 \text{kg/m}^2$; or
• Patient's BMI is greater than $35 \text{kg/m}^2$ and two or more clinically serious conditions exist (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension (high blood pressure), cardiomyopathy, musculoskeletal dysfunction, joint replacement, GERD, hypertriglyceridemia or hypercholesteremia, back pain, urinary incontinence, renal failure, arthritis).
• Surgical intervention indicated because patient has met all following:
  • Patient is well-informed and motivated and has failed previous non-surgical weight loss attempts;
  • No thyroid disorder (excluding thyroid problems currently being successfully treated) found by your physician [e.g., an endocrine (hormone) disorder];
  • Must have obtained full growth and be over the age of 18 years;
  • Documentation of a pre-operative psychological evaluation by a licensed clinical psychologist or psychiatrist within the last 90 days to determine if the patient has the emotional stability to follow through with the medical regimen that must accompany the surgery;
• Physician-supervised nutrition and exercise program: participant has complied for at least six months (without a gap) within the 12-month period prior to the scheduled surgical intervention in a physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record at each visit. The physician-supervised nutrition and exercise program must meet all the following criteria:
  • Participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the participant’s participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. For participants who participate in a physician-administered nutrition and exercise program (e.g., MediFast, OptiFast), program records documenting the participant’s participation and progress may substitute for physician medical records;
  • Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists, with a substantial face-to-face component (must not be entirely remote);
Nutrition and exercise program(s) must be for a cumulative total of six months or longer in duration and occur within the 12-month period prior to the scheduled surgical intervention; and

Patient has lost 10% of their initial weight per documentation in the medical record received from their supervising weight loss physician.

The participant must sign an agreement to attend monthly support meetings for one-year post-surgery (provided by in-network providers). The Program will allow an online waiver for patients residing 50 miles or more from the obesity surgeon’s office or facility where the support meetings are held.

Contraindications for Weight Loss Surgery

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

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

International Services

Medical Services

The Plan provides you with coverage worldwide. Whether you reside in the United States and you travel to a foreign country, or if you reside outside of the United States on a part-time basis, and require medical services, you may be eligible for reimbursement of the cost.

Please contact the claims administrator before traveling or moving to another country to discuss any criteria that may apply to a medical service reimbursement request. Typically, foreign countries do not accept payment directly from PEBP. You may be required to pay for medical care services and submit your receipts to claims administrator for possible reimbursement. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the US.

Medical and vision services received outside of the United States are subject to Plan provisions, limitations and exclusions, and clinical review if necessary to determine medical necessity.

The claims administrator may require a written notice from you or your designated representative explaining why you received the medical services from an out-of-country provider and why you were unable to travel to the United States for these services. This provision applies to elective and emergency services. For emergency services, PEBP provides benefits for transportation back to the United States.
If you are an employee or a dependent of an employee, this benefit is provided by United Healthcare Global, a subcontractor for Standard Insurance. For more information about this program, please refer to the website and telephone number for Standard Insurance provided in the Participant Contact Guide.

If you are a retiree or dependent of a retiree with life insurance through Standard Life Insurance Company, this benefit is available through United Healthcare Global, a subcontractor for Standard Insurance. For more information about this program, please refer to the website and telephone number for Standard Insurance provided in the Participant Contact Guide.

If you are not eligible for transportation services provided by United Healthcare Global or if you do not utilize United Healthcare Global for transportation, this Plan may provide benefits for the purposes of medical transportation. This Plan typically will pay for commercial transportation. Please contact the claims administrator for more information.

Prior to submitting receipts from a foreign country to the claims administrator, you must complete the following:

- Proof of payment from you to the provider of service (typically your credit invoice);
- Itemized bill to include complete description of the services rendered and admitting diagnosis(es);
- Itemized bill must be translated to English;
- Reimbursement request must be converted to the United States dollars; and
- Any foreign purchases of medical care and services will be subject to Plan limitations such as Deductibles, Coinsurance, frequency maximum, annual benefit maximums, FDA approval, and usual and customary charges.
- The Plan Administrator and the claims administrator reserve the right to request additional information. If the provider will accept payment directly from the Plan, you must also provide the following:
  - Assignment of benefits signed by you or an individual with the authority to sign on your behalf such as a legal guardian or Power of Attorney (POA); and
  - Once payment is made to you or to the out-of-country provider, PEBP and its vendors are released from any further liability for the out-of-country claim. PEBP has the exclusive authority to determine the eligibility of all medical services rendered by an out-of-country provider. PEBP may or may not authorize payment to you or to the out-of-country provider if all requirements of these provisions are not satisfied.
Prescription Drug Coverage

If you purchase prescription drugs in a foreign country, you will need to pay for the drug at the time of purchase and later submit for a Direct Claim Form available from Express-Scripts on request or by logging into express-scripts.com. Prescription drug purchases made outside of the United States are subject to Plan provisions, limitations and exclusions, clinical review and determination of medical necessity. The review will also include regulations determined by the FDA.

In addition to the Direct Claim Form, you are required to provide:

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

Any foreign purchases of prescription medications will be subject to Plan limitations such as Deductibles, Coinsurance, dispensing maximums, annual benefit maximums, medical necessity, and usual and customary review.

Applied Behavioral Analysis for the Treatment of Autism

Autism Spectrum Disorders

This Plan provides coverage for the screening of, diagnosing of and treatment of Autism Spectrum Disorder. NRS 689B.0335 provides the language specific to Autism Spectrum Disorder coverage and is provided below for convenience:

1. A health plan must provide coverage for screening for and diagnosis of Autism Spectrum Disorders and for treatment of Autism Spectrum Disorders to persons covered by the group health plan under the age of 18 years or, if enrolled in high school, until the person reaches the age of 22 years.

2. Coverage provided under this section is subject to:
   a. A maximum benefit of the actuarial equivalent of $72,000 per year for applied behavior analysis treatment; and
   b. Copayment, Deductible and Coinsurance provisions and any other general exclusion or limitation of a group health insurance to the same extent as other medical services or prescription drugs covered by the Plan.

3. A health plan that offers or issues a policy of group health insurance which provides coverage for outpatient care shall not:
   c. Require an insured to pay a higher Deductible, copayment or Coinsurance or require a longer waiting period for coverage for outpatient care related to Autism Spectrum Disorders that is required for other outpatient care covered by the policy; or
   d. Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future any of the services listed in subsection 1.
4. Except as otherwise provided in subsections 1 and 2, an insurer shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.

5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavioral therapy or therapeutic care that is:
   e. Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
   f. Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst. An insurer may request a copy of and review a treatment plan created pursuant to this subsection.

6. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2011, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which conflicts with subsection 1 or 2 is void.

7. Nothing in this section shall be construed as requiring governing body of any county, school district, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance to provide reimbursement to a school for services delivered through school services.

8. As used in this section:
   a. “Applied behavior analysis” means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
   b. “Autism behavior interventionist” means a person who is a Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board or its successor organization, and provides behavioral therapy under the supervision of:
      i. A licensed psychologist;
      ii. A licensed behavior analyst; or
      iii. A licensed assistant behavior analyst.
   c. “Autism Spectrum Disorder” has the meaning ascribed to it in NRS 427A [autism spectrum disorder means a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined].
   d. “Behavioral therapy” means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or autism behavioral interventionist.
e. “Applied behavior analysis” means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

f. “Autism behavior interventionist” means a person who is a Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board or its successor organization, and provides behavioral therapy under the supervision of:
   i. A licensed psychologist;
   ii. A licensed behavior analyst; or
   iii. A licensed assistant behavior analyst.

g. “Autism Spectrum Disorder” has the meaning ascribed to it in NRS 427A [autism spectrum disorder means a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined].

h. “Behavioral therapy” means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or autism behavioral interventionist.

i. “Screening for Autism Spectrum Disorders” means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an Autism Spectrum Disorder.

j. “Therapeutic care” means services provided by licensed or certified speech pathologists, Occupational Therapists and Physical Therapists.

k. “Treatment plan” means a plan to treat an Autism Spectrum Disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

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

Behavioral Health Services

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

The following behavioral health practitioners are payable under the Plan: psychiatrist (MD or DO), psychologist (Ph.D.), Masters’ prepared counselors, (e.g., MSW), licensed social associate in social work, independent social worker or clinical social worker.
Behavioral health services payable under this Plan include:

- Outpatient visits
- Inpatient admissions
- Partial day care
- Partial hospitalization
- Residential treatment
- Intensive outpatient therapy
- Day treatment
- Psychological testing

The provider must be licensed or approved by the state in which the services are provided. All care must be provided by licensed, eligible providers—such as hospitals or residential treatment programs for inpatient care and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care. Prior authorization is required for inpatient and outpatient care in a facility. For more information regarding prior authorization requirements, benefits and exclusions, refer to the Utilization Management, Key Terms and Definitions and Benefit Limitations and Exclusions sections.

**Gender Reassignment**

This Plan provides certain benefits to individuals who are seeking medical services for the treatment of gender dysphoria. Benefit coverage includes related mental health therapy, hormone therapy, prescription drug therapy and genital reconstruction surgery. Benefits are conditioned upon the participant or their covered dependent adhering to the requirements listed in this Plan document such as obtaining prior authorization and participating in case management. Other mandatory requirements include a mental health evaluation and mental health treatment to confirm a diagnosis of gender dysphoria.

Prior authorization is required for all services related to gender dysphoria (excluding mental health services). The UM company will determine the appropriateness of care and medical necessity. The prior authorization requirement applies to medical treatment related to hormone therapy, prescription drug therapy and genital reconstruction surgery. (Benefits payable for the services you fail to have pre-authorized will be reduced by 50% of the allowable charges. Please discuss this with your medical providers prior to receiving treatment. This provision applies to both in-network and out-of-network medical expenses. Expenses related to the penalty will not count toward your Plan Year Deductible or Out-of-Pocket Maximum.)

When reviewing services for appropriateness of care and medical necessity, the UM company may refer to guidelines published by organizations such as the World Professional Associations for Transgender Health (WPATH), Aetna, Cigna, Medicare and Blue Cross/Blue Shield.

Case Management services are mandatory for those who are seeking treatment of gender reassignment surgery. The Plan Administrator requires case management to help the participant, providers and other PEBP vendors to work together for successful outcomes. The participant
and their physician must contact the UM company to begin the process toward surgical intervention of gender dysphoria. The initial contact will include:

- Notification to the participant that the pre-authorization process will begin with the initial contact to the UM company.
- Documenting that the participant meets all criteria specified in the Mental Health Coverage and Hormone Therapy Coverage sections below.
- The UM company can advise participants of providers who specialize in this type of treatment to include genital reconstruction.

Prior authorization review and case management services will be initiated upon the first call to the UM company for prior authorization. Case management services are particularly helpful for a participant or their covered dependent who is receiving complex medical services for medical conditions such as gender dysphoria. A nurse case manager will be assigned to the participant and will help with any concerns such as continuity of care in finding providers or a provider who specializes in gender dysphoria.

Certain procedures are not covered by this Plan, including but not limited to breast augmentation, rhinoplasty and hair transplants. Refer to the Gender Dysphoria Services in the Benefit Limitations and Exclusions section for a list of benefit exclusions and limitations for gender dysphoria and reassignment surgery or contact the UM company to discuss any procedures not listed in the Benefit Limitations and Exclusions section.

**Mental Health Coverage**

If an individual is diagnosed with gender dysphoria and prior to submitting a recommendation for hormone and surgical treatment, the mental health professional’s evaluation should document the following for the gender reassignment patient:

- The individual’s general identifying characteristics;
- The initial and evolving gender, sexual and psychiatric diagnosis of the patient;
- Details regarding the type and duration of psychotherapy or evaluation the individual underwent;
- The mental health professional’s rationale for hormone therapy and surgery;
- The degree to which the individual has followed the standards of care and likelihood of continued compliance;
- Gender reassignment surgery must be pre-authorized and the participant or their covered dependent must participate in case management;
- The duration of case management will be determined by your case management nurse.

Note: Mental health coverages does NOT require prior authorization.

Benefit coverage includes transgender and associated co-morbid psychiatric diagnoses provided as any other outpatient mental health service under the Plan.

To determine which procedure may or may not be covered, the participant or their covered dependent should consult with their nurse case manager who works for this Plan’s UM company.
**Hormone Therapy Coverage**

Hormone therapy coverage requires prior authorization and case management. Hormone therapy is often medically necessary for successfully living in the new gender. Hormone therapy typically improves the quality of life and may limit any psychiatric co-morbidities. Benefits for oral and self-injectable hormone replacement treatment therapies should be obtained through an in-network pharmacy. Hormone therapy for individuals preparing for gender reassignment surgery is medically necessary when all the following criteria are met:

The patient must be at least 18 years old, and:

- Demonstrate knowledge of what hormones can and cannot do as well as their social benefits and risks;
- Document real-life experience of at least three months prior to the administration of hormones; or
- Undergo a period of psychotherapy of a duration specified by a mental health professional whose specialty is working with individuals with gender dysphoria (usually a minimum of three months).
- This Plan provides benefits for gender reassignment surgery referred to also as genital reconstruction.
- Gender reassignment surgery must be prior authorized and the participant or their covered dependent must participate in case management.
- The duration of case management will be determined by your case management nurse.
- In preparation for genital reconstruction, other procedures are also covered such as total hysterectomies and orchiectomies.

This Plan limits an individual to one gender reassignment surgery in an individual’s lifetime while covered under a PEBP self-funded Plan, including any previous PPO plan, this Plan or the Premier Plan. In other words, if an individual previously had surgery to change from female to male and the surgery was covered by a previous PEBP self-funded Plan, (CDHP or PPO plan) and the previous plan covered the procedure and later while covered under the PEBP CDHP or any other PEBP self-funded plan, the participant requests to change back from male to female, this Plan would not pay for the second procedure.

**Genetic Testing Program**

The following genetic testing and counseling services are covered under this Plan if determined medically necessary and prior authorized by the UM company. Refer to the Utilization Management, Benefit Limitations and Exclusions and Key Terms and Definitions section for genetic testing and counseling, including non-payment for pre-parental genetic testing and counseling.

- Amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in pregnant women only if the procedure is medically necessary as determined by utilization management company;

- Genetic counseling when provided before and/or after amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), and alpha-fetoprotein
(AFP) analysis. BRCA1 and BRCA2 counseling for individuals already diagnosed with breast and/or ovarian cancer;

- BRCA1 and BRCA2 genetic test for individuals already diagnosed with breast and/or ovarian cancer where results may affect the course of treatment of the participant. BRCA1 and BRCA2 testing may be covered under the wellness/preventive benefit; and

- Apo E genetic test to help physicians identify those individuals at highest risk for heart disease and determine the most appropriate dietary and fitness program for the participant.

**Chiropractic Care**
The Plan covers chiropractic care if services are performed by a licensed MD, DO, or chiropractor. Covered services include spinal manipulation and x-rays performed in conjunction with the chiropractic services (x-rays paid under the radiology section of this Schedule of Medical Benefits). Supporting documentation establishing medical necessity is required after 15 visits in a Plan Year.

**Specialty Radiology**
The Plan covers medically necessary specialty radiology including MRI, MRA, MRS, MRT, PET, SPEC, and CT scan. You are required to obtain a prior authorization for CT, MRI and PET scans that are not performed in an emergency room or considered urgent.

**Maternity and Reproductive Care**
The Plan pays maternity-related benefits the same as any eligible medical expense. The Plan will cover a 48-hour stay for a normal vaginal birth and a 96-hour stay for a normal cesarean birth.

Note: Pregnancy benefits for dependent children are limited to covered expenses for preventive care services and complications of pregnancy.

**Substance Abuse Treatment**
Services and supplies for treatment of alcoholism, chemical dependency or drug addiction are covered. The treatment plan must be recommended by a physician and be completed to be eligible for coverage. All care must be provided by licensed, eligible providers—such as hospitals or residential treatment programs for inpatient care, and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care.
Transplants (Organ, Bone Marrow and Tissue)
Coverage is provided for eligible services directly related to non-experimental transplants of human organs or tissue, along with the facility and other professional services, FDA approved drugs and medically necessary equipment and supplies.

Coverage is provided for the donor when the receiver is a participant on this Plan. Coverage is provided for organ or tissue procurement acquisition fees, including surgery, storage or tissue transport costs directly related to a living or non-living donor (transport within the United States and Canada only). When the donor has medical coverage, his or her plan will pay first and benefit under this Plan will be reduced by the amount payable by the other plan.

Expenses incurred by a participant of this Plan who donates an organ or tissue are not covered unless the person receiving the donated organ or tissue is also a participant covered on this Plan.

For more information, refer to Experimental and Investigational Services and Transplant Services listed Key Terms and Definitions and Benefit Limitations and Exclusions sections.

Use of Centers of Excellence for Transplant Procedures
The use of a Center of Excellence for transplant procedures is required to receive full benefits under the Plan. Call HealthSCOPE Benefits at 1-888-763-8232 for complete information on transplant benefits and Centers of Excellence.

Travel Expenses
This Plan allows for the reimbursement of certain travel and hotel accommodation expenses for the patient and one additional person when the expenses are associated with the following services and prior authorized by the UM company:

- Organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence;
- Elective surgeries performed as exclusive hospitals/ambulatory facilities; and
- Outpatient infusion services performed at exclusive outpatient infusion centers.

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

- Participants are required to use the least expensive method of transportation.
  - Standard mileage reimbursement for the use of a personal vehicle to travel to a Center of Excellence or to an exclusive hospital/ambulatory surgical facility or outpatient infusion center is based on the mileage from the participant’s residence to and from the facility (based on an objective source such as Google Maps).
The Plan Administrator or its designee has full authority to approve or deny all or part of your travel expenses. The denial of travel expenses cannot be appealed.

**In-State Travel (Nevada) – SAM 0212**

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

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

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

**Additional Requirements**

Reimbursement for meals while traveling must meet the following guidelines:

- Breakfast – must depart before 7:00a.m. or return after 9:00a.m.;
- Lunch- must depart before 11:00 a.m. or return after 1:00 p.m.; and
- Dinner- must depart before 5:00 p.m. or return after 7:00 p.m.

The Plan covers certain costs relating to travel associated with medical treatment for organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence, elective surgeries performed at exclusive Nevada hospitals/ambulatory surgical facilities, and outpatient infusion centers when the:

- Distance to the Center of Excellence, exclusive Nevada hospital or ambulatory surgical or outpatient infusion center is 50 miles or more from the participant’s residence.
Travel expenses are covered when incurred in conjunction with the patient’s:

- Transplant or bariatric surgery (does not include pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient’s surgeon. Travel expenses incurred on or after one year are not eligible for reimbursement;
- Elective surgery performed at an exclusive Nevada hospital/ambulatory surgery facility approved by utilization management company (including 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.

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

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 and or vehicle insurance;
- Flight insurance;
- Cards, stationery, stamps;
- Clothing and or dry cleaning;
- Entertainment (cable televisions, books, magazines, movie rentals);
- Flowers;
- Household products;
- Household utilities, including cell phone charges, maid, 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 or an exclusive hospital/ambulatory surgical facility; and
- Travel expenses incurred on or after one year following surgery are not eligible for reimbursement.
- Travel expenses are subject to the annual cost sharing requirements.
If the travel companion is another PEBP participant, reimbursement or Deductible credit will not be credited to PEBP participant who is not the recipient of the organ or tissue transplant or who is not the recipient of the elective inpatient or outpatient surgery. PEBP does not provide advance payment for travel expenses.

**Pre-Approval of Your Travel Expenses**

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

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

Pre-approval will provide an approximation of your travel reimbursement. Final reimbursement will be based on actual expenses using the actual number of days and travel times and may differ from the pre-approved approximation. PEBP has provided a pre-approval “Travel Expense Request” form on its website at www.pebp.state.nv.us.

**Submitting Your Travel Expense Receipts**

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

“Travel Expense Reimbursement” claims should be accompanied by original itemized receipts which include the name(s) of the person(s) incurring the expense. If the travel includes a commercial airline flight, an itinerary should be attached for meal justification. Reimbursement of eligible travel expenses, including any eligible travel expenses relating to a travel companion, will be payable to the primary participant (employee or retiree) and not to the service vendor (credit card company, hotel, hospital, restaurant, etc.).
**Prescription Drugs**

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

Coverage is also provided for (but not limited to):

- Shingles;
- Prenatal & pediatric prescription vitamins;
- Prescription female oral contraceptives;
- Insulin, and insulin injecting devices;
- Diabetic supplies;
- Influenza and pneumonia vaccines;
- HPV vaccine;
- Herpes Zoster vaccine; or
- TDAP (whooping cough) vaccine.

Some over-the-counter (OTC) drugs such as Prevacid and Promethazine HCL are covered when presented with a prescription from your physician to your pharmacy.

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

The Plan provides coverage for preferred generic and brand name drugs. If a non-preferred drug is dispensed, you will pay 100% of the discounted rate. Deductible credit and Out-of-Pocket Maximum credit does not apply.

Some OTC drugs and some prescription drugs are eligible to be covered under the Plan’s Preventive Care Services benefit, as defined by the Affordable Care Act, where the Plan waives the Deductible and products are paid at 100%. Examples include (this list is not all inclusive):

- Aspirin;
- Folic Acid;
- Smoking cessation products; and
- Female oral contraceptives
The Plan also offers several generic and preferred-brand preventive drugs where the Deductible is waived and only a Coinsurance applies. Examples of preventive medication categories are shown below and include both prescription and OTC medications.

- Blood pressure lowering medications;
- Cholesterol lowering medications;
- Agents to prevent osteoporosis;
- Asthma medications; and/or
- COPD medications.

Visit the PEBP website at www.pebp.state.nv.us or log on to express-scripts.com to see a list of common preventive drugs under this benefit. Please note that you must have an authorized prescription and the prescription must be filled at the Express-Scripts pharmacy or through an in-network retail pharmacy for the drug to qualify as preventive under the Plan.

Express-Scripts offers helpful tools that allow participants to manage their prescriptions. Go to express-scripts.com or download the free mobile app and have your identification card available to register. The Price a Medication menu option is used to determine estimated Out-of-Pocket cost, while the My Rx Choices link within Price a Medication displays clinically equivalent lower cost options along with any applicable coverage alerts (such as “prior authorization required”). See the Participant Contact Guide section or go to the PEBP website at www.pebp.state.nv.us.
Prescription Drug Summary of Benefits

Schedule of Medical Benefits

Prescription Drug Benefits
(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Benefit Limitations and Exclusions section for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Drugs</td>
<td>You pay 20% after Plan Year Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(Limited only to those preventive drugs identified by the pharmacy benefit manager.)</td>
<td>(Deductible does not apply)</td>
<td></td>
</tr>
<tr>
<td>*Preferred Generic Drugs</td>
<td>You Pay 20% after Plan Year Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>*Preferred Brand Drugs</td>
<td>You pay 20% after Plan Year Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>You pay 100% of the cost of the medication; Deductible and Out-of-Pocket Maximum credit is not applied</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialty Pharmaceutical Drug</td>
<td>You pay 20% after Plan Year Deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Explanations and Limitations
For Explanations and Limitations related to prescription drug benefits, including quantity limits, prior authorization requirements, retail and mail order pharmacy benefits, out-of-country purchases, etc., refer to the following categories in this Prescription Drug section:

- *Preventive Drug Program (includes prescription drug categories that are used for preventive purposes or conditions such as hypertension, asthma, or high cholesterol."
- 90-Day Retail Program and Smart90 Pharmacy Program
- Home Deliver Prescription Drug Program
- Specialty Medications; Diabetes Medications and Supplies
- Prior Authorization Requirements
- Quantity Limits and Extended Absence Benefit
- Out-of-Network Pharmacy Benefit and Out-of-Country Medication Purchases
- Other Limitations

*Orally Administered Chemotherapy – After the Deductible is met, the cost sharing for orally administered chemotherapy will not exceed $100 per 30-day supply (NRS 695G.167)
30-Day at Retail Program
To obtain a 30-day supply of drugs, present your ID card to any in-network retail pharmacy. You can find the location of in-network retail pharmacies by logging on to express-scripts.com or the mobile app and selecting the “Locate a Pharmacy” under the “Prescriptions” menu dropdown.

90-Day Retail Program
Through the 90-day retail program, you can receive a 90-day supply of your long-term maintenance prescription drugs at select retail pharmacies. Maintenance drugs include non-emergency, extended use prescription drugs such as those used for high blood pressure, lowering cholesterol, controlling diabetes or certain female oral contraceptives. To take advantage of this benefit, ask your physician to write a new prescription for a 90-day supply of any maintenance medication you are currently taking (plus refills of up to one year, if appropriate). To find the nearest participating retail pharmacy, log in or register at express-scripts.com/3month, select “Prescriptions,” and click “Find a Pharmacy”.

Smart90 Pharmacy Program
The Smart90 pharmacy program is voluntary and allows you to purchase a 90-day supply of your long-term maintenance medications. This program has a narrower network than the standard 90-Day Retail Program. Using a Smart90 pharmacy can help you lower your Out-of-Pocket costs. For information regarding the Smart90 program, contact Express Scripts at the number listed in the Participant Contact Guide section.

Preventive Drug Benefit Program
Wellness and good health depend on taking and finishing your preventive drugs prescribed to you by your physician. The Preventive Drug benefit program provides plan 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 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 www.pebp.state.nv.us or by contacting Express-Scripts located in the Participant Contact Guide section.

Many vaccines may also be administered through the prescription drug benefit with certain pharmacies. Contact the Pharmacy Benefit Manager listed in the Participant Contact Guide or visit www.express-scripts.com to check vaccine coverage and locate your nearest in-network pharmacy. Contact the pharmacy to verify their current vaccination schedule and vaccine availability.

Home Delivery Prescription Drug Program
You may use home delivery through the Express-Scripts Pharmacy to receive up to a 90-day supply of your maintenance drugs and have them mailed directly to you with free standard shipping. Not all drugs are available via mail order. Check with Express-Scripts for further information on the availability of your prescription medication.
Home delivery order forms are available at express-scripts.com or by contacting Express-Scripts. Allow up to 14 days to receive your first order. There are four ways to get started with home delivery:

- **E-Prescribe (electronic prescribing):** Have your physician send your 90-day prescription direct to the Express-Scripts Pharmacy for processing;
- **Phone:** call Express-Scripts and request that your prescription drugs be moved to home delivery. Express-Scripts will consult your physician and start the process;
- **Online:** register on express-scripts.com and choose to transfer medications to home delivery by clicking “Add to Cart” and selecting “Check Out” to process your order;
- **Mail:** complete a home delivery order form and submit it, along with a paper prescription from your physician.

**Specialty Drug Program**

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

**Diabetic Medications and Supplies**

Participants who enroll and participate in PEBP’s Diabetes Care Management Program may receive up to a 90-day supply of diabetic supplies not subject to annual Deductible or Coinsurance requirements. Diabetic supplies under this program must be filled through Express Scripts home delivery pharmacy and include blood glucose monitors, test strips, insulin, syringes, alcohol pads, and lancets. Please refer to the Home Delivery Program section above on how to fill your diabetic supplies through home delivery. Diabetic medications (such as insulin and Metformin) may be filled for up to a 90-day supply at participating retail pharmacies or through Express Scripts home delivery pharmacy.

Copayment for a prescription day supply between 31-90 days at retail will be subject to three times the listed 30-day retail copayment. Please refer to the Disease Management section of this document for further information. If you are not enrolled in the Diabetes Care Management Program or if you are enrolled and later dis-enroll or do not participate in the program, your supplies will be subject to the annual Deductible and Coinsurance requirements.

To enroll in the Diabetes Care Management Program, contact the claims administrator listed in the Participant Contact Guide.

To enroll in the preferred diabetic supplies home delivery program, contact the Pharmacy Benefit Manager listed in the Participant Contact Guide.

Note: Coverage is provided only for medications approved by the Food and Drug Administration as requiring a prescription and FDA approved for the condition, dose, route, duration and frequency, if prescribed by a physician or other health care practitioner.
Prior Authorization Requirements and Other Utilization Management Procedures for certain Prescription Drugs

Prior authorization (pre-certification) may be required from the prescription drug plan administrator for certain drugs. Prescription drugs that might need prior authorization should be reviewed prior to purchase to ensure that you do not incur additional expenses. Participants should contact the prescription drug administrator, or have their physician do so, if there are questions about a certain medication or its coverage.

The prior authorization process is designed to assist participants in the management of prescriptions that have significant potential for misuse/abuse and/or require close monitoring because of potentially serious side effects. Approval is required before such a prescription drug can be covered. Prior authorizations typically must be renewed annually. You and your physician will be notified of the length of your approved prior authorization. Prior authorization is usually contingent upon certain criteria, which could include, but not limited to:

- Documentation of specific diagnosis,
- Documentation of dosing regimen,
- Documented results of commonly recognized testing to determine medical necessity,
- Failure of or intolerance to first line agents, or
- Other relevant clinical characteristics that make the drug medically necessary.

If any medication you take requires a prior authorization all renewals for continued prescriptions must be requested before the current prescription is expired. For example, if you have a medication which requires a prior authorization and it is scheduled to expire in May, a renewal request of the prior authorization should be made in April. Contact the prescription drug plan administrator listed in the Participant Contact Guide for details of drugs such as:

Specialty drug medications including but not limited to:

- Self-injectables, such as medications for Multiple Sclerosis, Rheumatoid Arthritis and Growth Hormones
- Factor medications for treatment of Hemophilia
- Lovenox/Enoxaparin
- Oral Oncology Medications

Some prescription drugs have certain limitations which require prior authorization. It is always best to check with the prescription drug plan administrator to determine if your prescriptions require prior authorization or are subject to other limitations of the Plan.
Quantity Limits
Some drugs may have quantity limits per month, for example:

- Sexual dysfunction drugs such as Viagra, Cialis or Muse;
- Oral migraine medication such as Maxalt or Zomig, or injectables such as Imitrex;
- Epi-Pen and Glucagon (max 1 per year, however, you may be able to receive more than one of these medications at a time with prior authorization and a prescription from your doctor)

Contact the prescription drug Plan Administrator to determine if your prescription has quantity limits under the Plan.

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

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

Out-of-Country Medication Purchases
If you reside in the United States and you purchase prescription drugs in a foreign country while traveling, you will need to pay for the drug at the time of purchase and later submit for reimbursement from the prescription drug Plan Administrator. Prescription drug purchases made outside of the United States are subject to Plan provisions, limitations and exclusions, clinical review and determination of medical necessity. The review will also include regulations determined by the FDA. Out-of-Country medication purchases are only eligible for reimbursement while traveling outside of the US.

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

- A legitimate copy of the written prescription completed by your physician
- Proof of payment from you to the provider of service (typically your credit card invoice)
- Prescription and receipt must be translated to English and include the American equivalent National Drug Code for the prescription purchased
- Reimbursement request must be converted to United States dollars
The claim will be processed based on the American equivalent National Drug Code and charged based upon that drug copay tier.

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

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

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

Other Limitations

- This Plan does not coordinate prescription drug plan benefits.
- See exclusions related to medications in the Benefit Limitations and Exclusions section of this document.

Reconstructive Services and Breast Reconstruction after Mastectomy

This Plan complies with the Women’s Health and Cancer Rights Act. For any covered individual who is receiving benefits from a mastectomy who elects breast reconstruction in connection with it, coverage is provided for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or
- Prostheses and physical complications for mastectomy, including lymphedemas.

Reconstructive surgery if such procedures are intended to improve bodily function or to correct deformity from disease, infection, trauma, congenital anomaly, or results from a covered therapeutic procedure.

Treatment of leaking breast implant is covered; however, replacements of the implants are payable only if the reason for the implant(s) was due to a condition covered by the Women’s Health and Cancer Rights Act.
Prophylactic surgery is covered under certain circumstances:

- When prior authorization is provided by utilization management company;
- Women diagnosed with breast cancer at 45 years of age or younger;
- Women who are at increased risk for specific mutation(s) due to ethnic background (for instance: Ashkenazi Jewish descent) and who have one or more relatives with breast cancer or ovarian cancer at any age;
- Women who carry or have a first-degree relative who carries a genetic mutation in the TP53 or PTEN genes (Li-Fraumeni syndrome and Cowden and Bannayan-Riley-Ruvalcaba syndromes);
- Women who possess BRCA1 or BRCA2 mutations confirmed by molecular susceptibility testing for breast and/or ovarian cancer;
- Women who received radiation treatment to the chest between ages 10 and 30 years, such as for Hodgkin disease;
- Women with a first or second degree male relative with breast cancer;
- Women with a first or second degree relative with a BRCA1 or BRCA2 mutation;
- Women with multiple primary or bilateral breast cancers in a first or second-degree blood relative;
  - Women with multiple primary or bilateral breast cancers;
  - Women with one or more cases of ovarian cancer AND one or more first or second-degree blood relatives on the same side of the family with breast cancer; or
  - Women with three or more affected first or second-degree blood relatives on the same side of the family, irrespective of age at diagnosis.
Schedule of Medical Benefits

A schedule of the CDHP Medical Plan benefits appears on the following pages in a chart format. The schedule includes Explanations and Limitations that apply to each benefit; however, the Explanations and Limitations will not include every limitation. For more information relating to a specific benefit, refer to What is Covered Under the Plan, Utilization Management (for any prior authorization requirements), Benefit Limitations and Exclusions and Key Terms and Definitions and other sections that may apply to a specific benefit.

Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% Usual &amp; Customary (U&amp;C) after Plan Year Deductible</td>
</tr>
<tr>
<td>Acupuncture and Acupressure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Explanations and Limitations**
- Covered if performed by a licensed MD, DO, Acupuncturist (as defined in the Key Terms and Definitions section), or Oriental Medicine Doctor.
- Supporting documentation establishing medical necessity will be required after 15 visits in a Plan Year.
- Maintenance services are not a covered benefit.

<table>
<thead>
<tr>
<th>Allergy Services</th>
<th>Plan pays 80% after Plan Year Deductible</th>
<th>Plan pays 50% U&amp;C after Plan Year Deductible; or 110% of the Medi-Span Average Wholesale Price (AWP) after Plan Year Deductible</th>
</tr>
</thead>
</table>

**Explanations and Limitations**
- Allergy testing subject to prior authorization. See the Utilization Management section for details.
- Allergy services are covered only when ordered by a physician.
- Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast; Desensitization and hypo-sensitization (allergy shots given at periodic intervals); Allergy antigen solution.
Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground, Air and Water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground vehicle transportation</td>
<td>Plan pays 80% of PPO allowable after Plan Year Deductible</td>
<td>Play pays 80% of U&amp;C after Plan Year Deductible</td>
</tr>
<tr>
<td>Air transportation</td>
<td>Plan pays the lessor of 80% of PPO Allowable or 80% of the Maximum Allowable Charge*</td>
<td>Plan pays 80% of the Maximum Allowable Charge</td>
</tr>
</tbody>
</table>

Explanations and Limitations

In the event of a life-threatening emergency in which a participant uses an out-of-network provider, benefits will be paid at the in-network benefit level. “Life threatening emergency” means the sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child, impairment of a bodily function or dysfunction of any bodily organ or part.

Ground vehicle transportation to the nearest appropriate health care facility as medically necessary for the treatment of a medical emergency, acute illness or inter-health care facility transfer.

Air transportation to the nearest appropriate health care facility, only as medically necessary due to inaccessibility by ground transport and or if the use of ground transport would be detrimental to the patient’s health status.

Air ambulance Inter-facility transfers: Prior authorization is required for scheduled inter-health care facility patient transfers. Please see the Utilization Management section for details on requesting prior authorization.

Emergency Air Ambulance: This Plan covers emergency air ambulance services for participants and or their covered dependents whose medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the illness or injury. Air ambulance transportation must meet the criteria as specified in the What is Covered Under this Plan for Air/Flight Emergency Air Ambulance services.

Air ambulance services will be evaluated for reasonableness. This Plan’s air ambulance benefit is limited to the lower of the PPO allowable or the Maximum Allowable Charge of 250 percent of the applicable Medicare rate.
### Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the *Explanations and Limitations*, *What is Covered Under the Plan*, *Key Terms and Definitions* and the *Benefit Limitations and Exclusions* sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Autism Spectrum Disorders</strong></td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
<tr>
<td>Refer to the Applied Behavioral Analysis for the Treatment of Autism section</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Explanations and Limitations

Treatment of Autism Spectrum Disorder must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription drug care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with an Autism Spectrum Disorder by a licensed physician or licensed psychologist; and

(b) Provided for a person diagnosed with an Autism Spectrum Disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.

Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services.
## Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)  
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services (Mental Health and Substance Abuse Treatment)</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
<tr>
<td>Behavioral Health services payable by this Plan include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Partial day care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Day treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Psychological testing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Explanations and Limitations

See the Benefit Limitations and Exclusions related to behavioral health services, including learning disabilities. Benefits are payable only for services of behavioral health care practitioners listed in the Key Terms and Definitions section.

The following behavioral health practitioners are payable under the Plan: psychiatrist (MD or DO), psychologist (Ph.D.), Masters’ prepared counselors (e.g., MSW), licensed associate in social work, social worker, independent social worker or clinical social worker.

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

Outpatient prescription drugs for behavioral health payable under drugs in this Schedule of Medical Benefits.

Prior authorization required for certain Behavior Health Services. Refer to the Utilization Management section for prior authorization requirements.
## Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusions</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>
| Explanations and Limitations | • Blood transfusions, blood products and equipment for its administration.  
                               • Services are covered only when ordered by a physician. Expenses related to Autologous blood donation (patient’s own blood) are covered. |
| Breastfeeding Support     | Covered under Preventive benefit at 100% No Deductible | Plan pays 50% U&C after Plan Year Deductible |
| Explanations and Limitations | This Plan provides covers comprehensive lactation support and counseling from trained providers for women during the antenatal, perinatal and postpartum period and up to one year. Breastfeeding equipment and supplies in conjunction with each birth. |
| Chemotherapy              | Plan pays 80% after Plan Year Deductible        | 50% U&C or 110% of the Medi Span AWP, after Plan Year Deductible |
| Explanations and Limitations | Chemotherapy drugs and supplies administered under the direction of a physician in a hospital, health care facility, physician’s office or at home. Covered when ordered by a physician; chemotherapy must be pre-certified by the UM company. Orally administered chemotherapy drugs: Participant will pay 100% of the cost for preferred generic and preferred formulary brand orally administered chemotherapy drugs purchased from in-network retail, mail and Specialty Drug pharmacy. After the Deductible is met, the participant’s maximum cost per prescription will not exceed $100. |
| Chiropractic Services     | Plan pays 80% after Plan Year Deductible        | 50% U&C after Plan Year Deductible |
| Explanations and Limitations | • Services are covered if performed by a licensed MD, DO, or Chiropractor. Supporting documentation establishing medical necessity will be required after 15 visits in a Plan Year.  
                               • Maintenance services are not a covered benefit.  
                               X-rays performed in conjunction with chiropractic services are payable under the Radiology Services section of this Schedule of Medical Benefits. |

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## Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Trials</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

### Explanations and Limitations

(Example: Cancer or Chronic Fatigue syndrome clinical trials.)

- Nevada law allows some clinical trials taking place in Nevada to be covered if certain criteria are met. See “Experimental and or Investigational” in the Key Terms and Definitions section.
- Prior authorization must be obtained from the UM company.

### Corrective Appliances

(Prosthetic & Orthotic Devices, other than dental)

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Explanations and Limitations

- Coverage is provided for certain corrective appliances that are medically necessary and FDA approved. This Plan pays for the purchase of standard models at the option of the Plan. 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 satisfactorily repaired.
- Prosthetics such as limbs and ocular;
- Orthotics such as casts, splints and other orthotic devices used in the reduction of fractures and dislocations; colostomy or ostomy (Orthotic) supplies, hearing aid* (with limitations);
- Plan allows up to $120 for one set of lenses (contacts or frame-type) for the treatment of glaucoma or when required following cataract surgery.
- Soft lenses or sclera shells intended as corneal bandages for patients without the lens of the eye (aphakic).

To help determine what prosthetic or orthotic appliances are covered, see the definitions of “Prosthetics” and “Orthotics” in the Key Terms and Definitions section. Corrective appliances are covered only when ordered by a physician or health care practitioner. Orthopedic shoes and foot orthotics are not a covered benefit unless the shoe or foot orthotic is permanently attached to a brace.

**Hearing aids:** Maximum benefit after Deductible is $1,500 per ear every 3 years if the participant has a minimum of a 50% loss in one ear.

You must submit a copy of your payment receipt from the hearing aid provider to receive credit towards you or your family annual Out-of-Pocket Maximum. If you do not submit a payment receipt to PEBP’s third party claims administrator, you will not receive the Out-of-Pocket Maximum credit.

See the exclusions related to corrective appliances in the Benefit Limitations and Exclusions section.
Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

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<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Education Services</td>
<td>This Plan pays 80% after Plan Year Deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Explanations and Limitations**

- 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 requires 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 and actively engaged in the 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 Medical Benefits for the Diabetes Care Management Program.

| Dialysis                     | Plan pays 80% after Plan Year Deductible          | Plan pays 50% U&C after Plan Year Deductible |

**Explanations and Limitations**

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.

See the Utilization Management section for more information.
Schedule of Medical Benefits
(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

Explanations and Limitations

- DME requires prior authorization by the UM company when the cost is expected to exceed $1,000.
- Rental of DME to cover Medicare guidelines concerning rental to purchase criteria.

- 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.

- DME, including oxygen and equipment and supplies required for its administration, is covered only when its use is medically necessary, and it is ordered by a physician or health care practitioner.

- Certain blood glucose monitors are covered under this Plan. In-network, the Plan pays 80% after the Plan Year Deductible. Participants enrolled in and actively engaged 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 Disease Management section.

- Insulin pumps are eligible for purchase and must be prior authorized by the UM company.

- Rental to purchase following Medicare guidelines for certain lifelong durable DME such as oxygen concentrators, CPAP and BiPAP machines or electric wheelchairs for paralysis.

Some examples of lifelong durable medical equipment are oxygen concentrators, CPAP or BiPAP machines or electric wheelchairs for paralysis. Please check with PEBP’s third party administrator or utilization management company for assistance. Contact the claims administrator for the internet purchase of certain DME such as: CPAP machines or breast pumps.

See the Benefit Limitations and Exclusions section related to corrective appliances and durable medical equipment. To help determine what durable medical equipment is covered, see the definition of “Durable Medical Equipment” in Key Terms and Definitions section.
### Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room &amp; Urgent Care Services</td>
<td>Emergency Room: Medical Emergency: Plan pays 80% after Plan Year Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Room: Medical Emergency: Plan pays 80% after Plan Year Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent Care Facility: Plan pays 80% after Plan Year Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Room: Medical Emergency: Plan pays 80% U&amp;C after Plan Year Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent Care Facility: Plan pays 50% U&amp;C after Plan Year Deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Explanations and Limitations

- Hospital Emergency Room (ER) for a medical emergency; Use of an Urgent Care facility; Ancillary charges (such as lab or x-ray) performed during the ER or Urgent Care Visit. See also the Ambulance section of this Schedule of Medical Benefits.

- In-network and out-of-network expenses for emergency room services are covered at the in-network benefit level only when those services are for a medical emergency, as that term is defined below:

- Medical emergency means the sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child, impairment of a bodily function or dysfunction of any bodily organ or part.

- In the event of a medical emergency in which a participant uses an out-of-network provider, benefits will be paid at the in-network benefit level.
Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning/Contraceptives (Females Only)</td>
<td>Covered under Wellness/Preventive benefit at Plan pays 100% (No Deductible)</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

Explanations and Limitations

- Surgical sterilization- **Females Only** (e.g. tubal ligation)
- Prescription contraceptives including certain oral birth control pills, injectables (e.g., Depo-Provera), Intrauterine devices (IUD), diaphragms, implantable birth control devices and services (e.g., Nexplanon).
- This Plan covers up to a 12-month supply of all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The FDA requires the services to be “prescribed” by a physician even for covered over the counter methods. The following is a list of the FDA approved female contraceptive methods:
  1. Voluntary sterilization for women;
  2. Surgical sterilization implants for women;
  3. Implantable rods;
  4. Copper-based intrauterine devices;
  5. Progesterone-based intrauterine devices;
  6. Injections;
  7. Combined estrogen- and progestin-based drugs;
  8. Progestin-based drugs;
  9. Extended- or continuous-regimen drugs;
  10. Estrogen- and progestin-based patches;
  11. Vaginal contraceptive rings;
  12. Diaphragms with spermicide;
  13. Sponges with spermicide
  14. Cervical caps with spermicide;
  15. Female condoms;
  16. Spermicide;
  17. Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
  18. Ulipristal acetate for emergency contraception.
## Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the *Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions* sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fertility, Sexual Dysfunction Services and Male Contraception</strong></td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

### Explanations and Limitations

- Only diagnostic procedures for fertility and infertility are payable for the employee and spouse.
- Diagnostic procedures for fertility and infertility are subject to the Plan Year Deductible.
- Medical or surgical treatment for sexual dysfunction: There are some limits on sexual dysfunction drugs such as Viagra or Muse and are subject to the Plan Year Deductible.
- Procedures related to sexual dysfunction because of a medical diagnosis or procedure to treat a medical diagnosis may be covered. See the *Benefit Limitations and Exclusions* section of this document for more information.
- Male surgical sterilization is subject to the Plan Year Deductible and Coinsurance.
- Male contraception such as condoms are not covered under this Plan.
- No coverage for the treatment of fertility or infertility. See the *Benefit Limitations and Exclusions* section related to drugs, medicines and nutrition; fertility and infertility; maternity services; and sexual dysfunction services.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender Dysphoria</strong></td>
<td>Plan pays 80% PPO after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

### Explanations and Limitations

- Gender reassignment procedures including related mental health, hormone therapy, prescription drug therapy and genital reconstruction surgery under the condition that the patient adheres to the requirements of prior authorization review and case management are covered.
- Cosmetic related services such as hair removal are not covered.
- Lifetime maximum benefit for genital reconstruction surgery: participants or their covered dependents are limited to one genital reconstruction surgery while covered under this Plan (or any other PEBP self-funded Plan).

Gender reassignment surgery requires prior authorization. If prior authorization requirements of the Plan are not followed, benefits payable for the services you failed to pre-authorize will be reduced by 50% of the allowable charges. This provision applies to both in-network and out-of-network medical expenses. Expenses related to the penalty will not be counted to meet your Plan Year Deductible or Out-of-Pocket Maximum.
### Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic Testing and Counseling</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

#### Explanations and Limitations

- **Genetic Testing and Counseling requires prior authorization.**
- Benefits include: amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), alpha-fetoprotein (AFP), BRCA1 and BRCA2, apo E.
  - Amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in pregnant women only if the procedure is medically necessary as determined by the Plan Administrator or its designee.
  - Genetic counseling when provided before and/or after amniocentesis, non-invasive pre-natal testing for fetal aneuploidy, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis. BRCA1 and BRCA2 counseling for individuals already diagnosed with breast and/or ovarian cancer.
  - BRCA1 and BRCA2 genetic test for individuals already diagnosed with breast and/or ovarian cancer where results may affect the course of treatment of the covered PEBP participant. BRCA1 and BRCA 2 testing may be covered under the wellness/preventive benefit. Please refer to the wellness/preventive section of this document for a description of the benefit and the criteria for coverage.
  - Apo E genetic test to help physicians identify those individuals at highest risk for heart disease and determine the most appropriate dietary and fitness program for the covered PEBP participant.

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.

See the Key Terms and Definitions and the Benefit Limitations and Exclusions sections relating to genetic testing and counseling, including non-payment for pre-parental genetic testing.

<table>
<thead>
<tr>
<th>Hearing Aids</th>
<th></th>
</tr>
</thead>
</table>

#### Explanations and Limitations

See the Corrective Appliances section of this chart. Hearing aids are considered Orthotic devices under this Plan.
### Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health Care and Home Infusion Services</strong></td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible; or for infusion drug services 110% of the Medi-Span AWP after Plan Year Deductible</td>
</tr>
</tbody>
</table>

#### Explanations and Limitations

- **Home Health Care and Home Infusion Services require prior authorization.**
- Benefits include part-time, intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion services, subject to the maximum Plan benefits.
- See Benefit Limitations and Exclusions section related to home health care and custodial care (including personal care and childcare).
- Home health care and home infusion services are covered only when ordered by a physician or health care practitioner.
- The maximum Plan benefit for skilled nursing care services and supplies to provide home health care and home infusion services is 60 visits per person per Plan Year. 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.
- Enteral formulas for use at home (including parenteral nutrition and nutritional supplements) are payable for use as mandated by law. Also see Special Foods in the Key Terms and Definitions section.
- Home services other than skilled nursing care are not covered.

| Hospice                                    | Plan pays 80% after Plan Year Deductible        | Plan pays 80% U&C after Plan Year Deductible |

#### Hospice

- Hospice services and supplies are payable when the patient meets the criteria for receiving hospice care as described under hospice in the Key Terms and Definitions section to include:
  - Inpatient hospice care and home hospice services.

Bereavement counseling services provided by a licensed social worker or a licensed pastoral care counselor for the patient’s immediate family (covered spouse and or dependent children) as provided as part of the hospice service. Bereavement counseling beyond that included as part of the hospice program is payable under the Behavioral Health benefits of this Plan.
Schedule of Medical Benefits
(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Services (Inpatient)</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

**Explanations and Limitations**

- Benefits include:
  - Room and board and facility fees in a semiprivate room with general nursing services;
  - Specialty Care Units (e.g., intensive care unit, cardiac care unit);
  - Lab, x-ray and diagnostic services;
  - Related medically necessary ancillary services (e.g., prescriptions, supplies);
  - Newborn care and circumcision.

- **Elective hospitalization is subject to prior authorization.** All hospitalization is subject to concurrent review. See the Utilization Management section for more information.

- 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.

- Under certain circumstances (listed below) the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review firm determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services:
  - Patient is a child under age seven (7) years and has been diagnosed with extensive dental decay substantiated by x-rays and narrative provided by treating dentist, or
  - Patient has a documented illness, such as hemophilia or prior tissue or organ transplant requiring a hospital environment to monitor vital signs; or
  - Patient has a documented mental or physical impairment requiring general anesthesia in a hospital setting for the safety of the patient;
  - No payment is extended toward the dentist or any assistant dental provider under this Plan. Refer to the dental benefits described in the PEBP Self-Funded PPO Dental Plan Master Plan Document.

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

**No coverage for non-emergency hospital admission:** No coverage for 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.
## Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Services (Outpatient)</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
<tr>
<td>Technical and professional fees pre-admission testing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Explanations and Limitations

- **Covered only when ordered by a physician or health care practitioner.**

- **Inpatient laboratory services are covered under the hospital services section of this Schedule of Medical Benefits.**

- **Outpatient laboratory services such as but not limited to cholesterol screening, glucose and PSA must be provided at a contracted free-standing laboratory facility. Laboratory services performed at an outpatient acute hospital or outpatient acute facility (except for pre-admission testing, urgent care facility or emergency room) will not be covered unless an exception is warranted and approved by the Plan Administrator or its designee.**

- **Pre-Admission Testing:** outpatient laboratory tests performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

- **If an outpatient laboratory facility or draw station is not available to you within 50 miles of your residence, you may use an acute care hospital facility to receive your outpatient laboratory services.**

- **Refer to the Preventive Care Services section for information regarding benefits for screening tests and preventive laboratory testing.**
Schedule of Medical Benefits
(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

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<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Services</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

Explanations and Limitations
• This Plan covers hospital and birth (birthing) center charges and physician and midwife fees for medically necessary maternity services.
• See Breastfeeding Support section for information and benefits related to this type of service.
• See the exclusions related to Maternity Services in the Exclusions section.
• See the Enrollment and Eligibility Master Plan Document for information regarding how to enroll a newborn dependent child(ren).
• Prenatal and delivery is covered for a female employee or spouse only. For covered dependent children, only prenatal coverage is provided for maternity, except for complications of pregnancy for the dependent child (see the definition of Complications of Pregnancy in the Key Terms and Definitions section of this document).
• 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 in excess of 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 for newly born and adopted children and children placed for adoption consists of 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.
• Termination of pregnancy is covered only when the attending physician certifies that the mother’s health would be endangered if the fetus were carried to term.
• Termination of pregnancy - See the Genetic Testing section of this Schedule of Medical Benefits.
• Some preventive prenatal services such as obstetrical office visits, breastfeeding support, and screening for gestational diabetes, blood type and Rh lab services and ultrasounds for female participants, female spouses and female dependent children may be covered under the preventive care benefit. The preventive benefit does not include delivery of the newborn(s).
## Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the **Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections** for more information.

<table>
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<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nondurable Supplies</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C or 110% of the Medi-Span AWP after Plan Year Deductible</td>
</tr>
</tbody>
</table>

### Explanations and Limitations

- 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.
- Supplies needed for use by skilled home health or home infusion personnel, but only during their required services.
- To determine what nondurable medical supplies are covered, see the definition of Nondurable Supplies in the **Key Terms Definitions** section.
- Please see the **Participant Contact Guide** for information regarding the preferred diabetic supplies mail order program.
- Diabetic supplies are also payable under the prescription drug benefit, see the section on **prescription drug benefits** in this document for more information.

<table>
<thead>
<tr>
<th>Oral and Craniofacial Services</th>
<th>Plan pays 80% after Plan Year Deductible</th>
<th>Plan pays 50% U&amp;C after Plan Year Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral and Craniofacial Services</td>
<td>Plan pays 50% after Plan Year Deductible for TMJ* related services</td>
<td>Plan pays 50% of U&amp;C for TMJ* related</td>
</tr>
<tr>
<td>Injury to sound and natural teeth;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral and craniofacial surgery.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Explanations and Limitations

- See the **Benefits Limitations and Exclusions** section related to dental services.
- Treatment of injury to sound and natural teeth must be provided by a dentist or physician and is limited to restoration of sound and natural teeth to a functional level, as determined by the Plan Administrator or its designee (see the definition of “Sound and Natural Teeth” in the **Key Terms and Definitions** section).
- Certain oral or craniofacial surgery is required to be prior authorized by PEBP’s utilization management company. See the **UM** section of this document or refer to the **Participant Contact Guide**.
- Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, abscess including dental abscess and cellulitis, or for acute injury. No coverage for dental services such as removal of wisdom teeth, root canal, gingivectomy and periodontal disease, preparing the mouth for the fitting of or use of dentures, or services related to orthodontia. Orthodontia is a specific Plan exclusion.
- *Temporomandibular Joint (TMJ) services are payable 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.*
## Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

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<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery Facility</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

### Explanations and Limitations

- Ambulatory (outpatient) surgical facility (e.g., surgical-center).

- (Physician fees payable under the physician services section of this Schedule of Medical Benefits.)

- **All outpatient surgery performed in a surgery center or outpatient hospital setting require prior authorization by the UM company.** Outpatient surgery with an observation period that lasts more than 23 hours will be considered and paid as an Inpatient confinement under this medical Plan.

  Under certain circumstances the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services performed in an outpatient surgical facility if the following criteria is met:

  - Patient is a child under age seven (7) years and has been diagnosed with extensive dental decay substantiated by x-rays and narrative provided by treating dentist;

  - Patient has a documented illness, such as hemophilia or prior tissue or organ transplant that requires a hospital environment to monitor vital signs;

  - Patient has a documented mental or physical impairment that requires general anesthesia in a hospital setting for the safety of the patient;

- No payment is extended toward the dentist or any assistant dental provider fees under this medical Plan.
### Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the *Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions* sections for more information.

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<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician and Other Health Care Practitioner Services</strong></td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
<tr>
<td>(PCP or Specialist Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient or Outpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Explanations and Limitations

Physician and health care practitioner’s professional fees for services provided in a hospital, emergency room, urgent care center, a health care practitioner’s office or at home, except as otherwise indicated in this *Schedule of Medical Benefits*. Payable physician and health care practitioners include:

- Surgeon;
- Assistant surgeon (if medically necessary);
- Anesthesia by physicians and Certified Registered Nurse Anesthetists (CRNA);
- Pathologist; Radiologist;
- Physician Assistant; Nurse Practitioner; Nurse Midwife;
- Homeopathic physicians;
- Christian Science Practitioners;
- Oriental Medicine Doctor (OMD) only for Acupuncture

“Primary Care physician (PCP)” means a physician in family practice, internal medicine, obstetrics and gynecology and pediatrics.

“Specialist” means a physician with advanced education and training in clinical medicine or surgery who is not a primary care physician as defined under this Plan.

Carpal tunnel surgery and foot surgery subject to prior authorization. See the *Utilization Management* section for details.

The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of “surgery” in the *Key Terms and Definitions* section. Assistant surgeon fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. A Certified Surgical Assistant (see *Key Terms and Definitions* section) is payable as an assistant surgeon.

No coverage is provided for prophylactic surgery or treatment as defined in the *Key Terms and Definitions* section and as explained in the *Benefit Limitations and Exclusions* section, unless otherwise specified in this document. No coverage for homeopathic treatments, supplies, remedies or substances.
Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explanations and Limitations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See “Corrective Appliances” in this Schedule of Medical Benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology (X-Ray), Nuclear Medicine &amp; Radiation Therapy Services (Outpatient)</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
<tr>
<td><strong>Explanations and Limitations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Technical and professional fees associated with diagnostic and curative services, including radiation therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-admission testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Covered only when ordered by a physician or health care practitioner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Refer to the Preventive Care Services section of this document for information regarding benefits for screening radiology services and other preventive radiology testing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-Admission Testing: Outpatient radiology tests performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconstructive Services and Breast Reconstruction After Mastectomy</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

**Explanations and Limitations**

This Plan complies with the Women’s Health and Cancer Rights Act, any covered individual who is receiving benefits from a mastectomy who elects breast reconstruction in connection with it, coverage is provided for:

- Reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and physical complications for mastectomy, including lymphedemas. Reconstructive surgery if such procedures are intended to improve bodily function or to correct deformity from disease, infection, trauma, congenital anomaly, or results from a covered therapeutic procedure.

Treatment of leaking breast implant is covered; however, replacements of the implants are payable only if the reason for the implant(s) was due to a condition covered by the Women’s Health and Cancer Rights Act.

Prophylactic surgery is covered under certain circumstances:

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

No coverage is provided for prophylactic surgery or treatment as defined in the Key Terms and Definitions and Benefit Limitations and Exclusions sections. Also see the Benefit Limitations and Exclusions section related to cosmetic services including reconstructive surgery.
### Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Services (Cardiac)</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
</tbody>
</table>

#### Explanations and Limitations

- Cardiac rehabilitation is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.)
- Cardiac rehabilitation programs must be ordered by a physician.
- See also the definition of cardiac rehabilitation in the Key Terms and Definitions section.

<table>
<thead>
<tr>
<th>Rehabilitation Services (Physical, Occupational, and Speech Therapy)</th>
<th>Inpatient or Outpatient: Plan pays 80% after Plan Year Deductible</th>
<th>Inpatient or Outpatient: Plan pays 50% U&amp;C after Plan Year Deductible</th>
</tr>
</thead>
</table>

#### Explanations and Limitations

- Short term active, progressive rehabilitation services (occupational, physical, or speech therapy) performed by licensed or duly qualified therapists as ordered by a physician.
- 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.
- Inpatient rehabilitation admission requires prior authorization (see the Utilization Management section for details).
- Maintenance Rehabilitation and coma stimulation services are not covered (see specific exclusions relating to rehabilitation therapies in the Benefit Limitations and Exclusions section).
- Rehabilitation services are covered only when ordered by a physician.
- 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 a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy), an injury, or sickness that is other than a learning or mental disorder.
Schedule of Medical Benefits
(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Physician Opinion</td>
<td>Plan pays 80% after Plan Year Deductible</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible</td>
</tr>
<tr>
<td>Includes only one office visit per opinion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explanations and Limitations
For your second opinion, you may choose any in-network, Board-certified specialist who is not an associate of the attending physician.

| Skilled Nursing Facility (SNF) and Subacute Care Facility | Plan pays 80% after Plan Year Deductible | Plan pays 50% U&C after Plan Year Deductible |

Explanations and Limitations
- Admission to a skilled nursing facility or subacute care facility requires prior authorization (see the Utilization Management section of this document).
- Services must be ordered by a physician.
- Skilled nursing facility (SNF) confinement or subacute care facility confinement payable up to 60 days per Plan Year for all confinements related to the same cause.
Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Food Products for Inherited Metabolic Disorders</td>
<td>Plan pays 80% after Plan Year Deductible up to the benefit maximum</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible up to benefit maximum</td>
</tr>
</tbody>
</table>

Explanations and Limitations

- Special Food Products are payable for persons with Inherited Metabolic Disorders (as those terms are defined in the Key Terms and Definitions section of this document) subject to certain conditions.
- **Special Food Products** (defined in this Plan) are payable for persons with inherited metabolic diseases/disorders (a disease caused by an inherited abnormality of the body chemistry of a person) to a maximum of $2,500 per person per Plan Year subject to the following provisions, as determined by the Plan Administrator or its designee.
- Must be prescribed by a physician to treat a diagnosis of inherited metabolic disorder.
- Documentation to substantiate the presence of an inherited metabolic disorder and that the products purchased are “Special Food Products” may be required before the Plan will reimburse the participant for costs associated with this benefit.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>You pay after Deductible:</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telemedicine</strong> (Doctor on Demand)</td>
<td><strong>$49</strong> for primary care visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>$79</strong> for 25-minute psychology visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>$119</strong> for 50-minute psychology visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>$299</strong> for initial 45-minute psychiatry visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>$99</strong> for 15-minute follow-up psychiatry visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>applies to Deductible and Out-of-Pocket Maximum</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Plan pays 80% after Plan Year Deductible; applies to Out-of-Pocket Maximum</th>
<th>Plan pays 50% U&amp;C after Out-of-Network Plan Year Deductible; applies to Out-of-Pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telemedicine</strong> (All other telemedicine providers except Doctor on Demand)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explanations and Limitations

Doctor on Demand telemedicine services provided by this Plan are considered in-network.
To learn more, visit http://www.doctorondemand.com/pebp.

Doctor on Demand visits are subject to the in-network Deductible. Out of pocket costs apply to Deductible and Out-of-Pocket Maximum.
### Schedule of Medical Benefits
(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants (Organ and Tissue)</td>
<td>Plan pays 80% after Plan Year Deductible up to the benefit maximum</td>
<td>Plan pays 50% U&amp;C after Plan Year Deductible up to benefit maximum</td>
</tr>
</tbody>
</table>

**Explanations and Limitations**

- Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.
- Coverage is provided for organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his or her plan will pay first and benefits under this Plan will be reduced by that payable under the donor’s plan.
- Transplantation-related services require Prior authorization (see the Utilization Management section of this document for details). Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.
- See the Benefit Limitations and Exclusions section related to experimental and investigational services and transplants.
- Expenses incurred by a PEBP participant who donates an organ or tissue are not covered unless the person who receives the donated organ/tissue is also a participant covered by this Plan.
- Participants and their covered dependents are required to use a Center of Excellence for organ and tissue transplants. An appropriate Center of Excellence facility will be identified by PEBP’s national PPO network or PEBP’s third party claims administrator.
- This Plan provides for reimbursement of certain costs associated with travel and hotel accommodations for the patient and one additional individual person (spouse/domestic partner, family member or friend) when associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to the Transplants (Organ, Bone Marrow and Tissue section for additional information.
- Expenses incurred for travel and hotel accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.
- PEBP does not provide advance payment for travel expenses related to organ or tissue transplants.
### Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)
See also the Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Screening Exam*</td>
<td>You pay $25 Copay $95 maximum Plan benefit per Plan Year Amounts greater than $95 is not payable under this Plan. Not subject to Deductible.</td>
<td>You pay $25 Copay $95 maximum Plan benefit per Plan Year Amounts greater than $95 is not payable under this Plan. Not subject to Deductible.</td>
</tr>
</tbody>
</table>

#### Explanations and Limitations

- One annual preventive vision screening exam including refractive error testing per Plan Year.
- 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.*
- *PEBP does not maintain a network specific to vision care; however, the PPO network does have a list of some vision providers. PEBP will reimburse providers selected from the in-network provider search up to $95 once each Plan Year participant responsible for $25 copay at time of service.*

<table>
<thead>
<tr>
<th>Wellness (Preventive) Benefit</th>
<th>The Plan pays 100% Not subject to Deductible</th>
<th>Not covered</th>
</tr>
</thead>
</table>

#### Explanations and Limitations

- Wellness (Preventive) benefits are healthcare services that are not provided because of illness, injury or congenital defect. Your physician may recommend a service that is not listed. Please contact the claims administrator listed in the Participant Contact Guide for coverage information or refer to the Preventive Services section of this document.
- Deductible does not apply to these eligible wellness or preventive benefits received from in-network providers. Unless coverage is mandated by law, you are responsible for any expenses incurred that are not listed in this document or do not meet the preventive services guidelines.

- Physical exam, screening lab and x-rays
- Well Child Visits and services
- HPV vaccination
- Prostate screening
- Routine sigmoidoscopy or colonoscopy* Adult immunizations Mammogram* Pelvic exam and Pap smear lab test
- Hypertension screening Skin Cancer screening Routine hearing exam Weight Loss program, medically supervised Osteoporosis screening
- Stress management programs Breastfeeding support Prenatal obstetrical office visits
## Schedule of Medical Benefits

(All benefits are subject to the Deductible and Out-of-Pocket Maximum except where noted)

See also the *Explanations and Limitations, What is Covered Under the Plan, Key Terms and Definitions and the Benefit Limitations and Exclusions* sections for more information.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness (Preventive) Benefit</td>
<td>The Plan pays 100%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Not subject to Deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Explanations and Limitations

**Wellness (Preventive) Benefit continued:**

- *The first billed procedure of the Plan Year for a colonoscopy or mammogram will be considered preventive regardless of the diagnosis. Preventive mammograms are limited to one 2-D or 3-D mammogram per Plan Year.*

- Benefits are payable for medically supervised weight loss treatment programs. Does not include programs such as Weight Watchers, Jenny Craig, Slim Fast or the rental/purchase of exercise equipment. Refer to the weight management exclusion in the *Benefit Limitations and Exclusions* section of this document. Weight loss program benefits are not payable if provided out-of-network.

- Outpatient newborn, well child visits and routine childhood immunizations (e.g. DPT, Polio, MMR, Hib, hepatitis, chicken pox, tetanus).

- 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. Benefits for over-the-counter products are limited to recommendations by the Surgeon General, located in the *Preventive Care Services* section of this document.

- Refer to the following examples of wellness or preventive services or see the *Preventive Services* section of this document. To confirm what services are covered under the preventive benefit, contact the claims administrator listed in the *Participant Contact Guide*.
Health Savings Accounts for CDHP Participants

Active Employees Only

The Consumer Driven Health Plan (CDHP) is an IRS qualified High Deductible Health Plan. This means the CDHP complies with federal requirements regarding Deductibles, Out-of-Pocket Maximums, and certain other features. As a qualified High Deductible Health Plan, the CDHP is coupled with a Health Savings Account (HSA). A Health Savings Account is a tax-exempt account that you can use to pay or reimburse yourself for certain medical expenses you incur.

HSAs are employee-owned accounts, meaning the funds in the HSA remain with the employee and will 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 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 keeps 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.

There are limits on the amount an eligible individual 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 your tax return and not claimed as a tax dependent on someone else’s return.

You must be an eligible individual 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);
- 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 the employee loses eligibility to contribute to a Health Savings Account (HSA) for any reason, then the Plan reserves the right to cease processing employee contributions to the HSA for the remainder of the Plan Year. If the employee elects to continue coverage in the Plan for the subsequent Plan Year, then the employee will only be eligible to enroll in the Health Reimbursement Arrangement (HRA) to receive PEBP contributions as described below. The HSA claims administrator reserves the right to verify Medicare eligibility with the Centers for Medicare and Medicaid Services (CMS).

Employees who wish to establish or contribute to an HSA should contact the HSA 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 coverage effective date 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 reimbursement expenses incurred after the HSA is established and can only be reimbursed if there are available HSA funds in the account.

HealthSCOPE Benefits is the claims administrator for the HSA. However, Healthcare Bank is the HSA provider to which it will forward PEBP contributions and voluntary HSA pre-tax payroll deductions. PEBP does not (i) endorse Healthcare Bank 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 Healthcare Bank. Employees may choose to establish an HSA with any HSA trustee or custodian and may transfer funds deposited into a Healthcare Bank HSA 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 14 days of the employee’s health coverage effective date, the HSA will not be opened. 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.

<table>
<thead>
<tr>
<th>CDHP HSA Contributions – State and Non-State Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State and Non-State Employees</strong></td>
</tr>
<tr>
<td>Participant Only</td>
</tr>
<tr>
<td>Dependents</td>
</tr>
</tbody>
</table>

*The Preventive Program contribution only applies to primary participants covered under the CDHP on July 1, 2018. Preventive Program contribution is contingent upon the primary participant completing a series of wellness activities during the Plan Year (July 1, 2018 – June 30, 2019). To qualify for the $100 Preventive Program Contribution, participants must receive a dental exam, teeth cleaning, and one physical exam with their primary care provider and have one preventive laboratory blood test. (This Plan requires the preventive lab draw to be performed at an independent free-standing facility to be covered.) This contribution will be awarded when the claims administrator confirms all the required Preventive Program activities have been completed.

Participants will receive $100 for completing registration with Doctor on Demand and the completing a guided tour using the Healthcare Blue Book (HCBB) program. This contribution will be awarded when the claims administrator confirms these activities have been completed.

New hires effective August 1, 2018 and later receive a pro-rated base contribution (participant and dependents) based on their CDHP coverage effective date.
### Calendar Year 2018 HSA Contribution Limits

<table>
<thead>
<tr>
<th>Individual</th>
<th>Family (two or more HSA eligible family members)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,450</td>
<td>$6,900</td>
</tr>
</tbody>
</table>

The total contributions (combined employee/employer) cannot exceed the 2018 calendar year limit. To contribute the family maximum, the employee and at least one dependent must be covered on the CDHP Plan. The dependent must also be claimed as IRS tax dependent. The Family maximum applies regardless of whether two employees are married 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 $6,900. Employees age 55 years and older at the end of the tax year may contribute an additional $1,000 to the HSA.

### Health Reimbursement Arrangement for CDHP Participants

#### Active Employees and Retirees

This section provides summary information only. For more detailed information regarding this important benefit, see Internal Revenue Service (IRS) Publication 502 or contact the HRA claims administrator listed in the Participant Contact Guide.

For employees who are on the Plan who are not eligible for an HSA, or who fail to establish an HSA and retirees covered under this Plan will receive a CDHP Health Reimbursement Arrangement (HRA) account. CDHP HRAs are not available for PEBP’s Premier (EPO) Plan or HMO participants.

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 as defined by the IRS (see IRS Publication 502), other than premiums, including payment of Deductibles, Coinsurance, and other Out-of-Pocket qualifying healthcare expenses not covered by this Plan.

The CDHP’s HRA may only be used to pay or reimburse qualified Out-of-Pocket health care expenses incurred by the participant, the participant’s spouse and/or dependents enrolled in the CDHP (or other non-HRA coverage) and claimed on the participant’s annual tax return. CDHP HRA funds may not be used for a person who does not meet the IRS definition of a qualified tax dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant’s tax return, regardless of whether PEBP provides coverage for the dependent.

The entire annual PEBP base contribution for Plan Year 2019 will be available for use at the beginning of the Plan Year on or about July 1, 2018 (subject to certain limitations). Participants and dependents who become eligible for PEBP coverage after July 1, 2018 will receive a pro-rated 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 cannot contribute to a 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 roll 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 CDHP HRA. Any reimbursement from the CDHP HRA will be the lesser of the available CDHP HRA balance or the claim amount paid to the provider.

CDHP HRA funds are not portable; participants cannot use CDHP HRA funds if they are no longer covered by the CDHP HRA. If a participant terminates their CDHP coverage, the remaining balance in the CDHP HRA account will revert to PEBP. Participants enrolled in the CDHP HRA who change plans during the Open Enrollment period to the CDHP HSA plan will forfeit any remaining funds in their CDHP HRA account.

Active employees who retire and who are not Medicare age (typically at age 65 years) can maintain the balance in their CDHP HRA account when they retire if they elect to continue coverage under the CDHP plan or elect COBRA coverage if there is no break in the CDHP coverage. If a participant elects COBRA coverage, the CDHP 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.

Retirees who have a CDHP HRA balance and who transition to the Medicare Exchange will forfeit any remaining funds in the HRA current with 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.

**Timely Filing of HRA Claims**

In accordance with [NAC 287.610](#), all claim requests must be submitted to the claims administrator within one year (12 months) from the date service(s) were incurred. No plan benefits will be paid for any claim requests submitted after this period.

When your CDHP coverage ends and you are an HRA participant you will have one year (12 months) from the date your coverage ends to file a claim for reimbursement from your HRA for eligible claims incurred during your coverage period.

CDHP HRA funds may not be used to pay premiums.
### CDHP HRA Contributions

#### State and Non-State Retirees and Employees

<table>
<thead>
<tr>
<th>Employees and Retirees</th>
<th>Base Contribution</th>
<th>Preventive Program Contribution*</th>
<th>DoD and Healthcare Blue Book Registration Contribution*</th>
<th>Total Base and Contribution*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Only</td>
<td>$700</td>
<td>$100</td>
<td>$100</td>
<td>$900</td>
</tr>
<tr>
<td>Dependents</td>
<td>$200 per dependent, maximum 3 dependents</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>$200 per dependent, maximum 3 dependents</td>
</tr>
</tbody>
</table>

*The Preventive Program contribution only applies to primary participants covered under the CDHP on July 1, 2018. Preventive Program contribution is contingent upon the primary participant completing a series of wellness activities during the Plan Year (July 1, 2018 – June 30, 2019). Participants must receive a dental exam, teeth cleaning, and one physical exam with their primary care provider and have one preventive laboratory blood test. The standard Plan exclusions regarding lab draw outpatient free-standing (independent) stations applies. Participants must also register with the Doctor on Demand and Healthcare Blue Book (HCBB) (registration with HCBB requires the completion of a guided tour of the program). Participants will not be awarded the $200 Program contribution until the claims administrator confirms all required activities have been completed.

New hires effective August 1, 2018 and later receive a pro-rated base contribution (participant and dependents) based on their CDHP coverage effective date.

### Benefit Limitations and Exclusions

Although the Plan covers most medically necessary medical expenses, there are some expenses that are not covered. This section outlines limitations and exclusions of your medical coverage. This list is not all-inclusive; if you have questions about a health care service or supply, contact the claims administrator listed in the Participant Contact Guide.

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

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

- All expenses for medical services or supplies that are not covered by the Plan including but not limited to expenses that exceed the network contract rate and services listed in the Benefit Limitations and Exclusions section;
- All charges exceeding the Usual and Customary Charge as determined by the Plan Administrator;
• Any additional amounts or penalties you must pay because you failed to comply with the UM program described in the Utilization Management section;
• Benefits exceeding those services or supplies subject to maximum individual limit(s) for certain eligible medical expenses as listed in the Schedule of Medical Benefits; and
• Certain wellness or preventive services that are paid by the Plan at 100% do not accumulate towards the Out-of-Pocket Maximum.

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

Lifetime Maximum

The following Maximum Individual Limit(s) apply:

• Lifetime maximum on bariatric surgery: The Plan’s lifetime maximum is one bariatric surgery while covered under any previous PEBP self-funded PPO Plan, including the CDHP and the Premier Plan; and
• Lifetime maximum on gender reassignment surgery: The Plan’s lifetime maximum is one surgery while covered under any previous PEBP self-funded PPO Plan, including the CDHP and the Premier Plan.

Note: Other lifetime maximums may apply. For more information, refer to the Schedule of Medical Benefits section and the What’s Covered Under the Plan section. If you need additional information, contact the claims administrator.

Exclusions under the Medical Plan

The following is a list of services and supplies or expenses not covered by the Plan. The Plan Administrator and its designee will have discretionary authority to determine the applicability of these exclusions and terms of the Plan and determines eligibility and entitlement to Plan benefits. General exclusions are listed first followed by specific medically related Plan exclusion(s). Any amount you pay toward services that are not covered or otherwise excluded will not count towards the Deductible or the Out-of-Pocket Maximum.

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

Alternative/Complimentary Health Care Exclusions: Expenses for chelation therapy, except as may be medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron. Expenses for prayer, religious healing or spiritual healing, except services provided by a Christian Science Practitioner. Expenses for naturopathic, Naprapathic services or treatment/supplies. Expenses for homeopathic treatments/supplies that are not FDA approved;

Note: Homeopathic office visits are payable under physician services in the Schedule of Medical Benefits.
**Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Plan administrator or its designee.

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

**Charges for care or services:** Charges for care or services provided before the effective date or after the termination of coverage.

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

1. A managed care organization that offers or issues a health care plan which provides coverage for prescription drugs:
   a) Must authorize coverage for and may apply a copayment and Deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for synchronizing the insured’s chronic medications:
      1. The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the insured; and
      2. He insured requests less than a 30-day supply.
   b) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the managed care organization.
   c) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).
2. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.
3. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.
4. As used in this section:
(a) “Chronic medication” means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent or lasting indefinitely.

(b) “Synchronization” means the alignment of the dispensing of multiple medications by a single contracted pharmacy for improving a patient’s adherence to a prescribed course of medication.

(c) “Unit-of-use packaging” means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

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

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

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

1. The provisions of this section apply to a health care plan offered or issued by a managed care organization if an insured covered by the health care plan receives health care through a defined set of providers of health care who are under contract with the managed care organization.

2. Except as otherwise provided in this section, if an insured who is covered by a health care plan described in subsection 1 is receiving medical treatment for a medical condition from a provider of health care whose contract with the managed care organization is terminated during the medical treatment, the health care plan must provide that:

3. The insured may continue to obtain medical treatment for the medical condition from the provider of health care pursuant to this section, if:

   a. The insured is actively undergoing a medically necessary course of treatment; and
   b. The provider of health care and the insured agree that the continuity of care is desirable.

4. The provider of health care is entitled to receive reimbursement from the managed care organization for the medical treatment the provider of health care provides to the insured pursuant to this section, if the provider of health care agrees:

   a. To provide medical treatment under the terms of the contract between the provider of health care and the managed care organization with regard to the insured, including, without limitation, the rates of payment for providing medical service, as those terms existed before the termination of the contract between the provider of health care and the managed care organization; and
   b. Not to seek payment from the insured for any medical service provided by the provider of health care that the provider of health care could not have received from the insured were the provider of health care still under contract with the managed care organization.
1. The coverage required by subsection 2 must be provided until the later of:
   (a) The 120th day after the date the contract is terminated; or
   (b) If the medical condition is pregnancy, the 45th day after:
      i. The date of delivery; or
      ii. If the pregnancy does not end in delivery, the date of the end of the pregnancy.

5. The requirements of this section do not apply to a provider of health care if:
6. The provider of health care was under contract with the managed care organization and the managed care organization terminated that contract because of the medical incompetence or professional misconduct of the provider of health care; and
   (b) The managed care organization did not enter into another contract with the provider of health care after the contract was terminated pursuant to paragraph (a).

7. An evidence of coverage for a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2003, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal thereof that conflicts with this section is void.

8. The Commissioner shall adopt regulations to carry out the provisions of this section.

9. (Added to NRS by 2003, 3370)

**Contraception or its Therapeutic Equivalent:** 2017 Legislative Session (AB 249)

1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:
   a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;
   b) Any type of device for contraception or its therapeutic equivalent which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;
   c) Insertion or removal of a device for contraception;
   d) Education and counseling relating to contraception;
   e) Management of side effects relating to contraception; and
   f) Voluntary sterilization for men and women.

2. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the managed care organization.

3. A managed care organization that offers or issues a health care plan shall not:
   a) Require an insured to pay a higher Deductible, any copayment or Coinsurance or require a longer waiting period or other condition to obtain any benefit included in the health care plan pursuant to subsection 1;
   b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefits;
   c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefits;
   d) Penalize a provider of health care who provides any such benefits to an insured, including, without limitation, reducing the reimbursement of the provider of health care;
(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefits to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefits, including, without limitation, a program of step therapy or prior authorization.

4. Coverage pursuant to this section for a covered spouse or the covered dependent of an insured must be the same as for the insured.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

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

1. Except as otherwise provided in subsection 2, a managed care organization shall not:
   (a) Deny a claim under a health care plan solely because the claim involves an injury sustained by an insured because of being intoxicated or under the influence of a controlled substance.
   (b) Cancel participation under a health care plan solely because an insured has made a claim involving an injury sustained by the insured because of being intoxicated or under the influence of a controlled substance.
   (c) Refuse participation under a health care plan to an eligible applicant solely because the applicant has made a claim involving an injury sustained by the applicant because of being intoxicated or under the influence of a controlled substance.

2. The provisions of subsection 1 do not prohibit a managed care organization from enforcing a provision included in a health care plan to:
   (a) Deny a claim which involves an injury to which a contributing cause was the insured’s commission of or attempt to commit a felony;
   (b) Cancel participation under a health care plan solely because of such a claim; or
   (c) Refuse participation under a health care plan to an eligible applicant solely because of such a claim.

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

**Cosmetic Surgery:** Expenses related to surgery or medical treatment to improve or preserve physical appearance, but not physical function, and complications thereof, are not covered. Cosmetic surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The medical program does cover medically necessary reconstructive services such as services related to leaking breast implants and services under the Women’s Health and Cancer Rights Act.

**Corrective Appliance, Orthotic Device Expenses, and Appliances:** Any items that are not corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment (as each of those terms is defined in the Key Terms and Definitions section), including (but not
limited to) personal comfort items like air purifiers, humidifiers, electric heating units, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, orthopedic mattresses, water beds, and air conditioners are excluded. Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment are not covered. Orthopedic shoes and foot orthotics are not a covered benefit unless the shoe or foot orthotic is permanently attached to a brace.

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

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

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

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

Dental Services:
- Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body.
- Expenses for dental services may be covered under the medical Plan if they are incurred for the repair or replacement of injury to sound and natural teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing. See Oral, Craniofacial and TMJ services in the Schedule of Medical Benefits to determine if those services are covered. Coverage for dental services as the result of an injury to sound and natural teeth will be extended under the medical Plan to a maximum of two 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 www.pebp.state.nv.us.
- Expenses for oral surgery to remove teeth (including wisdom teeth), gingivectomies, treatment of dental abscesses, root canal (endodontic) therapy, except those oral surgery
services listed as payable under the Oral and Craniofacial section of the Schedule of Medical Benefits.

Drugs, Medicines and Nutrition:

- 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 as defined in the Key Terms and Definitions section; or are experimental and/or investigational (as defined in the Key Terms and Definitions section).
- Non-prescription (non-legend or over-the-counter) drugs or medicines, except insulin and Prilosec.
- Foods and nutritional supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except: when provided during hospitalization; prenatal vitamins or minerals requiring a prescription; and medical foods (as defined in the Key Terms and Definitions section) unless noted as payable in the Schedule of Medical Benefits.
- Special food products (as defined in the Key Terms and Definitions section), except for the benefit described as covered under Medical Foods in the Schedule of Medical Benefits section or elsewhere in this document under the section titled “Obesity and Overweight Care Management Program”.
- Naturopathic, Naprapathic or homeopathic treatments/substances.
- Weight control or anorexiants (phentermine, Xenical), except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy or where noted in this document under the Obesity and Overweight Care Management Program section.
- 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, except those provided under the Preventive Care Services benefit for children and/or adults; and those required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin).
- Medical marijuana is not an eligible medical expense and is an exclusion of the Plan.
- Outpatient prescription drugs are payable only via the prescription drug program listed under drugs in the Schedule of Medical Benefits.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the prescription drug program. See the Preventive Care Services section for information regarding tobacco/smoking cessation products.

Drugs, Medicines or Devices for:

- Drugs to enhance athletic performance such as anabolic steroids;
- Non-prescription male contraceptives, e.g. condoms;
- Treatment of fertility and/or infertility;
- Dental products such as topical fluoride preparations and products for periodontal disease;
- Hair removal or hair growth products (i.e., Propecia, Rogaine, Minoxidil, Vaniqa);
- Vitamin A derivatives (retinoids) for dermatologic use.

NOTE: This Plan does not coordinate pharmacy benefits as the secondary payor.

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

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

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

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefits as described in the Medical Expense Coverage section.

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

Expenses for Which a Third Party Is Responsible: Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party (see the provisions relating to third party liability in the Subrogation and Third-Party Recovery section for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies).

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 or its designee to be Experimental and/or Investigational services as defined in the Key Terms and Definitions section.
Fertility and Infertility Services:
Expenses for the treatment of infertility, along with services to induce pregnancy (and complications thereof), including (but not limited to): services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses and reversal of sterilization procedures.

Foot/Hand Care:
Expenses for treatment of weak, strained, flat, unstable or unbalanced feet; metatarsalgia (pain in metatarsal bones of the feet); or bunions. Surgery to correct bunions or hammer toes is payable (when prior authorized).

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.

Gender Dysphoria Services: Certain procedures associated with gender dysphoria treatment are considered non-medically necessary, such as (this is not an all-inclusive list):
- Participants or their covered Dependent are limited to one gender reassignment surgery in the individual’s lifetime while covered under the PEBP CDHP Plan or any previous self-funded PPO Plan. Certain procedures are considered cosmetic, such as (this is not an all-inclusive list):
  - Blepharoplasty
  - Hair transplants
  - Breast augmentation even if your physician indicates that having the procedure would mean greater comfort in the new gender role
  - Rhinoplasty
  - Electrolysis (hair removal)
  - Laser hair removal
  - Facial reconstruction including facial feminization surgery to include but not be limited to facial bone reduction, face lift and certain facial plastic reconstruction NOTE: The UM company to determine if a procedure is cosmetic and the Plan Administrator as discretionary authority to determine coverage.
- Other Exclusions include (this is not an all-inclusive list):
  - Sperm preservation in advance of hormone treatment or gender Surgery
  - Cryopreservation of fertilized embryos
  - Voice modification Surgery
  - Voice therapy
  - Drugs for sexual performance or cosmetic purposes (except for hormone therapy as described in this document)
Transportation, meals, lodging or other similar expenses associated with gender dysphoria services

Note: Please be advised that UM company has full authority to determine if a procedure is non-medically necessary.

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

**Government-Provided Services (Tricare/CHAMPUS, VA, etc.):** Expenses for services provided to a covered individual also covered under any government-sponsored plan or program unless the governmental program provides otherwise.

**Growth Hormone:** Off-labeled use of growth hormone is excluded.

**Gym Fees:** Fees by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists are excluded, even if recommended by a professional to treat a medical condition.

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

**Hearing Care:** Special education and associated costs in conjunction with sign language education for a patient or family members.
Home Health Care:
- Expenses for any home health care services other than part-time, intermittent skilled nursing services and supplies.
- Expenses under a home health care program for services that are provided by an immediate relative or someone who ordinarily lives in the patient’s home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a physician.
- Expenses for a homemaker, custodial care, childcare, adult care or personal care attendant, except as provided under the Plan’s hospice coverage.

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

Human Papillomavirus Vaccine: (NRS 695G.171) Required provision concerning coverage for human papillomavirus vaccine.
1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.
2. A health care plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.
3. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal thereof which conflicts with subsection 1 is void.
4. For the purposes of this section, “human papillomavirus vaccine” means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

The Plan Administrator’s determination that this exclusion applies shall not be affected by any prosecution, or acquittal of (or failure to prosecute) the covered individual in connection with the acts involved, unless such injury is the result of a physical or mental health condition or domestic violence.

Internet/Virtual Office Visit: Expenses related to an online internet consultation with an out-of-network physician or other health care practitioner (also called a virtual office visit/consultation), physician-patient web service or physician-patient e-mail service (including receipt of advice, treatment plan, prescription drugs or medical supplies obtained) from an online internet provider who is not a participating provider in the PPO provider network. Exception: Doctor on Demand is considered an in-network provider for individuals covered under this Plan.
Maternity/Family Planning:
- Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms.
- Termination of Pregnancy: Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies the health of the mother would be endangered if the fetus were carried to term.
- Childbirth courses.
- Expenses related to delivery expenses associated with a pregnant dependent child, except for expenses related to complications of pregnancy.
- Expenses related to the maternity care and delivery expenses associated with a surrogate mother’s pregnancy.
- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs.
- For nondurable supplies.
- Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals are excluded.

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

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

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required because of an injury, illness or disability of a covered individual, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, etc.).
No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

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

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

Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergent travel or transportation (including lodging, meals and related expenses) of a provider, covered individual, or family member of a covered individual except where otherwise noted under travel expenses for organ/ tissue transplants and bariatric weight loss surgery or certain surgeries performed in a surgery center or outpatient setting as determined by the UM company.

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

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

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

2. The provisions of this section do not affect any Deductibles, copayments or Coinsurance authorized or required pursuant to the health care plan.

3. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2016, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void. As used in this section, “topical ophthalmic product” means a liquid prescription drug which is applied directly to the eye from a bottle or by means of a drop.
**Orally Administered Chemotherapy:** This Plan complies with NRS 695G.167; Required provision concerning coverage for orally administered chemotherapy.

A managed care organization that offers or issues a health care plan which provides coverage for the treatment of cancer using chemotherapy shall not:

1. Require a copayment, Deductible or Coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the Deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a High Deductible Health Plan, as defined in 26 U.S.C. § 223, and the amount of the annual Deductible has not been satisfied.

   a) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

   b) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. An evidence of coverage for a health care plan subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring a managed care organization to provide coverage for the treatment of cancer using chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

**Orthodontia:** Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an injury or illness.

**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 accommodations, or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

**Prophylactic Surgery or Treatment:**

Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery (as defined in the Key Terms and Definitions section of this document), 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 section in this document titled Reconstructive Services and Breast Reconstruction after Mastectomy. For additional information, please contact the UM company or claims administrator.

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

Rehabilitation Therapy Exclusions (Inpatient or Outpatient):
• Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
• Expenses for massage therapy, Rolfing and related services.
• Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
• Expenses for maintenance rehabilitation, as defined under rehabilitation in the Key Terms and Definitions section of this document.
• Expenses for speech therapy for functional purposes including (but not limited to) stuttering, stammering and conditions of psychoneurotic origin; or for childhood developmental speech delays and disorders.
• Expenses for treatment of delays in childhood speech development, unless as a direct result of an injury, surgery or the result of a covered treatment.

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

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

**NOTE:** Prescription smoking/tobacco cessation products are payable under the prescription drug benefit as described in the *Schedule of Medical Benefits* and *Preventive Care Services* section of this document.

**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.

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

**Telehealth:** *(NRS 695G.162)* Required provision concerning coverage for services provided through telehealth.
A health care plan issued by a managed care organization for group coverage must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means.
A managed care organization shall not:
(a) Require an insured to establish a relationship in person with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to providing the coverage described in subsection 1;
(b) Require a provider of health care to demonstrate that it is necessary to provide services to an insured through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to providing the coverage described in subsection 1;
(c) Refuse to provide the coverage described in subsection 1 because of the distant site from which a provider of health care provides services through telehealth or the originating site at which an insured receives services through telehealth; or
(d) Require covered services to be provided through telehealth as a condition to providing coverage for such services.

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

**Topical Ophthalmic Products:** (NRS 695G.172) Required provision concerning coverage for
early refills of topical ophthalmic products.
1. A managed care organization which offers or issues a health care plan that provides
   coverage for prescription drugs shall not deny coverage for a topical ophthalmic product which is
   otherwise approved for coverage by the managed care organization when the insured,
   pursuant to NRS 639.2395, receives a refill of the product:
   (a) After 21 days or more but before 30 days after receiving any 30-day supply of the
       product;
   (b) After 42 days or more but before 60 days after receiving any 60-day supply of the
       product; or
   (c) After 63 days or more but before 90 days after receiving any 90-day supply of the
       product.
2. The provisions of this section do not affect any Deductibles, copayments or Coinsurance
   authorized or required pursuant to the health care plan.
3. An evidence of coverage subject to the provisions of this chapter which provides
   coverage for prescription drugs and that is delivered, issued for delivery or renewed on
   or after January 1, 2016, has the legal effect of including the coverage required by this
   section, and any provision of the evidence of coverage or renewal which conflicts with
   this section is void.
4. As used in this section, “topical ophthalmic product” means a liquid prescription drug
   which is applied directly to the eye from a bottle or by means of a dropper.

**Transplant (Organ and Tissue):**
- Expenses for human organ and/or tissue transplants that are experimental and/or
  Investigational, including (but not limited to) donor screening, acquisition and selection,
  organ or tissue removal, transportation, transplants, post-operative services and drugs or
  medicines, and all complications thereof, except those transplant services as described
  under Transplants in the Schedule of Medical Benefits.
- Expenses related to non-human (Engrafted) organ and/or tissue transplants or implants,
  except heart valves.
• Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this Plan.

**Vision Care:**
Any vision care services more than the vision care benefit maximums. Vision therapy (orthoptics) unless prior approved by PEBP or the claims administrator, elective corrective eye surgeries (such as Lasik surgery), materials and supplies.

**War or Similar Event:** Expenses incurred because of an injury or illness due to you or your covered dependent(s)’ participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

**Weight Management and Physical Fitness:**
Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs and prescription drugs, except the services payable under the Wellness/Preventive section of the *Schedule of Medical Benefits*.

• Surgery for weight reduction is payable only if prior authorized by the Plan Administrator or its designee. Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Please refer to the *Utilization Management* section of this document for more information.

• If you do not follow the required prior authorization review process for weight reduction surgery, benefits payable for the services you failed to pre-authorize will be reduced by 50% of the allowable charges. Expenses related to the penalty will not be counted to meet your Plan Year Deductible or Out-of-Pocket Maximum.

• Benefits are payable for medically supervised weight loss treatment programs under the Wellness benefit. Please refer to the Wellness section of this document for more information. The benefit does not include programs such as Weight Watchers, Jenny Craig, Nutri-Systems, Slim Fast or the rental or purchase of any form of exercise equipment.

• Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient’s age, sex, height and body frame based on weight tables generally used by physicians to determine normal body weight.

• Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.

• One obesity related surgery per lifetime while covered under the PEBP CDHP or any previous PEBP PPO Plan.

**Exclusions under the Prescription Drug Plan**
No payment will be made under any benefit for expenses incurred in connection with the following, unless specifically stated otherwise in this document:

• 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 as defined in the Key Terms and Definitions section; or are Experimental and/or Investigational (as defined in the Key Terms and Definitions section);

- Non-prescription (non-legend or OTC) drugs or medicines, except insulin and Prilosec;
- 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; and special food products (as defined in the Key Terms and Definitions section) unless noted as payable in the Schedule of Medical Benefits;
- Special Food Product (as defined in the Key Terms and Definitions section), except for the benefit described as covered under special food products in the Schedule of Medical Benefits section or elsewhere in this document under the section titled Obesity and Overweight Care Management Program;
- Naturopathic, Naprapathic or homeopathic treatments/substances;
- Weight control or anorexiants (phentermine, Xenical), except those anorexiants used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy or where noted in this document under the section titled Obesity and Overweight 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, except those provided under the Preventive Care Services benefit for children and/or adults; and those required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin);
- Medical marijuana is not an eligible medical expense and is an exclusion of the Plan;
- Outpatient prescription drugs are payable only via the prescription drug program listed under drugs in the Schedule of Medical Benefits;
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the prescription drug program;
- Drugs, medicines or devices for:
  - Enhancing athletic performance such as anabolic steroids; or
  - Non-prescription male contraceptives, e.g. condoms.
- Dental products such as topical fluoride preparations and products for periodontal disease;
- Hair removal or hair growth products (i.e., Propecia, Rogaine, Minoxidil, Vaniqa); and/or
- Vitamin A derivatives (retinoids) for dermatologic use.
Description of In-Network and Out-of-Network under the Plan

This section includes information about how in-network and out-of-network benefits work and how emergency health services are covered.

In-Network Benefits
The Plan only provides in-network benefits, which generally pay at a higher level than out-of-network benefits. In-network benefits are payable for covered expenses which are:

- Provided by an in-network physician or other in-network provider; or
- Considered to be an out-of-network benefit exception.

Payment for in-network benefits are based on the in-network provider’s negotiated rate as established by the network.

Provider Network
The Plan or its designee arranges for providers to participate in a network. In-network providers are independent practitioners; they are not the Plan’s employee or employees of any Plan designee. It is your responsibility to select your provider.

The credentialing process confirms public information about the provider’s licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the network status of a provider. A provider’s status may change. You are responsible for verifying a provider’s network status prior to receiving services, even when you are referred by another in-network provider. You can verify the provider’s status by calling HealthSCOPE Benefits.

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

Do not assume that an in-network provider’s agreement includes all covered expenses. Some in-network providers agree to provide only certain covered expenses, but not all covered expenses. Some in-network providers choose to be an in-network provider for only some products. You may contact HealthSCOPE Benefits for assistance in choosing a provider or with questions about a provider’s network participation.

Other Providers
If you have a medical condition that HealthSCOPE Benefits or the utilization management company believes needs special services, they may direct you to a provider chosen by them. If you require certain complex covered services for which expertise is limited, HealthSCOPE Benefits or the utilization management company may direct you to an out-of-network provider.
In both cases, benefits will only be paid if your covered expenses for that condition are provided by or arranged by the other provider chosen by HealthSCOPE Benefits or the utilization management company.

**Out-of-Network Benefits**

Out-of-network benefits are provided under the Plan at a Coinsurance rate of 50% of eligible billed charges.

**Out-of-Network Benefits Exceptions**

**Travel**

If there is no in-network provider within 50-miles of your home, you may be eligible to receive benefits for certain covered expenses paid at the in-network level. You may check a provider’s status in your area by contacting HealthSCOPE Benefits. All benefits that fall under this category must be approved prior to receipt of care and are subject to any Plan limitations or exclusions set forth in this MPD.

If you are traveling outside your network and you need medical care, you should contact Customer Service at the telephone number appearing on the identification card or log onto www.healthscopebenefits.com for assistance in locating the nearest in-network provider. If you need emergency care, however, go ahead and get the care you need. The Plan will pay your claim at the in-network provider level (based on billed charges) regardless of the provider’s network status.

**Emergency Care**

The Plan provides benefits for emergency care when required for stabilization and initiation of treatment as provided by or under the direction of a physician.

In-network benefits are paid for emergency care, even if the services are provided by an out-of-network provider.

**Confinement in an out-of-network hospital following an emergency**

If you are confined in an out-of-network hospital after you receive emergency services, then utilization management company must be notified within two business days or on the same day of admission if reasonably possible. UM company may elect to transfer you to an in-network hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-network hospital after the date utilization management company decides a transfer is medically appropriate, out-of-network benefits may be available if the continued stay is determined to be a covered service.

**Other Exceptions**

If, while an inpatient or receiving outpatient services, you have an x-ray, receive laboratory services, or anesthesia services from an out-of-network provider while you are in an in-network facility, the Plan will cover the service at the in-network benefit level.
CDHP Medical Claims Administration

How Medical Benefits are Paid
Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP’s third party claims administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or copayments apply, you are responsible for paying your share of these charges. If services are provided through the PPO network, the PPO health care provider may submit the proof of claim directly to PEBP’s third party administrator; however, you will be responsible for the payment to the PPO health care provider for any applicable Deductible, Coinsurance or copayments.

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

How to File a Medical Claim
All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan’s provisions in place on the date of service. Most providers send their bills directly to the PEBP’s claims administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP’s third party claims administrator or PEBP’s website (see the Participant Contact Guide in this document for details on address, phone and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is “none” or “not applicable (N/A).”
- The instructions on the claim form will tell you what documents or medical information is necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains all the following information:
  - A description of the services or supplies provided including Appropriate procedure codes;
  - Details of the charges for those services or supplies;
  - appropriate diagnosis code;
  - Date(s) the services or supplies were provided;
  - Patient’s name;
  - Provider’s name, address, phone number, and professional degree or license;
  - Provider’s federal tax identification number (TIN);
  - Provider’s signature.
Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the claims administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan’s Explanation of Benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny Deductible and Out-of-Pocket Maximum credit or payment to a provider if the provider’s bill does not include or is missing one or more of the following components. This is not an all-inclusive list:

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9 and ICD 10.
- Date(s) of service.
- Place of service.
- Provider’s Tax Identification Number.
- Provider’s signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- Providers such as hospitals and facilities that bill for single or bulk items such as orthopedic devices/implants or other types of biomaterial shall provide to the claims administrator a copy of the manufacturer’s/organization’s invoice (that directly supplied the device/implant/biomaterial to the healthcare provider). This Plan will deny payment for such medical devices until a copy of the invoice is provided to this Plan’s claims administrator.

**NOTE:** Claims are processed by this Plan’s claims administrator in the order they are received. If a claim is held or “soft denied” that means the claims administrator is holding the claim to receive additional information, either from the participant, the provider or to get clarification on benefits to be paid. A claim that is held or soft denied will be paid or processed when the requested additional information is received. Claims filed while another claim(s) is held or soft denied may be paid or processed even though they were received at a later date.

It is your responsibility to maintain copies of the EOB documents provided to you by PEBP’s third party claims administrator or prescription drug administrator. Copies of EOB documents are available on the claims administrator’s website but cannot be reproduced. PEBP and its claims administrator do not provide printed copies of EOB documents outside of the original mailing.
Where to Send the Claim Form
Send the completed claim form, the bill you received (retain a copy for your records) and any other required information to the claims administrator at the address listed in the Participant Contact Guide in this document.

Appeals Procedures

What Can Be Appealed?
You have the right to ask PEBP or its designees to reconsider an Adverse Benefit Determination resulting in a denial, reduction, termination, failure to provide or make payments (in whole or in part) for a service or treatment, or Rescission of coverage (retroactive cancellation).

Discretionary Authority of 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.

Internal Appeals (Medical, UM Determination, Rescission of Benefits)
Written Notice of Adverse Benefit Determination
The Plan or its designee, typically HealthSCOPE Benefits, will notify you in writing of an Adverse Benefit Determination resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. It will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination. The notice will explain what steps you may take to submit a first level internal appeal of the Adverse Benefit Determination. When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or State of Nevada) in a court proceeding.

The appeal process works as follows:

Level 1 Appeal (Medical, Rescission of Benefits)
If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Appeal from HealthSCOPE Benefits within 180 days of the date you received the EOB with the initial claim determination. Failure to request a review in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan unless PEBP determines that the failure was acceptable. The written request for appeal must include:

- The name and Social Security Number, or identification number, of the participant;
- A copy of the EOB and claim; and
- A detailed written explanation why the claim is being appealed.
You have the right to review documents applicable to the denial and to submit your own comments in writing. HealthSCOPE Benefits will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The decision on your appeal will be given to you in writing. Ordinarily, a decision on your appeal will be reached within 20 days after receipt of your request for appeal.

If the decision upholds the denial of benefits in whole or in part, the notification to you will explain the reasons for the decision, with reference to the applicable provisions of the Plan upon which the denial is based. It will also explain the steps necessary if you wish to proceed to a Level 2 Appeal if you are not satisfied with the response at Level 1. NAC 287.670

**Level 2 Appeal (Medical, Rescission of Benefits)**

To file a Level 2 Appeal, PEBP encourages you to complete a Claim Appeal Request form. To obtain a Claim Appeal Request form, contact PEBP Customer Service or refer to the PEBP website.

If, after a Level 1 Appeal is completed, you are still dissatisfied with the denial of your claim, Rescission of coverage, or amount paid on your claim you may submit your written request to the Executive Officer of PEBP or his designee (see the Participant Contact Guide for the address) within 35 days after you receive the decision on the Level 1 Appeal, together with any additional information you have in support of your request. Your Level 2 Appeal request must include a copy of:

- The Level 1 Appeal review request;
- A copy of the decision made on review; and
- Any other documentation provided to HealthSCOPE Benefits by the participant.

The Executive Officer or his designee will use all resources available, including but not limited to, members of the staff, of the Board, HealthSCOPE Benefits, prescription drug administrator, internet, and the PEBP Master Plan Document for Enrollment and Eligibility to determine if the claim was adjudicated correctly.

A decision on a Level 2 Appeal will be given to you in writing within 30 days after the Level 2 Appeal request is received by the Executive Officer or his designee and will explain the reasons for the decision. If the appeals review results in a denial of benefits in whole or in part, it will explain the reasons for the decision, with reference to the applicable provisions of the Plan upon which the denial is based.

**Appealing a UM Determination**

Per NAC 287.680, you may request an internal appeal of any adverse benefit determination made during the prior authorization, concurrent review, retrospective review, or case management process as described in this section.
The appeal process for determinations made by the utilization management company may be initiated by the participant, treating provider, parent, legal guardian, or person authorized to make health care decisions by a power of attorney. There are two types of internal appeals resulting from adverse benefit determinations resulting from the UM program:

- Expedited Appeal; and
- Standard Appeal.

A physician (other than the physician who rendered the original decision) is utilized to review the appeal. This physician is Board Certified in the area under review and is in active practice. The name, address and phone number of the utilization management company is in the Participant Contact Guide and on the PEBP website (pebp.state.nv.us).

**Expedited Appeal Process**

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

Requests for expedited appeal may be made by telephone or any other reasonable means to the utilization management company that will ensure the timely receipt of the information required to complete the appeal process. If your physician requests a consultation with the reviewing physician, this will occur within one business day. The utilization management 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 via a phone call and in writing to the patient, managing physician, facility and HealthSCOPE Benefits. Upon receipt of a request, the utilization management company will provide the recipients of an adverse benefit determination letter with the clinical rationale for the non-certification decision. If non-certification is upheld, you may pursue an external appeal as described in NRS 695G.241 - NRS 695G.275.

**Standard Appeal Process**

If you 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 you do not qualify for an expedited appeal, you may request a standard appeal review. Requests for standard appeal review may be made by writing to the utilization management 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 utilization management company’s receipt of the request. Appeals for post-service treatment will be completed within 20 days of the receipt of the request. The results of the determination of a
standard appeal will be provided in writing to the patient, managing physician, facility and HealthSCOPE Benefits.

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

**External Reviews (Medical Claims Only)**
An external review (medical claims only) may be requested by a participant and/or the participant’s treating physician after you have exhausted the internal claim appeal review process. This means that you may have a right to have the Plan’s (or its designee’s) decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

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

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

The request must be submitted to:

Office for Consumer Health Assistance  
555 East Washington #4800  
Las Vegas NV 89101  
Phone: (702) 486-3587, (888) 333-1597  
Fax 702-486-3586  
Web: [www.govcha.nv.gov](http://www.govcha.nv.gov)

For standard external review, a decision will be made within 45 days of receiving the request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an expedited external review. If the denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental and/or investigational, you also may be entitled to file a request for external review of the denial. Please refer to the section in this document titled experimental and/or investigational external review.

**Pre-Service Urgent Care Claim Appeal (Expedited External Review)**
If you need a quick decision, you may request that your external appeal be handled on an expedited basis.
Expedited external review is available only if 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. An expedited external review decision must be completed at most within 72 hours of receipt. As with the standard external review, an expedited external review must be submitted to the Office for Consumer Health Assistance at the contact information listed above.

For instructions on how to submit a request for an expedited external review, please refer to the form located on the PEBP website www.pebp.state.nv.us titled “Certification of Treating Provider for Expedited Consideration of a Patient’s External Review.”

**Experimental and/or Investigational External Review**

If you have had a service such as drug therapy, durable medical equipment, procedure or other therapy denied because PEBP or its designee (HealthSCOPE Benefits, Express-Scripts, or the utilization management company) determined that the proposed therapy is experimental and/or investigational, you may request an external review. To proceed with the experimental and/or investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not promptly initiated.

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

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

Office for Consumer Health Assistance  
555 East Washington #4800  
Las Vegas NV 89101  
Phone: (702) 486-3587,  
(888) 333-1597  
Fax 702-486-3586  
Web: www.govcha.nv.gov

**Prescription Drug Review and Appeals**

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

**Clinical Coverage Review**

The initial clinical coverage review is a request for coverage or medication that is based on clinical conditions of coverage that are set by this Plan—for example, medications that require a prior authorization. To make an initial determination for a clinical coverage review request, the prescribing physician must submit specific information for review.
How to Request a Clinical Coverage Review
The preferred method to request an initial clinical review is for the prescribing physician to submit the prior authorization request electronically. Alternately, the participant’s prescribing physician or pharmacist may call Express-Scripts at 1-855-889-7708 or the prescriber may submit a completed Initial Coverage Review form obtained online at www.express-scripts.com/services/physicians/. (Home delivery coverage review requests are automatically initiated by the home delivery pharmacy as part of filling the prescription.)

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

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

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

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

If the necessary information is provided to Express-Scripts so that a determination can be made, the initial determination and notification for a clinical coverage or administrative coverage review will be made within the timeframe below:
- Standard Pre-Service: 15 days for retail pharmacy and five days for home delivery; and
- Standard Post-Service: 30 days.

Level 1 Appeal or Urgent Appeal
When an initial administrative or clinical coverage review request has been denied, a request for appeal of the denial may be submitted by the participant within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to Express-Scripts’ Benefit Coverage Review Department:
- Name of patient;
- participant ID number;
- Phone number;
- The drug name for which benefit coverage has been denied;
- Brief description of why the claimant disagrees with the initial adverse benefit determination; and
• Any additional information that may be relevant to the appeal, including physician/prescriber statements/letters, bills or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function or would subject the patient to 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 at 1-800-753-2851 or fax 1-877-852-4070 to Express-Scripts. Appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

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

Level 1 Appeal Decisions and Notifications
Express-Scripts will render Level 1 Appeal determinations within the following timeframes:
- Standard pre-service: 15 days;
- Standard post-service: 20 days; and
- Urgent*: 72 hours.

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse benefit determination. Standard Post-Service: NAC 287.670

Level 2 Appeal
When a Level 1 Appeal has been denied, a request for a Level 2 Appeal may be submitted by the participant within 35 days from receipt of notice of the Level 1 Appeal denial. To initiate a Level 2 Appeal, you must request by mail or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department.

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

Urgent appeals must be submitted by phone or fax to the appropriate Clinical Coverage or Administrative Coverage Review Request department (see the Participant Contact Guide section). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.
Level 2 Appeal Decisions and Notifications
Express-Scripts will render Level 2 Appeal determinations within the following timeframes:

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

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

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

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

Standard External Review: the pharmacy benefit manager will review the external review request within 5 business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and the patient will be notified within 1 business day of the decision.

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

Urgent External Review
Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regarding maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the Appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Coordination of Benefits

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

- Any primary payer besides this Plan;
- Any other group health care plan or individual policy;
- Any other coverage or policy covering the participant or covered dependent;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company;
- Medicare;
- Other government programs, such as: Medicaid, Tricare/CHAMPUS, a program of the U.S. Department of Veterans Affairs, or any coverage provided by a federal, state or local government or agency; or
- Workers’ Compensation.

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

When and How Coordination of Benefits (COB) Applies
Many individuals have family members who are covered by more than one medical or dental plan or policy. If this is the case with your family, you must let the Plan Administrator, or its designee know about all your coverages when you submit a claim.
Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan or policy, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

If the CDHP is secondary coverage, the participant will be required to pay their copayments and/or Coinsurance as applicable.

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

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

Examples of expenses that are not allowable under this Plan:
- The difference between the cost of a semi-private room in the hospital and a private room;
- When both plans use usual and customary (U&C) fees, any amount in excess of the highest of the U&C fee for a specific benefit;
- When both plans use negotiated fees, any amount in excess of the highest negotiated fee is not an allowable expense (except for Medicare negotiated fees, which will always take precedence); and
- When one plan uses U&C fees and another plan uses negotiated fees, the secondary plan's payment arrangement is not the allowable expense.

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

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

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

**Rule 1: Non-Dependent/Dependent**

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

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

This rule applies when both spouses are employed and cover each other as dependents under their respective plans. The plan covering the person as an employee pays first, and the plan covering the same person as a dependent 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 pays second.
- The word “birthday” refers only to the month and day in a calendar year; not the year in which the person was born.

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

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

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

**Rule 3: Active/Laid-Off or Retired Employee**

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

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

**Rule 4: Continuation Coverage**

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

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

**Rule 5: Longer/Shorter Length of Coverage**

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

**Administration of COB**

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

- Exchange information with other plans involved in paying claims;
- Require that you or your health care provider furnish any necessary information;
- Reimburse any plan that made payments this Plan should have made; or
- Recover any overpayment from your hospital, physician, dentist, other health care provider, other insurance company, you or your dependent.
If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount the Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

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

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

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

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

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

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. Refer to the Enrollment and Eligibility MPD for more information regarding enrollment in the Medicare Exchange.
Entitlement to Medicare Coverage (Retirees and their Covered Dependents)
When you or your dependent reach Medicare eligible age, you must enroll in the Medicare plan for which you are eligible. Generally, anyone age 65 years or older is entitled to Medicare Part A and Medicare Part B coverage. Anyone under age 65 years who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

Ineligible for Premium-Free Medicare Part A
This Plan will pay as primary for services that would have been covered by Part A when you are not eligible for premium-free Medicare Part A. However, you must enroll in Medicare Part B and this Plan will be the secondary payer for Medicare Part B services. This Plan will always be secondary to Medicare Part B, whether or not you have enrolled. This Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

Coverage under Medicare and This Plan when You Have End-Stage Renal Disease (ESRD)
If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan will remain as the primary payor for the first 30 months of your or your dependent’s eligibility or entitlement to Medicare. However, if this Plan is currently paying benefits as secondary to Medicare for you or your dependent, this Plan will remain secondary upon your or your dependent’s eligibility or entitlement to Medicare due to ESRD.

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

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

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

If a Part B eligible retiree or the dependent of a retiree is not enrolled in Part B coverage, this Plan will estimate the Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only pay consider the remaining 20% of Part B expenses.

Note: A Medicare participant has the right to enter into a Medicare private contract with certain health care practitioners. Under Medicare private contracts, the participant agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that practitioner. If a PEBP Medicare participant enters into such a contract, this Plan will NOT
pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to the private contract.

Coordination with Other Government Programs

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

Coordination with Medicare
If you are age 65 or older, entitled to benefits under Medicare, and work for an employer that did not employ 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding Plan Year, then Medicare is the primary payer for you and your spouse. The benefits of this Plan will then be the secondary form of coverage.

If you or your spouse is age 65 or older, entitled to benefits under Medicare, and work for an employer that employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding Plan Year, the following rules apply:

- This Plan is primary payer for any person age 65 or older who is an active employee or the spouse of an active employee of any age.

Tricare
If a participant is covered by both this Plan and Tricare (the program that provides health care services to active or retired armed services personnel and their eligible dependents), this Plan will pay first, and Tricare will pay second. For an employee called to active duty for more than 30 days, Tricare is primary, and this Plan is secondary.

Veterans Affairs Facility Services
If a participant receives services in a U.S. Department of Veterans Affairs Hospital or facility because of a military service-related illness or injury, Benefits are not payable by the Plan. If a participant receives services in a U.S. Department of Veterans Affairs hospital or facility because of any other condition that is not a military service-related illness or injury, benefits are payable by 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 when it is determined that they are covered under a Workers’ Compensation or occupational disease law. However, before such payment will be made, you and/or your covered dependent must execute a subrogation and reimbursement agreement that is acceptable to the Plan Administrator or its designee.
**Disability**

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

**Prescription Drug Plan**

This Plan does not coordinate prescription drug plan benefits.

**Subrogation and Third-Party Recovery**

Subrogation applies to situations where the participant is injured, and another person is or may be responsible, for whatever reason, for the payment of damages (including but not limited to medical expenses, pain and suffering, or loss of consortium) arising from or related in any way to the participant’s injury. The other person who may be responsible for the payment of damages may be an individual, a corporation or some other form of business entity, an insurance company (including the participant’s own insurance company), or a public or private entity. By way of example only, and without limitation, automobile accident injuries or personal illness on another’s property are examples of cases frequently subject to subrogation. Subrogation includes situations where the injury is or may be covered by another insurance policy, including but not limited to the participant’s own first party automobile insurance, third party automobile liability insurance, any applicable no-fault insurance, and premises medical payments coverage.

The subrogation and third-party recovery provision allows for the right of recovery for certain payments made by the Plan, irrespective of fault, wrongdoing, or negligence. All payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment or settlement obtained by the participant in relation to the injury. Refer to the separate Health and Welfare Benefits Wrap Plan document for more information regarding third party liability and subrogation.
## Participant Contact Guide

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<tr>
<th>General Contacts</th>
<th>Service</th>
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| **Public Employees’ Benefits Program (PEBP)** 901 S. Stewart Street, Suite 1001 Carson City, NV 89701 Customer Service: (775) 684-7000 or (800) 326-5496 Fax: (775) 684-7028 www.pebp.state.nv.us | **Plan Administrator**  
- Enrollment and change of status  
- Certificate of creditable coverage  
- COBRA information and premium payments  
- Level 2 claim appeals  
- External review coordination |
| **Office for Consumer Health Assistance** 555 E. Washington Avenue, Suite 4800 Las Vegas, NV 89101 Customer Service: (702) 486-3587 or (888) 333-1597 http://dhhs.nv.gov | **Consumer Health Assistance**  
- Concerns and problems related to coverage  
- Provider billing issues  
- External review information |
| **Nevada Secretary of State Office**  
The Living Will Lockbox c/o Nevada Secretary of State 101 North Carson St., Ste. 3 Carson City NV 89701 Phone: (775) 684-5708 Fax: (775) 684-7177 www.livingwilllockbox.com | **Living Will Information**  
- Declaration governing the withholding or withdrawal of life-sustaining treatment  
- Durable power of attorney for health care decisions  
- Do not resuscitate order |
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<th>CDHP and Premier Plan In-State PPO Network (Statewide PPO and EPO Network)</th>
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<td><strong>CDHP Statewide PPO Network</strong>&lt;br&gt;Customer Service: (800) 336-0123&lt;br&gt;www.pebp.state.nv.us</td>
<td>Statewide (Nevada) PPO Medical Network&lt;br&gt;• Network Providers&lt;br&gt;• Provider directory&lt;br&gt;• Additions/deletions of Providers</td>
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<td><strong>Aetna Signature National PPO Network</strong>&lt;br&gt;Contact HealthSCOPE Benefits: (888) 763-8232</td>
<td>National PPO Network (outside of Nevada)&lt;br&gt;• Network Providers&lt;br&gt;• Provider directory&lt;br&gt;• Additions/deletions of Providers</td>
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<td><strong>HealthSCOPE Benefits</strong>&lt;br&gt;Claims Submission:&lt;br&gt;HealthSCOPE Benefits&lt;br&gt;P O Box 91603&lt;br&gt;Lubbock, TX 79490-1603&lt;br&gt;Appeal of Claims:&lt;br&gt;HealthSCOPE Benefits&lt;br&gt;P O Box 2860&lt;br&gt;Little Rock, AR 72203&lt;br&gt;Group Number: NVPEB&lt;br&gt;Customer Service: (888) 763-8232&lt;br&gt;www.healthscopebenefits.com&lt;br&gt;<strong>Diabetes Care Management forms submission:</strong>&lt;br&gt;Mail: HealthSCOPE Benefits&lt;br&gt;27 Corporate Hill Drive&lt;br&gt;Little Rock, AR 77205&lt;br&gt;Fax: 800-458-0701&lt;br&gt;Email: <a href="mailto:diabetes@healthscopebenefits.com">diabetes@healthscopebenefits.com</a></td>
<td><strong>Claims Administrator/Third Party Administrator/Disease Management Administrator for Diabetes</strong>&lt;br&gt;• Claim submission&lt;br&gt;• Claim status inquiries&lt;br&gt;• Level 1 claim appeals&lt;br&gt;• Verification of eligibility&lt;br&gt;• Plan Benefit Information&lt;br&gt;• CDHP &amp; Dental only ID Cards&lt;br&gt;• HSA and HRA Claims Administrator&lt;br&gt;• Healthcare Bluebook&lt;br&gt;• Obesity Care Management Program&lt;br&gt;• Disease Care Management Program</td>
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<td><strong>Hometown Health</strong>&lt;br&gt;Utilization Management Company for the CDHP and Premier Plan&lt;br&gt;Customer Service: (775) 982-3232 or (888) 323-1461&lt;br&gt;<a href="http://stateofnv.hometownhealth.com/">http://stateofnv.hometownhealth.com/</a></td>
<td>• Prior authorization&lt;br&gt;• Utilization management&lt;br&gt;• Case management</td>
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<td><strong>Express Scripts Pharmacy Benefit Administrator For the CDHP and Premier Plan</strong>&lt;br&gt;Customer Service and Prior Authorization (855) 889-7708&lt;br&gt;Formulary, forms, online ordering: <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a></td>
<td>Pharmacy Benefit Manager for the CDHP and the Premier Plan&lt;br&gt;• Prescription Drug information&lt;br&gt;• Retail Network Pharmacies&lt;br&gt;• Prior authorization&lt;br&gt;• Price a Medication tool&lt;br&gt;• Home Delivery service and Mail Order Forms&lt;br&gt;• Preferred Mail Order for Diabetic Supplies</td>
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<tr>
<td><strong>Express Scripts Home Delivery</strong>&lt;br&gt;PO Box 66566&lt;br&gt;St. Louis, MO 63166-6566&lt;br&gt;Customer Service: (855) 889-7708</td>
<td>Accredo Specialty Drug Services Provider&lt;br&gt;Refills and order status</td>
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<tr>
<td><strong>Accredo Specialty Pharmacy</strong>&lt;br&gt;Customer Service: (855) 889-7708</td>
<td>Administrative Coverage Review and Administrative Reviews and Appeals</td>
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<tr>
<td><strong>Express Scripts Benefit Coverage Review Department</strong>&lt;br&gt;PO Box 66587, St. Louis, MO 63166-6587&lt;br&gt;Phone: 800-946-3979</td>
<td>Clinical Reviews</td>
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<tr>
<td><strong>Express Scripts Clinical Appeals Department</strong>&lt;br&gt;PO Box 66588 St. Louis, MO 63166-6588&lt;br&gt;Phone: 800-753-2851&lt;br&gt;Fax: 877-852-4070</td>
<td>External Review Requests for Adverse Benefit Determinations</td>
</tr>
<tr>
<td><strong>MCMC LLC</strong>&lt;br&gt;Attn: Express Scripts Appeal Program&lt;br&gt;300 Crown Colony Dr. Suite 203&lt;br&gt;Quincy, MA 02169-0929&lt;br&gt;Phone: 617-375-7700 ext. 28253&lt;br&gt;Fax: 617-375-7683</td>
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<td><strong>Public Employees’ Benefits Program</strong></td>
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<td><strong>PPO Dental Plan</strong> (available to CDHP, Premier Plan, HPN and Medicare Exchange Retirees)</td>
<td><strong>Service</strong></td>
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<tr>
<td><strong>Diversified Dental Services</strong>&lt;br&gt;PO Box 36100&lt;br&gt;Las Vegas, NV 89133-6100&lt;br&gt;Customer Service: Northern Nevada: (866) 270-8326&lt;br&gt;Southern Nevada: (800) 249-3538&lt;br&gt;www.ddsppo.com</td>
<td>PPO Dental Network&lt;br&gt;• Statewide PPO Dental Providers&lt;br&gt;• National PPO Dental Providers&lt;br&gt;Dental Provider directory</td>
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<td><strong>Health Plan of Nevada (HMO Plan)</strong></td>
<td><strong>Service</strong></td>
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<tr>
<td><strong>Health Plan of Nevada HMO</strong>&lt;br&gt;(702) 242-7300 or (877) 545-7378&lt;br&gt;www.stateofnv.healthplanofnevada.com</td>
<td>Southern Nevada Health Maintenance Organization (HMO)&lt;br&gt;• Medical claims&lt;br&gt;• Pre-authorization&lt;br&gt;• Provider network</td>
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<td><strong>The Standard Insurance</strong></td>
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<tr>
<td><strong>The Standard Insurance Company</strong>&lt;br&gt;900 SW Fifth Avenue&lt;br&gt;Portland, OR 97204&lt;br&gt;(888) 288-1270&lt;br&gt;www.standard.com/mybenefits</td>
<td>• Basic Life Insurance&lt;br&gt;• Voluntary (Supplemental) Life Insurance&lt;br&gt;• Long-Term Disability&lt;br&gt;• Voluntary Short-Term Disability&lt;br&gt;• United HealthCare Global Travel Assistance&lt;br&gt;• Beneficiary designations</td>
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<td><strong>Via Benefits (Formerly Towers Watson’s One Exchange)</strong></td>
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<tr>
<td><strong>Via Benefits</strong>&lt;br&gt;10975 Sterling View Drive, Suite A1&lt;br&gt;South Jordan, UT 84095&lt;br&gt;(888) 598-7545&lt;br&gt;<a href="https://my.viabenefits.com/pebp">https://my.viabenefits.com/pebp</a></td>
<td>Medicare Exchange offering Medicare Supplemental or replacement medical coverage for retirees and covered dependents with Medicare Parts A and B.</td>
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<td>PayFlex</td>
<td>Service</td>
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<tr>
<td>PO Box 3039, Omaha, NE 68103-3039</td>
<td>HRA claims processing administrator for retirees enrolled in a medical plan through the Medicare Exchange (Via Benefits)</td>
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<tr>
<td>Customer Service: (888) 598-7545</td>
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<tr>
<td>General Fax: (402) 231-4300</td>
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<tr>
<td>Claims Fax: (402) 231-4310</td>
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<td><a href="http://www.payflex.com">www.payflex.com</a></td>
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<tr>
<td>Customer Service: (800) 637-7026</td>
<td>Voluntary home, auto, boat, RV, etc. insurance.</td>
</tr>
<tr>
<td><a href="mailto:Gary.bishop@libertymutual.com">Gary.bishop@libertymutual.com</a></td>
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<td>Claims Submission:</td>
<td>• Flexible Spending Account claims administration</td>
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<tr>
<td>HealthSCOPE Benefits P.O. Box 3627</td>
<td>• Limited scope Flexible Spending Account</td>
</tr>
<tr>
<td>Little Rock, AR 72203</td>
<td>• Medical Flexible Spending</td>
</tr>
<tr>
<td>Customer Service: (888) 763-8232</td>
<td>• Dependent Care Flexible Spending</td>
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<tr>
<td>Fax: (877) 240-0135</td>
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<tr>
<td><a href="mailto:pebphsahra@healthscopebenefits.com">pebphsahra@healthscopebenefits.com</a></td>
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<tr>
<td>Customer Service: (800) 227-4165 Option #4</td>
<td>Voluntary Long-Term Care Insurance</td>
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Key Terms and Definitions

The following terms or phrases are used throughout the MPD. These terms or phrases have the following meanings. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

**Accident:** A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

**Active Rehabilitation** refers to therapy in which a patient, who can learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

**Actively Engaged:** Means
1. Participation in regular office visits with your provider. The frequency of the office visits will be determined by your provider who will in turn report this information to HealthSCOPE Benefits for monitoring;
2. Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss provider including but not limited to routine exercise, proper nutrition and diet, and pharmacotherapy if prescribed. Commitment to your weight loss treatment will be measured by HealthSCOPE Benefits who will review monthly progress reports submitted by the provider; and
3. Losing weight at a rate determined by the weight loss provider.

**Activities of Daily Living:** Activities performed as part of a person’s daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

**Acupuncture:** A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

When benefits for the services of an acupuncturist are payable by this Plan, the acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, be certified by the National Certification Commission for Acupuncturists (NCCA).

**Adverse Benefit Determination:** A determination based upon the information provided that a request for a benefit under the Plan upon application of any utilization review technique does not meet the Plan’s requirement for medical necessity, appropriateness, health care setting, level of care or effectiveness, is determined not to be a covered service or is determined to be experimental and/or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit. Adverse benefit determination includes a rescission of coverage determination.
**Allogenic:** Refers to Transplants of organs, tissues or cells from one person to another person. Heart Transplants are always Allogenic.

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

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

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

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

- It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements:
  - It is operated under the supervision of a licensed physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area;
  - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure;
  - It provides at least one operating room and at least one post-anesthesia recovery room;
  - It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services;
  - It has trained personnel and necessary equipment to handle emergency situations;
  - It has immediate access to a blood bank or blood supplies;
  - It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room; and
  - It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), an operative report and a discharge summary.
An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.

**Ancillary Services/Charges:** Charges for services provided by a hospital or other facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

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

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

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

**Appropriate:** See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

**Approved Clinical Trial:** A phase I, II, III, or IV trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted.

An Approved Clinical Trial’s study must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCPR), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCPR, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA), (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

**Autism Behavioral Interventionist:** A person who is a Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board or its successor organization, and provides behavioral therapy under the supervision of:

- A licensed psychologist;
- A licensed behavior analyst; or
- A licensed assistant behavior analyst.

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

**Autologous:** Refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.

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

**Base Plan:** The self-funded Consumer Driven Health Plan (CDHP); the base plan is also defined as the “default plan” where applicable in this document and other materials produced by PEBP.

**Behavioral Health Disorder:** Any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorders covered under this Plan may include, but are not limited to: depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods and is provided by behavioral health practitioners as defined in this section. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the *Benefit Exclusions and Limitations* section.

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

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

**Behavioral Health Treatment Facility:** A specialized facility that is established, equipped, operated and staffed primarily for providing a program for diagnosis, evaluation and effective treatment of behavioral health disorders and which fully meets one of the following two tests:
- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
Where licensing is not required, it meets all the following requirements: has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the direction of a full-time registered nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.

A behavioral health treatment facility that qualifies as a hospital is covered by this Plan as a hospital and not a behavioral health treatment facility. A transitional facility, group home, halfway house or temporary shelter is not a behavioral health treatment facility under this Plan unless it meets the requirements above in the definition of behavioral health treatment facility.

**Benefit, Benefit Payment, Plan Benefit:** The amount of money payable for a claim, based on the usual and customary charge, after calculation of all Deductibles, Coinsurance and copayments, and after determination of the Plan’s exclusions, limitations and maximums.

**Birth (or Birthing) Center:** A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements:
  - It is operated and equipped in accordance with any applicable state law for providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.
  - It is equipped to perform routine diagnostic and laboratory examinations, including (but not limited to) hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
  - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including (but not limited to) oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
  - It provides at least two beds or two birthing rooms.
  - It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.
  - It has a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.
  - It has trained personnel and necessary equipment to handle emergency situations.
  - It has immediate access to a blood bank or blood supplies.
  - It has the capacity to administer local anesthetic and to perform minor surgery.
  - It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
  - It is expected to discharge or transfer patients within 48 hours following delivery.

A birth (or birthing) center that is part of a hospital, as defined in this section, will be a birth (or birthing) center for the purposes of this Plan.
Business Day: Refers to all weekdays, except Saturday or Sunday, or a state or federal holiday.

Case Management: A process administered by the UM company in which its medical professionals work with the patient, family, care-givers, providers, claims administrator, pharmacy benefit manager and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential providers.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

Certified Surgical Assistant: A person who does not hold a valid healthcare license as an RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon. Such individuals are payable by this Plan, including designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

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

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

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

Chiropractic Services: PEBP considers chiropractic services are medically necessary when all the following criteria are met:

- The participant has a neuro-musculoskeletal disorder; and
- The medical necessity for treatment is clearly documented.

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings.
**Claims Administrator:** The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

**Coinsurance:** That portion of eligible medical expenses for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses in excess of the Plan’s Deductible. The Coinsurance varies depending on whether in-network or out-of-network providers are used.

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

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

**Concierge Medicine:** Is a relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of all medical or dental care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care, and direct practice medicine. Most concierge medicine practices do not bill insurance.

**Concurrent Review:** A managed care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the 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.

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

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

**Copayment, Copay:** The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. This can be in addition to Coinsurance amounts due on the same incurred charges. Copayments are limited to certain benefits under this program.
Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or device) and Prosthetic Appliance (or device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes (but is not limited to) removal of tattoos, breast augmentation, or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

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

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

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

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

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

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

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

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

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

- Natural child,
- Child(ren) of a domestic partner,
- Stepchild,
- Legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- Child who qualifies for benefits under a QMCSO/NMSN
- Child under age 19 years for whom you have legal guardianship under a court order; or
- Over age of 26 years if the adult child is deemed permanently disabled, has maintained continuous medical coverage, is incapable of self-sustaining employment and depends chiefly on the participant or the participant’s spouse or domestic partner for support and maintenance, and claimed on the participant’s previous year’s tax return as a dependent. (NAC 287.312)

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

**Domestic Partner:** As defined by NRS 122A.030.

**Drug:** See the definition for Prescription Drug.

**Durable Medical Equipment:** Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient’s home. Durable medical equipment includes (but is not limited to) apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

**Elective Hospital Admission, Service or Procedure:** Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient’s or physician’s convenience without jeopardizing the patient’s life or causing serious impairment of body function.
**Eligible Medical Expenses:** Expenses for medical services or supplies, but only to the extent that they are medically necessary; and the charges for them are usual and customary; and coverage for the services or supplies is not excluded (as provided in the *Benefit Limitations and Exclusions* section); and the Plan Year maximum benefits for those services or supplies has not been reached.

**Emergency:** See the definition for Medical Emergency.

**Emergency Care:** Medical and health services provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health or survival of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

This Plan does not require prior authorization for medically necessary emergency services provided at any hospital in accordance with NRS 695G.170. For information, refer to the separate PEBP Plan Year 2019 Health and Welfare Wrap Document available at www.pebp.state.nv.us.

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

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

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

**Exclusions:** Specific conditions, circumstances, and limitations, as set forth in the *Benefit Limitations and Exclusions* section for which the Plan does not provide Plan benefits.

**Experimental and/or Investigational Services:** NRS 695G.173 Required provision concerning coverage for treatment received as part of clinical trial or study. Unless mandated by law, the Plan Administrator or its designee has the discretion and authority to determine if a service or supply is, or should be, classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for prior authorization under the Plan’s utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:
The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply;

The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;

In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered experimental and/or investigational if it is:

- Approved by the FDA as an “Investigational new drug for treatment use”;
- Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life threatening disease,” as that term is defined in FDA regulations; or
- Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided or considered for prior authorization under the Plan’s utilization management program:

- Medical records of the covered person;
- The consent document signed, or required to be signed, to receive the prescribed service or supply;
- Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply;
- Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person’s diagnosis, including (but not limited to) “United States Pharmacopoeia Dispensing Information”; and “American Hospital Formulary Service”;

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The published opinions of: the American Medical Association (AMA), such as “The AMA Drug Evaluations” and “The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies;

Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply;


Nevada Statutes mandate the following criteria be met in cases of Cancer and Chronic Fatigue Syndrome:

1. A policy of health insurance must provide coverage for medical treatment in a clinical study or trial if:
   a. Treatment is for either Phase I, II, III, IV cancer or Phase II, III, IV Chronic Fatigue Syndrome;
   b. Study is approved by:
      i. Agency of National Institute of Health;
      ii. A cooperative group (see bill for exact definition);
      iii. FDA for new investigational drug
      iv. US Dept. of Veteran Affairs;
      v. US Dept. of Defense;
   c. Health care provider and facility have authority to provide the care for Phase I cancer;
   d. Health care provider and facility have experience to provide the care for Phase II, III, IV cancer or Chronic Fatigue Syndrome;
   e. No other treatment considered a more appropriate alternative;
   f. Reasonable expectation based on clinical data that treatment will be at least as effective as other treatments;
   g. Study is conducted in Nevada;
   h. Participant signs a statement of consent that he has been informed of:
      i. The procedure to be undertaken;
      ii. Alternative methods of treatment;

2. Coverage for medical treatment is limited to:
   a. A drug or device approved for sale by the FDA;
   b. Reasonable necessary required services provided in treatment or as a result of complications to the extent that they would have otherwise been covered for Phase II, III, IV cancer or Chronic Fatigue Syndrome;
   c. The cost of any routine health care services that otherwise would have been covered for an insured for Phase I cancer;
   d. Initial consultation; and
   e. Clinically appropriate monitoring.

3. Treatment not required to be covered if provided free by sponsor.

4. Coverage does not include:
   a. Portions customarily paid by other government or industry entities;
   b. A drug or device paid for by manufacturer or distributor;
c. Excluded health care services;
d. Services customarily provided free in study;
e. Extraneous expenses related to study;
f. Expenses for persons accompanying participant in study;
g. Any item or service provided for data collection not directly related to study;
h. Expenses for research management of study.

NOTE: To determine how to obtain a prior authorization of any procedure that might be deemed to be experimental and/or investigational, see the Prior Authorization in the Utilization Management section.

Explanation of Benefits (EOB): When a claim is processed by the claims administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your Deductible, if your out of pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

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

Expedited Appeal: If a participant appeals a decision regarding a denied request for prior authorization (pre-service claim) for an urgent care claim, the participant or participant’s authorized representative can request an expedited appeal, either orally or in writing. Decisions regarding an expedited appeal are generally made within seventy-two (72) hours from the Plan’s receipt of the request.

External Review: An independent review of an adverse benefit determination conducted by an external review organization.

External Review Organization: An organization that 1) conducts an external review of a final adverse benefit determination; and 2) is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.


Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Formulary: A list of generic and brand name drug products available for use by participants.

Gender Dysphoria/Gender Identity Disorder/Transsexualism/Gender Nonconforming: Gender Dysphoria is a condition in which the person has the desire to live as a member of the opposite sex and progressively take steps to live in the opposite sex role full-time.
**Generic; Generic Drug:** A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the pharmacist as being generic. (See also the Prescription Drug section of the Schedule of Medical Benefits and the Prescription Drug subsection of the Medical Exclusion section).

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

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

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

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

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

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

**Health Savings Account (HSA):** An account that allows individuals to pay for current health expenses and save for future qualified medical and Retiree health expenses on a tax-free basis.

**HIPAA:** Health Insurance Portability and Accountability Act of 1996. Federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

**HIPAA Special Enrollment:** Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

**Home Health Care:** Intermittent skilled nursing care services provided by a licensed home health care agency (as those terms are defined in this section).

**Home Health Care Agency:** An agency or organization that provides a program of Home Health Care and meets one of the following three tests:
- It is approved by Medicare; or
- It is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
  - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or registered nurse to the home.
  - It has a full-time administrator.
  - It is run according to rules established by a group of professional health care providers including physicians and registered nurses.
  - It maintains written clinical records of services provided to all patients.
  - Its staff includes at least one registered nurse, or it has nursing care by a registered nurse available.
  - Its employees are bonded.
  - It maintains malpractice insurance coverage.

**Homeopathy:** A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body’s natural protective mechanisms based on a theory that “like cures like” or “treatment by similar.” See also the *Benefit Limitations and Exclusions* section of this document regarding homeopathic treatment and services. When the services of homeopaths are payable by this Plan (e.g., an office visit), the homeopath must be properly licensed to practice homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American
Institute of Homeopathy and completed at least 90 hours of formal post-graduate courses or training in a program approved by the American Institute of Homeopathy.

**Hospice:** An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family.

The agency must meet one of the following tests:
- It is approved by Medicare; or is licensed as a hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all the following requirements:
  - It provides 24 hour-a-day, 7 day-a-week service.
  - It is under the direct supervision of a duly qualified physician.
  - It has a full-time administrator.
  - It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
  - The main purpose of the agency is to provide hospice services.
  - It maintains written records of services provided to the patient.
  - It maintains malpractice insurance coverage.
  - A hospice that is part of a hospital will be considered a hospice for the purposes of this Plan.

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

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

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

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

**Inherited Metabolic Disorder**: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an Inherited Metabolic Disorder under this Plan. See Special Food Products.

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

**Injury to Sound and Natural Teeth (ISNT)**: An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to sound and natural teeth are payable under the medical Plan (see also the definition of Sound and Natural Teeth).

**In-Network Provider**: Means an in-network provider that the network or one of its rental networks have contracted with or have arrangements with to provide health services to covered individuals. An in-network provider has agreed to charge participants a discounted rate. To determine if a provider is an in-network provider log on to www.pebp.state.nv.us. You may also call the number of the back of your ID card and a customer service representative can help you locate an in-network provider.

**In-Network Services**: Services provided by a health care provider that is a member of the Plan’s Preferred Provider Organization (PPO), as distinguished from out-of-network services that are provided by a health care provider that is not a member of the PPO network.

**In-Network Contracted Rate**: The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the in-network contracted amount may be applied to out-of-network provider charges.

**Inpatient Services**: Services provided in a hospital or other health care facility during the period when charges are made for room and board.

**Intensive Care Unit**: A section, ward or wing within the hospital which:
- Is separated from other hospital facilities;
- Is operated exclusively for providing professional care and treatment for critically ill patients;
- Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
- Provides room and board; and
- Provides constant observation and care by registered nurses or other specially trained hospital personnel.
**Maintenance Care:** Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

**Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and or preserve the patient’s functional level. Maintenance rehabilitation is not covered by the Plan.

**Managed Care:** Procedures designed to help control health care costs by avoiding unnecessary services or services that are costlier than others that can achieve the same result.

**Maximum Amount; Maximum Allowable Charge:** The benefit payable for a specific coverage item or benefit under the Plan. Maximum allowable charge(s) shall be calculated by the Plan Administrator considering and after having analyzed:

- The reasonable and appropriate amount;
- The terms of the Plan;
- Plan negotiated and contractual rates with provider(s);
- The actual billed charges for the covered services; and
- Unusual circumstances or complications requiring additional time, skill and experience in connection with a service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s).

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

**Medical Emergency:** The sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child, impairment of a bodily function or dysfunction of any bodily organ or part.

**Medically Necessary:** A medical or dental service or supply will be determined to be “medically necessary” by the Plan Administrator or its designee if it:

- Is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- Is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and Dental standards; and
- Is determined by the Plan Administrator or its designee to meet all the following requirements:
  - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
• It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
• It is an appropriate service or supply given the patient’s circumstances and condition; and
• It is a cost-efficient supply or level of service that can be safely provided to the patient; and
• It is safe and effective for the illness or injury for which it is used.

A medical or dental service or supply 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 all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be 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 to be medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient’s family, any person who cares for the patient, any dental or health care practitioner, hospital or health care facility.

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

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.
Medicare Part A: Hospital insurance provided by the federal government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the federal government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the federal government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.

Medi-Span: A national drug pricing information database for drug pricing analysis and comparison.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a Midwife or certified as a Certified Nurse Midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

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

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Non-Participating Provider: A health care provider who does not participate in the Plan’s Preferred Provider Organization (PPO).

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

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

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

**Occupational Therapist:** A person legally licensed as a professional occupational therapist who acts within the scope of their license and acts under the direction of a physician to assess the presence of defects in an individual’s ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual’s ability to perform such skills to regain independence.

**Office Visit:** A direct personal contact between a physician or other health care practitioner and a patient in the health care practitioner’s office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a physician or other health care practitioner nor a visit to a health care practitioner’s office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is an office visit for the purposes of this Plan.

**Open Enrollment Period:** The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage.

**Oral Surgery:** The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

**Orthognathic Services:** Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism, Retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

**Orthotic (Appliance or Device):** A type of corrective appliance or device, either customized or available “over-the-counter,” designed to support a weakened body part, including (but not limited to) crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical Plan, this definition does not include dental orthotics. See also the
definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

**Other Prescription Drugs:** Drugs that require a prescription under state law but not under federal law.

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

**Out-of-Pocket Maximum:** The maximum amount of Coinsurance each covered person or family is responsible for paying during a Plan Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of eligible covered expenses for the remainder of the Plan Year. See the section on Out-of-Pocket Maximum in the *Medical Expense Coverage* section for details about what expenses do not count toward the Out-of-Pocket Maximum.

**Outpatient Services:** Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

**Participant:** The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse or dependent of a retiree. NAC 287.095

**Participating Provider:** A health care provider who participates in the Plan’s Preferred Provider Organization (PPO).

**Passive Rehabilitation** refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until the patient can achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be medically necessary for the purposes of this Plan.

**Pharmacy:** A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Pharmacist:** A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

**Physical Therapy:** Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen
muscles, return motion, and/or train/retrain an individual to perform Activities of daily living such as walking and getting in and out of bed.

**Physician:** A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

**Physician Assistant (PA):** A person legally licensed as a physician assistant, who acts within the scope of his or her license and acts under the supervision of a physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising physician; under the laws of the state or jurisdiction where the services are rendered.

**Plan, The Plan, This Plan:** In most cases, the programs, benefits and provisions described in this document as provided by the Public Employees’ Benefits Program (PEBP).

**Plan Administrator:** The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

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

**Plan Year Deductible:** The amount you must pay each Plan Year before the Plan pays benefits.

**Plan Year Maximum Benefits:** The maximum amount of benefits payable each Plan Year for certain medical expenses incurred by any covered Plan participant (or covered family member of the Plan participant).

**Podiatrist:** A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

**Positive Annual Open Enrollment Period:** This process requires that each eligible employee or eligible retiree affirmatively make his or her benefit elections during the PEBP annual enrollment period. Even if you do not want to make any coverage changes, you must affirmatively make your elections, or you will be defaulted to self-coverage only under the PEBP base Plan.
**Pre-Admission Testing:** Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis, 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury.

**Preferred Provider Organization (PPO):** A group or network of health care providers (e.g., hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted or reduced rates.

**Prescribed for a Medically Necessary Indication:** The term medically accepted indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

**Prescription Drugs:** For the purposes of this Plan, prescription drugs include:

1. Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug, and Cosmetic Act requires to be labeled, “Caution - Federal law prohibits dispensing without prescription”;
2. Other prescription drugs: drugs that require a prescription under state law but not under federal law; or
3. Compound drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

**Prior Authorization:** Prior authorization (pre-certification) is a review procedure performed by the UM company before services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and medically necessary.

**Prognathism:** The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

**Program:** Means the Public Employees’ Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

**Prophylactic Surgery:** A surgical procedure performed for (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality.
or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

**Prophylaxis:** The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth is performed by a dentist or dental hygienist.

**Prosthetic Appliance (or Device):** A type of corrective appliance or device designed to replace all or part of a missing body part, including (but not limited to) artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

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

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

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

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

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

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

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.
To be reasonable, charges must follow generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether a charge is reasonable. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charges that are not reasonable and therefore not eligible for payment by the Plan.

**Reconstructive Surgery:** A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

**Reference Based Pricing/Reference Price:** The maximum amount the Plan will pay for a specific covered healthcare service as determined by the Plan Administrator.

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

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

**Rescission:** A cancellation or discontinuance of coverage under the Plan that has a retroactive effect. Rescission does not include a cancellation or discontinuance of coverage under the Plan if (a) The cancellation or discontinuance of coverage has only a prospective effect; or (b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or (c) fraud.

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

**Retrognathism:** The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.
**Retrospective Review:** Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges.

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

**Service Area:** The geographic area serviced by the in-network providers who have agreements with the Plan’s network.

**Significantly Inferior Coverage:** The PEBP Board has defined Significantly Inferior Coverage as either:
1. A mini-med or other limited benefit plan; or
2. Catastrophic coverage plans with a Deductible equal to or greater than $5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement.

**Skilled Nursing Care:** Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

**Skilled Nursing Facility or Extended Care/Skilled Nursing Facility:** A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, sick people or people with disabilities, and that meets all the following requirements:
- Is licensed pursuant to state and local laws;
- Is operated primarily for providing skilled nursing care and treatment for individuals convalescing from injury or illness;
- Is approved by and is a participating facility with Medicare;
- Has organized facilities for medical treatment;
- Provides 24-hour-a-day nursing service under the full-time supervision of a physician or registered nurse;
- Maintains daily clinical records on each patient;
- Has available the services of a physician under an established agreement;
- Provides appropriate methods for dispensing and administering drugs and medicines;
- Has transfer arrangements with one or more hospitals; a utilization review plan in effect; and operational policies developed with the advice of and reviewed by a professional group including at least one physician; and
- Is not an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; or a place for the treatment of mental illness.
A skilled nursing facility that is part of a hospital, as defined in this document, will be considered a skilled nursing facility for the purposes of this Plan.

**Sound and Natural Teeth:** Sound and natural teeth (not dentures, bridges, pontics or artificial teeth) that are free of active or chronic clinical decay; and have at least 50% bony support; and are functional in the arch; and have not been excessively weakened by previous dental procedures.

**Special Food Product:** A food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. Special food products do not include a food that is naturally low in protein or foods or formulas for persons who do not have inherited metabolic diseases/disorders as that term is defined in this document, unless otherwise authorized by the Plan.

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

**Speech Therapy:** Rehabilitation directed at treating defects and disorders of spoken and written communication to restore normal speech or to correct dysphagic or swallowing defects and disorders lost due to illness, injury or surgical procedure. Speech therapy for functional purposes, including (but not limited to) a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays/disorders are excluded from coverage.

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

**Spouse:** The employee’s lawful spouse (opposite sex or same sex) as determined by the laws of the State of Nevada. The Plan will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

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

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

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

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

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of behavioral health disorders and chemical dependency.

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

Multiple Surgical Procedure Allowances:

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

Telehealth: This Plan complies NRS 69G.162 provision concerning coverage for telehealth. For more information, refer to the separate PEBP Plan Year 2019 Health and Welfare Wrap Document available at www.pebp.state.nv.us.
**Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome:** The Temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ Dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

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

**Tortfeasor:** Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

**Transplant, Transplantation:** The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. (See the Schedule of Medical Benefits and the Benefit Limitations and Exclusions section for additional information regarding transplants. See also the utilization management section of this document for information about prior authorization requirements for transplantation services).

**Xerographic:** refers to transplants of organs, tissues or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xerographic transplants are not covered by this Plan, except heart valves.

**Urgent Care:** Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate, even though health and life are not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include (but are not limited to) fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

**Urgent Care Claim:** Means a claim for benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not urgent care claims could seriously jeopardize the participant’s life, health or the ability to regain maximum function by waiting for a routine appeal decision. An urgent care claim also means a claim for benefits that, in the opinion of a physician with knowledge of the participant’s medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for prior authorization of an urgent care service was denied, the participant could request an expedited appeal for the urgent care claim.
**Urgent Care Facility:** A public or private hospital-based or free-standing facility, that includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance when the facility is open.

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

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

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

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

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

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

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

**Visit:** See the definition of office visit.

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

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