



**State of Nevada
Public Employees' Benefits Program**

**Master Plan Document for the
PEBP Consumer Driven Health Plan for
Medical, Vision and Prescription Drug Benefits
Summary of Benefits for
Health Savings Account, Health Reimbursement Account**

**Plan Year 2018
July 1, 2017 – June 30, 2018**

**www.pebp.state.nv.us
(775) 684-7000 or (800) 326-5496**

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 (Consumer Driven Health Plan, Self-funded Dental PPO Plan or HMO) is offered in your geographical area that best meets your needs, subject to specific eligibility and plan requirements. You are also encouraged to research Plan Provider access and quality of care in your Service Area.

The Consumer Driven Health Plan is a self-funded medical Plan that is eligible for use with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA).

All PEBP Participants choosing the Consumer Driven Health Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD) and the PEBP Enrollment and Eligibility MPD to become more knowledgeable about their health Benefits.

PEBP Participants who choose an HMO option should examine the PEBP Self-Funded PPO Dental Plan Master Plan Document which includes a summary of Benefits for Life and Long-Term Disability (LTD) insurance and the PEBP Enrollment and Eligibility Master Plan Document. If you choose an HMO option, you should review their respective Evidence of Coverage documents available on the PEBP website at www.pebp.state.nv.us.

PEBP Retirees covered under the Medicare Exchange who elect PEBP Dental coverage should review the PEBP Self-Funded PPO Dental Plan MPD which includes a summary of benefits for Life insurance and the PEBP Enrollment and Eligibility MPD.

Master Plan Documents are a comprehensive description of the Benefits available to you. Relevant statutes and regulations are noted throughout this 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

NOTE: Words that are capitalized throughout this document are generally defined in the Plan Definitions section. Headings, font and style do not modify Plan provisions. The headings of sections and subsections and text appearing in bold or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

Introduction

This Master Plan Document describes the Consumer Driven Health Plan (also referred to as the CDHP, the Self-Funded CDHP or the Self-Funded PPO CDHP) for medical and Prescription Drug Benefits for Employees and certain Retirees, and their eligible Dependents, participating in the Public Employees' Benefits Program, hereafter referred to as PEBP. Additional Benefits are also described in this document.

- This PEBP 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, 2017**, and unless stated differently, replaces all other Self-funded PPO 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 the Public Employees' Benefits Program (PEBP). You should review it and also 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 Exclusions and Definitions sections. **Remember, not every expense you incur for health care is covered by the 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. The Participant Contact Guide section provides you with contact information for the various components of the Public Employees' Benefits Program.

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.

This Plan is administered in accordance with regulations of section 125 of the Internal Revenue Code. For information regarding section 125, please see the Section 125 Health and Welfare Benefits Plan Document available at www.pebp.state.nv.us.

This Plan is not established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The self-funded portions of this Plan are funded with contributions from participating employers and eligible

Participants, held in an internal service fund. An independent Claims Administrator pays Benefits out of the fund's assets.

The Benefits offered are the Self-Funded Consumer Driven Health Plan, Prescription Drug Plan and the Self-Funded PPO Dental plan. The medical and Prescription drug Benefits are described in this document. An independent Claims Administrator pays the claims for medical and Dental Benefits. An independent Claims Administrator pays the claims for prescription drug Benefits.

The self-funded Consumer Driven Health Plan also provides Health Savings Accounts (HSA) and Health Reimbursement Arrangement (HRA) benefits.

- The **fully insured Benefits offered** include the HMO options (whose Benefits are not described here but are discussed in documents provided to you by those HMO insurance companies), life insurance, and long-term disability (LTD) insurance as described in the Self-Funded PEBP PPO Dental Plan and Summary of Benefits for Life and Long Term-Disability Insurance document. **For more information about the fully insured Benefits, contact PEBP or visit the PEBP website.**

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 particular attention to the following:

- **Review the Table of Contents.** The **Table of Contents** provides you with an outline of the sections.
- **Become familiar with PEBP vendors** and the services they provide by reviewing the **Participant Contact Guide**.
- Review the **Participant Rights and Responsibilities section** located in the Introduction section of this document.
- The **Definitions** section explains many technical, medical and legal terms that appear in the text.
- **Review the Medical Expense, Schedule of Medical Benefits and Medical Exclusions sections.** These describe Your Benefits in more detail. There are examples, charts and tables to help clarify key provisions and details of the Plan Benefits.
- **Read the Wellness/Preventive section** to see the variety of preventive services covered under the Plan to help you proactively manage Your personal health.
- **Refer to the General Provisions and Notices section** for information regarding Your rights and general provisions of the Plan.
- **Refer to the How to File a Medical Claim section** to find out what you must do to file a claim.
- **Refer to the CDHP Claim Appeal Process section** to find out how to seek a review (appeal) if you are dissatisfied with a claims decision.
- **The section on Coordination of Benefits** discusses situations where you have coverage under more than one health care plan including Medicare. This section also provides you with information regarding how the Plan subrogates with a third party who wrongfully caused an Injury or Illness to you.

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.
- 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 that PEBP and/or Your health care professionals need in order to provide care.
- Follow Your Physicians' recommended treatment plan and ask questions if you do not fully understand Your treatment plan and what is expected of you.
- Follow all of the Plan's guidelines, provisions, policies and procedures.

- Inform PEBP if you experience any life changes such as a name change, change of address or changes to Your coverage status because of marriage, divorce, domestic partnership, birth of a Child(ren) or adoption of a Child(ren).
- Provide PEBP with accurate and complete information needed to administer Your health Benefit Plan, including if you or a covered Dependent has other health Benefit coverage.
- Retain copies of the documents provided to you from PEBP and PEBP's vendors. These documents include but are not limited to:
 - Copies of the Explanation of Benefits (EOB) from PEBP's third party 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.
 - Copies of your enrollment forms submitted to PEBP.
 - Copies of your medical, vision and Dental bills.
 - 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.

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Participant Contact Guide

General Contacts	Service
<p>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</p>	<p>Plan Administrator</p> <ul style="list-style-type: none"> • Enrollment and change of status • Certificate of creditable coverage • COBRA information and premium payments • Level 2 claim appeals • External review coordination
<p>Office for Consumer Health Assistance 555 E. Washington Avenue, Suite 4800 Las Vegas, NV 89101 Customer Service: (702) 486-3587 or (888) 333-1597 www.govcha.state.nv.us</p>	<p>Consumer Health Assistance</p> <ul style="list-style-type: none"> • Concerns and problems related to coverage • Provider billing issues • External review information
<p>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</p>	<p>Living Will Information</p> <ul style="list-style-type: none"> • Declaration governing the withholding or withdrawal of life-sustaining treatment • Durable power of attorney for health care decisions • Do not resuscitate order
Consumer Driven Health Plan Medical, Vision and Dental Contacts	Service
<p>PEBP Statewide PPO Network Administered by Hometown Health Providers and Sierra Health Care Options Customer Service: (800) 336-0123 www.pebp.state.nv.us</p>	<p>In-State PPO Medical Network</p> <ul style="list-style-type: none"> • Network Providers • Provider directory • Additions/deletions of Providers • In-Network pricing tool
<p>Aetna Signature Administrators PPO Network Participants who reside outside of Nevada who need assistance locating a provider may contact HealthSCOPE Benefits at (888) 763-8232 or www.aetna.com/asa</p>	<p>National Medical Network/Outside of Nevada</p> <ul style="list-style-type: none"> • Network Providers • Provider directory (website only) • Additions/deletions of Providers <p>The National Medical Network is available to CDHP <u>Participants who reside outside of Nevada</u> or who live in Nevada but choose to seek health care outside of Nevada.</p>

Consumer Driven Health Plan Medical, Vision and Dental Contacts	Service
<p>Diversified Dental Services PO Box 36100 Las Vegas, NV 89133-6100 Customer Service: Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538 www.ddsppo.com</p>	<p>Self-funded PPO Dental Network</p> <ul style="list-style-type: none"> • General information on statewide PPO Dental Providers • General information on national PPO Dental Providers • Dental Provider directory
<p>HealthSCOPE Benefits Claims Submission: HealthSCOPE Benefits P O Box 91603 Lubbock, TX 79490-1603 Appeal of Claims: HealthSCOPE Benefits P O Box 2860 Little Rock, AR 72203 Group Number: NVPEB Customer Service: (888) 763-8232 www.healthscopebenefits.com</p> <p><u>Diabetes Care Management forms submission:</u> <u>Mail: HealthSCOPE Benefits</u> <u>27Corporate Hill Drive</u> <u>Little Rock, AR 77205</u> <u>Fax: 800-458-0701</u> <u>Email: diabetes@healthscopebenefits.com</u></p>	<p>Claims Administrator/ Third Party Administrator/Disease Management Administrator for Diabetes</p> <ul style="list-style-type: none"> • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit information • CDHP & Dental only ID Cards • Health Savings Account (HSA) Administrator • Health Reimbursement Arrangement (HRA) Administrator • In-Network Pricing Tool • Obesity Care Management Program • Disease Management for Diabetes
<p>Hometown Health Providers Customer Service: (775) 982-3232 or (888) 323-1461 www.stateofnv.hometownhealth.com</p>	<p>Medical Utilization Management & Case Management Services</p> <ul style="list-style-type: none"> • Pre-certification, for example: <ul style="list-style-type: none"> ○ Inpatient hospital admissions ○ Outpatient Surgeries performed in a surgery center or outpatient setting ○ All spinal surgeries ○ All bariatric (weight loss) surgeries ○ Transgender services ○ Outpatient non-emergent cardiac surgeries ○ Any jaw/face/TMJ procedures • Large case and complex case management

Consumer Driven Health Plan Medical, Vision and Dental Contacts	Service
<p>Express Scripts Pharmacy Benefit Administrator Customer Service and Prior Authorization (855) 889-7708 Formulary, forms, online ordering: www.Express-Scripts.com</p> <p>Express Scripts Home Delivery PO Box 66566 St. Louis, MO 63166-6566 Customer Service: (855) 889-7708</p> <p>Accredo Specialty Pharmacy Customer Service: (855) 809-7708</p> <p>Express Scripts Benefit Coverage Review Department PO Box 66587 St. Louis, MO 63166-6587 Phone: 800-753-2851</p> <p>Express Scripts Clinical Appeals Department PO Box 66588 St. Louis, MO 63166-6588 Phone: 800-753-2851 Fax: 877-852-4070</p> <p>MCMC LLC Attn: Express Scripts Appeal Program 300 Crown Colony Dr. Suite 203 Quincy, MA 02169-0929 Phone: 617-375-7700 ext. 28253 Fax: 617-375-7683</p>	<p>Pharmacy Benefit Manager - Prescription Drug Plan</p> <ul style="list-style-type: none"> • Prescription Drug information • Retail Network Pharmacies • Prior authorization • Price a Medication tool • Home Delivery service and Mail Order Forms • Preferred Mail Order for Diabetic Supplies <p>Accredo Specialty Drug Services Provider Refills and order status</p> <p>Administrative Coverage Review and Administrative Reviews and Appeals</p> <p>Clinical Reviews</p> <p>External Review Requests for Adverse Benefit Determinations</p>

Fully Insured Product Contacts	Service
<p>The Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html</p>	<p>Basic Life Insurance</p> <ul style="list-style-type: none"> • Benefits • Filing a life insurance claim • Beneficiary financial counseling • United Healthcare Global travel assistance

Fully Insured Product Contacts	Service
<p>The Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html</p>	<p>Long-term Disability (LTD)</p> <ul style="list-style-type: none"> • LTD Benefits • Filing a long-term disability claim
<p>Hometown Health Plan HMO Customer Service: (775) 982-3232 or (800) 336-0123 www.stateofnv.hometownhealth.com</p>	<p>Northern Nevada Health Maintenance Organization (HMO)</p> <ul style="list-style-type: none"> • Medical claims • Pre-authorization • Provider network
<p>Health Plan of Nevada HMO Customer Service: (702) 242-7300 or (877) 545-7378 www.stateofnv.healthplanofnevada.com</p>	<p>Southern Nevada Health Maintenance Organization (HMO)</p> <ul style="list-style-type: none"> • Medical claims • Pre-authorization • Provider network
<p>Towers Watson's OneExchange 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 Customer Service: (888) 598-7545 TTY: (866) 508-5123 www.medicare.oneexchange.com/pebp</p> <p>PayFlex PO Box 3039 Omaha, NE 68103-3039 Customer Service: (888) 598-7545 General Fax: (402) 231-4300 Claims Fax: (402) 231-4310 www.payflex.com</p>	<p>Medicare Exchange Supplemental or replacement medical coverage for Retirees and covered Dependents with Medicare Parts A and B</p> <p>Health Reimbursement Arrangement</p> <ul style="list-style-type: none"> • Health Reimbursement arrangement for Retirees with Medicare Parts A and B • Premium reimbursement

Voluntary Product Contacts	Service
<p>The Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html</p>	<p>Life Insurance – Additional Voluntary life insurance benefits</p>
<p>The Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html</p>	<p>Short-term Disability Insurance Voluntary short-term disability benefits</p>
<p>Liberty Mutual Customer Service: (800) 637-7026 Gary.bishop@libertymutual.com</p>	<p>Home and Auto Insurance</p> <ul style="list-style-type: none"> • Voluntary homeowners and auto insurance • Voluntary RV insurance
<p>HealthSCOPE Benefits Claims Submission: HealthSCOPE Benefits P.O. Box 3627 Little Rock, AR 72203 Customer Service: (888) 763-8232 Fax: (877) 240-0135</p> <p>Email: pebphsahra@healthscopebenefits.com Online Claims Submission: www.healthscopebenefits.com Click Member Type PEBP as the company name Click Flexible Spending Account (FSA) Status Login to your Member Dashboard</p>	<p>Flexible Spending Accounts</p> <ul style="list-style-type: none"> • Limited scope Flexible Spending Account • Dental expenses • Dependent Care Flexible Spending Account
<p>UNUM Provident Customer Service: (800) 227-4165 Option #4</p>	<p>Long-Term Care Insurance Voluntary long-term care insurance benefits</p>

Summary of Benefit Options

	Full-Time Employees			Active Legislator	Retirees (non-Medicare)			Survivors of Retirees (non-Medicare)		COBRA
	State	Non- State	NSHE		State	Non- State	Reinstated (State or Non-State)	Spouse	Dependent Child	
Medical Options										
Consumer Driven Health Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hometown Health Plans (HHP) HMO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Plan of Nevada (HPN) HMO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Other Options										
Self-funded PPO Dental	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basic Life	✓	✓	✓	✓	✓	✓				
Long-Term Disability (LTD)	✓	✓	✓	✓						
					Retirees eligible for Medicare Parts A and B			Survivors of Retirees		
Medicare Exchange for Medicare eligible Retirees and their covered Medicare eligible Dependents					✓	✓	✓	✓		
Voluntary Products										
Short-Term Disability	✓	✓	✓	✓						
Long-Term Care	✓	✓	✓	✓						
Home and Auto	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Flex Plan (Section 125 pre-tax)	✓			✓						
Additional Life	✓	✓	✓	✓	✓	✓				

Identification Cards

Medical and Pharmacy and Dental Benefits

The PEBP CDHP Medical, Pharmacy and Dental ID card contains important coverage information and should be carried at all times. ID cards are issued under the Participant's name and unique ID number only. This card will not be issued to Employees and Retirees who elect HMO coverage.

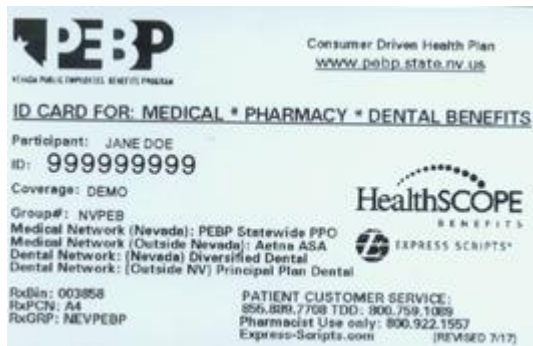
Under normal circumstances only two ID cards are issued. Eligible Dependents will not receive individual ID cards. ID cards are issued under the Participant's name and unique ID number only. If additional cards are needed, please contact HealthSCOPE Benefits. Information regarding HealthSCOPE is located in this document under the section titled "Participant Contact Guide." If you notice that any coverage information is not correct, please contact PEBP.

Consumer Driven Health Plan (CDHP) - Benefits ID Card

*Issued to CDHP Participants residing
in Nevada.*

Consumer Driven Health Plan (CDHP) - Benefits ID Card

*Issued to CDHP Participants
residing outside Nevada.*



PEBP
NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Consumer Driven Health Plan
www.pebp.state.nv.us

ID CARD FOR: MEDICAL * PHARMACY * DENTAL BENEFITS

Participant: JANE DOE
ID: 9999999999

Coverage: DEMO

Group#: NVPEB

Medical Network (Nevada): PEBP Statewide PPO
Medical Network (Outside Nevada): Aetna ASA
Dental Network: (Nevada) Diversified Dental
Dental Network: (Outside NV) Principal Plan Dental

RxBin: 003858
RxCN: A4
RxGRP: NEVPEBP

HealthSCOPE
BENEFITS

EXPRESS SCRIPTS®

PATIENT CUSTOMER SERVICE:
856.889.7708 TDD: 800.759.1089
Pharmacist Use only: 800.922.1557
Express-Scripts.com (REVISED 7/17)



PEBP
NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Aetna Signature Administrators' PPO
by **aetna**

Consumer Driven Health Plan

ID CARD FOR: MEDICAL * PHARMACY * DENTAL BENEFITS

Participant: JOHN CHRISTOPHER DOE
ID: 9999999999

Coverage: DEMO

Group#: NVPEB

Medical Network: Aetna Signature Administrators PPO
Dental Network: (Nevada) Diversified Dental
Dental Network: (Outside NV) Principal Plan Dental

RxBin: 003858
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To avoid penalties, preauthorization is required prior to non-emergency, elective hospital admissions and other specified medical services. For an emergency hospital admission, hospital should contact PEBP's UH Company within 1 business day of the admission to allow a concurrent review. Prior Authorization required for air ambulance facility to facility transfers. *For Medical Preauthorization and Concurrent review, call 1-888-323-1481

Participant and Provider Inquiries: www.healthscopebenefits.com or call 1-888-7NEVADA (1-888-763-8232)

Aetna Participating doctors and hospitals are independent providers and are neither agents nor employees of Aetna. To locate an Aetna provider, please visit www.aetna.com/usa

Submit Claims to HealthSCOPE Benefits, PO Box 91603, Lubbock, TX 79485-1603
EDI PAYER # 71062

Hometown Health Funds
Sera HealthCare Group
Principal Financial Group
Aetna Signature Administrators' PPO by aetna
DDS, Inc.

This card is for identification purposes ONLY and is not a guarantee of coverage.

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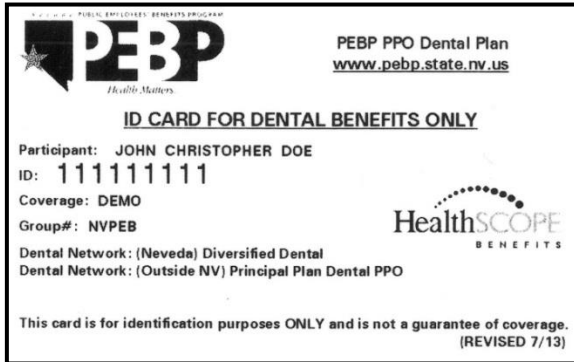
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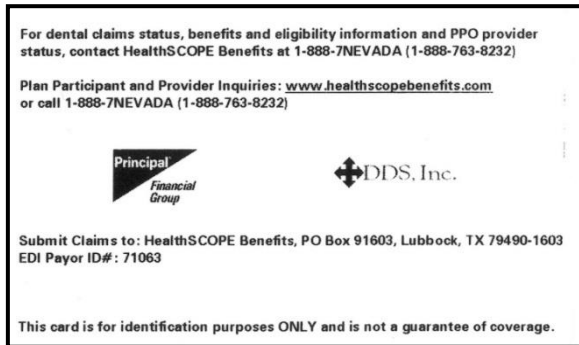
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PPO Dental Benefits ID card
Issued to Retirees covered under the Medicare Exchange who elect the PEBP Self-Funded PPO Dental Plan and to Participants enrolled in a PEBP-sponsored HMO Plan.



Summary of CDHP Plan Components

Deductibles

Medical and Prescription Drugs

Each Plan Year, before the Plan begins to pay Benefits, You are responsible for paying Your entire eligible medical and Prescription Drug expenses up to the Plan Year Deductible. Eligible medical and Prescription Drug expenses are applied to the Deductibles in the order in which claims are received by the Plan. Only eligible medical and Prescription Drug expenses can be used to satisfy the Plan's Deductibles. Non-eligible medical and Prescription Drug expenses described in the following sections do not count toward the Deductibles. Deductibles accumulate on a Plan Year basis and reset to zero at the start of each new Plan Year. Deductible credit is based on the date of service for the medical or Prescription Drug expense and not when the medical or Prescription Drug expense is received by the Plan.

In Network

Deductible Type	Individual (self-coverage only)	Individual (when two or more family members are covered)	Family (when two or more family members are covered)
Annual Medical and Prescription Drug	\$1,500.00	\$2,600.00	\$3,000.00

Out of Network

Deductible Type	Individual (self-coverage only)	Individual (when two or more family members are covered)	Family (when two or more family members are covered)
Annual Medical and Prescription Drug	\$1,500.00	\$2,600.00	\$3,000.00

Medical Plan (including Outpatient Prescription Drugs) - Annual Deductible

- Medical Deductibles, for individual or family coverage, accumulate separately for In-Network provider expenses and Out-of-Network provider expenses. If both In-Network and Out-of-Network Providers are used, the Deductible will have to be met separately, meaning a separate deductible for In-Network utilization and a separate Deductible for Out-of-Network Services.
- Family coverage means Employee/Retiree plus one or more covered Dependents. The family Deductible may be satisfied by any combination of eligible medical and Prescription Drug expenses from *two or more* members of the same family coverage unit. The family Deductible may be satisfied cumulatively. For the family coverage Deductible, under no circumstances will a single individual be required to pay more than \$2,600 toward the Deductible.

Example – Individual Family Member Deductible:

1. Family member #1 incurs \$2,800 in eligible In-Network medical expenses, of which \$2,600 is applied to the individual In-Network Deductible and \$2,600 is also applied to the family Deductible of \$3,000. In this example, the individual has met his In-Network Deductible and the remaining In-Network family Deductible is \$400. The remaining \$200 is paid at the appropriate Coinsurance rate.
 2. Family member #2 incurs \$2,000 in eligible In-Network medical expenses: \$400 is applied toward the remaining family In-Network Deductible, which satisfies the \$3,000 Annual family In-Network Deductible amount. The remaining \$1,600 is paid at the appropriate Coinsurance rate.
- Certain preventive medical, Prescription Drug and certain over the counter medications expenses are not subject to Deductible. See the Schedule of Medical Benefits to determine when Eligible Medical Expenses are not subject to Deductibles.

NOTE FOR PERSONS WHOSE STATUS CHANGES FROM EMPLOYEE/RETIREE TO DEPENDENT OR FROM DEPENDENT TO EMPLOYEE:

As long as the person is continuously covered under this Plan before, during and after the change in status, credit will be given for portions of the medical, Prescription Drug and Dental Deductibles already met, and Benefit maximum accumulators (e.g. medical Out-of-Pocket Maximums, Dental frequency maximums and Annual Benefit maximum) will continue without interruption.

Coinsurance

Once you have met Your Annual Deductible (individual or family), the Plan generally pays a percentage of the Eligible Medical Expenses and you are responsible for paying the rest. The part you pay is called the Coinsurance. If you use the services of a Health Care Provider who is a member of the Plan's PPO network, you will be responsible for paying less money out of Your pocket. This feature is described in more detail in the Medical Provider (PPO) Networks section of this document. In-Network, the Plan generally pays 80% of the Provider's contracted In-Network rate and You pay the remaining 20%. Out-of-Network, the Plan generally pays 50% of Usual and Customary (U&C) charges and you pay the remaining 50%. Out-of-Network Service Providers can also bill you directly for any difference between their billed charges and the U&C charges allowed by the Plan.

NOTE FOR WHEN YOU DO NOT 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.

Plan Year Out-of-Pocket Maximums

Medical and Prescription Drugs

The Plan limits the amount a Participant might pay each Plan Year. The Out-of-Pocket Maximums accumulate separately for In- and Out-of-Network Providers. After an individual or family has paid eligible medical and Prescription Drug expenses exceeding the Deductible and Coinsurance amounts up to the maximum Out-of-Pocket cost, no further Coinsurance or Deductible will apply to covered eligible medical and Prescription Drug expenses for the remainder of the current Plan Year. As a result, after the Out-of-Pocket Maximum has been reached, the Plan will pay 100% of all covered eligible medical and Prescription Drug expenses that are incurred during the remainder of the Plan Year. The Out-of-Pocket Maximum accumulates on a Plan Year basis and resets to zero at the start of each new Plan Year. Accumulation of the Out-of-Pocket Maximum is based on the date of service for the medical or Prescription Drug expense and not when the medical or Prescription Drug expense is received by the Plan. Only expenses where the Plan's Coinsurance is applied are eligible for the Out-of-Pocket Maximum. The Out-of-Pocket Maximums are as follows:

Coverage Tier	In-Network Individual Out-of-Pocket Maximum (when two or more family members are covered)	Out-of-Network Out-of-Pocket Maximum
Individual (Participant only coverage tier)	\$3,900 Individual	\$10,600 Individual
Family (when two or more family members are covered)	\$7,800 Family (combination of health care expenses from one or more family members)	\$21,200 Family
Individual Family Member (when two or family members are covered on the Plan)	\$6,850 Individual Family Member means that one person in the coverage tier will never pay more than \$6,850 for eligible In-Network health care expenses in the Plan Year.	

The Out-of-Pocket Maximums are a combination of covered Out-of-Pocket expenses, including Deductible and Coinsurance and excluding the Out-of-Pocket expenses listed below. The Family In-Network Out-of-Pocket Maximum contains an embedded "Individual Out-of-Pocket Maximum". This means that one individual in the family unit cannot pay more than \$6,850 as an Out-of-Pocket expense even if the individual's expenses have not reached the family's Out-of-Pocket Maximum. The Family Out-of-Pocket Maximum can be met by a combination of Out-of-Pocket expenses from all covered family members.

NOTE: In- and Out-of-Network maximums are **not** combined to reach Your Plan Year Out-of-Pocket Maximum. A Participant who uses both In- and Out-of-Network Providers could pay a total of \$14,500 for "Participant-only" coverage or one individual in the "Family coverage" unit can incur up to \$28,050 in Out-of-Pocket expenses. This also means that a combination of In- and Out-of-Network expenses from everyone in the "Family coverage" unit could pay a total of \$29,000 in Out-of-Pocket expenses.

Example – Family Out-of-Pocket Maximum:

1. Family member #1 incurs \$2,800 in eligible In-Network medical expenses, of which \$2,600 is applied to the "individual" In-Network Deductible and \$2,600 is also applied to the "family" Deductible of \$3,000. In this example, the individual has satisfied his In-Network Deductible requirement and the remaining In-Network family Deductible is \$400. The remaining \$200 is paid at the appropriate Coinsurance rate, which in this Plan Year is 80%. The Plan pays \$160 and member #1 pays \$40 in Coinsurance and \$2,600 for the charge is applied towards the Deductible for a total out of pocket for this claim of \$2,640. The amount applied to member #1's Deductible (\$2,600) and member #1's Coinsurance (\$40) is applied towards the "\$6,850 individual" Out-of-Pocket Maximum and \$2,640 is also applied to the \$7,800 "family" Out-of-Pocket Maximum reducing the "individual" Out-of-Pocket Maximum to \$4,210 and the "family" Out-of-Pocket Maximum to \$5,160.
2. Family member #2 incurs \$2,000 in eligible In-Network medical expenses: \$400 is applied toward the remaining family In-Network Deductible, which satisfies the \$3,000 Annual family In-Network Deductible amount. The remaining \$1,600 is paid at the appropriate Coinsurance rate, which in this Plan Year is 80%. The Plan pays \$1,280 and member #2 pays a total of \$720 (Deductible \$400 plus Coinsurance \$320). The amount applied to member #2's Deductible (\$400) and member #2's Coinsurance (\$320) is applied towards the remaining family out of pocket maximum of \$5,160 reducing the family Out-of-Pocket Maximum to \$4,440.
3. Family member #3 incurs \$25,000 in eligible In-Network medical expenses. The In-Network family Deductible has been satisfied by the previous family members and the remaining family out of pocket maximum is \$4,440. In this example, the family member is responsible for 20% of covered Eligible Medical Expenses up to \$4,440 and the Plan would pay 100% of all remaining Covered Medical Expenses, in this case \$20,560. For the remainder of the Plan Year, the In-Network family Deductible and the In-Network family Out-of-Pocket Maximum have been satisfied and the Plan will pay 100% of all eligible medical and Prescription Drug expenses for all the covered members of the family.

The In-Network and Out-of-Network Out-of-Pocket Maximums are **not** interchangeable, meaning you may not use any portion of an In-Network Out-of-Pocket Maximum to meet an Out-of-Network Out-of-Pocket Maximum, and vice versa.

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

The Plan never pays Benefits equal to all the medical expenses you may incur. You are always responsible for paying for certain expenses for medical services and supplies yourself. The following services **do not** accumulate toward **the 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, to include but not limited to expenses that exceed the PPO provider contract rate, services listed in the Exclusions section of this document and Dental expenses (unless deemed medical as described in this document).
- All charges in excess of the Usual and Customary Charge determined by the Plan.
- Any additional amounts you have 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 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.

Self-Funded CDHP/ PPO Medical Benefits

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) (as those terms are defined in the Definitions section of this document); and
- not services or supplies that are excluded from coverage (as provided in the Exclusions section of this document); and
- services or supplies; the charges for which are not in excess of the Limited Overall and/or Plan Year Maximum Benefits shown in the Schedule of Medical Benefits.

Generally, the Plan will not reimburse you for all Eligible Medical Expenses. Usually you will have to satisfy some Deductibles, 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 that Plan Year. There are also maximum Plan 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 be in excess of the Usual and Customary Charges;
- not covered by the Plan,
- in excess of a maximum Plan Benefit; or,
- payable on account of a penalty for failure to comply with the Plan's Utilization Management requirements.

Non-eligible medical expenses do not contribute to the Deductible or Out-of-Pocket Maximums as determined by the Plan for Your specific coverage tier.

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 members 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

The self-funded CDHP 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 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 PEBP's third party 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 PEBP. You may be required to pay for medical and vision care services and submit your receipts to PEBP's third party administrator for possible reimbursement. Medical and vision services received outside of the United States are subject to Plan provisions, limitations and Exclusions, clinical review if necessary and determination of Medical Necessity. The review may include regulations determined by the FDA.

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, PEBP provides 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 located in the front section of this document.
- 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 located in the front section of this document.
- If you are not eligible for transportation services provided by United Healthcare Global or if you do not utilize United Healthcare Global for transportation, PEBP may provide Benefits through the self-funded CDHP Plan for the purposes of medical transportation. PEBP typically will pay for commercial transportation. Refer to PEBP's third party administrator, listed in the Participant Contact Guide, for more information.

Prior to submitting receipts from a foreign country to PEBP's third party 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 must be converted to United States dollars
 - Any foreign purchases of medical care and services will be subject to Plan limitations such as:
 - Deductibles
 - Coinsurance
 - Frequency maximums
 - Annual Benefit maximums
 - Medical Necessity
 - FDA approval
 - Usual and Customary (U & C)

PEBP and PEBP's third party administrator reserve the right to request additional information. If the Provider will accept payment directly from PEBP 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, 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 any and 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.

Ambulance (Ground)

Transportation by professional 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 is connected with an inpatient confinement.

Ambulance (Air/ Flight) Inter-Facility Transfer

Inter-facility patient transport by air transport, for Participants if there is a life-threatening situation or it is deemed to be Medically Necessary.

For a Participant who is in a Hospital or other health care facility under the care or supervision of a licensed health care Provider, Pre-certification is required before transport of the Participant by air transport via any form of flight to another Hospital or facility.

Failure to obtain a Pre-certification may, solely in the Plan Administrator's discretion, 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 Pre-certification will not apply to the Annual Out-of-Pocket Maximum.

As part of Pre-certification review, the Plan Administrator retains the discretionary authority to limit benefit availability to alternative Providers of flight-based inter-facility patient transport if and when a Provider fails to comply with the terms of the Plan, or proposed 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 percent of the applicable Medicare rate.

Ambulance (Air/Flight) Emergency

This Plan provides coverage for emergency air ambulance transportation for Participants and/or 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/injury. Air ambulance transportation should meet the following criteria:

- 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.

As part of Pre-certification review, the Plan Administrator retains discretionary authority to limit benefit availability if and 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 percent of the applicable Medicare rate.

Autism Spectrum Disorders

This Plan provides coverage for the screening of, diagnosing of and treatment of Autism Spectrum Disorders. Autism Spectrum Disorder is defined in the Definitions section of this document. For Benefit Exclusions and limitations, please refer to the Schedule of Medical Benefits section of this document.

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 policy.
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 is in conflict with subsection 1 or 2 is void.
7. Nothing in this section shall be construed as requiring an insurer to provide reimbursement to an early intervention agency or school for services delivered through early intervention or 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:
 1. A licensed psychologist;
 2. A licensed behavior analyst; or
 3. A licensed assistant behavior analyst.
- (c) Autism Spectrum Disorders means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.
- (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) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to Autism Spectrum Disorders.
- (f) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.
- (g) "Licensed assistant behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.
- (h) "Licensed behavior analyst" means a person who holds current certification or meets the standards to be certified as a board-certified behavior analyst or a board-certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, and who is licensed as a behavior analyst by the Board of Psychological Examiners.
- (i) "Prescription care" means medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.
- (j) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- (k) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- (l) "Screening for Autism Spectrum Disorders" means Medically Necessary assessments, evaluations or tests to screen and diagnose whether a person has an Autism Spectrum Disorder.

- (m) "Therapeutic care" means services provided by licensed or certified speech pathologists, Occupational Therapists and Physical Therapists.
- (n) "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.

Schedule of Medical Benefits

A schedule of the CDHP Medical Plan Benefits appears on the following pages in a chart format. Explanations and limitations that apply to each of the Benefits are shown in the second column. Specific differences in the Benefits when they are provided In-Network (when you use PPO network Providers) and Out-of-Network (when you use Non-Network Non-PPO Providers) are shown in the subsequent columns, if applicable.

The Benefits are listed in alphabetical order. To determine the extent to which limitations apply to the Benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, and you should also check the Exclusions section of this document.

Plan Year 2018 Schedule of Medical Benefits
This chart explains the Benefits payable by the CDHP.
All Benefits are subject to the Deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Acupuncture</u> Acupuncture and acupressure</p>	<p>Covered if performed by a licensed MD, DO, Acupuncturist (as defined in this Plan), or Oriental Medicine Doctor</p> <ul style="list-style-type: none"> • Supporting documentation establishing Medical Necessity will be required after 15 visits in a Plan Year • Maintenance services are not a covered Benefit 	<p>80% PPO after Plan Year Deductible (PPO= Preferred Provider Organization negotiated fee schedule)</p>	<p>50% U&C after Plan Year Deductible (U&C= Usual and Customary fee schedule)</p>
<p><u>Allergy Services</u> Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast</p> <p>Desensitization and hypo-sensitization (allergy shots given at periodic intervals)</p> <p>Allergy antigen solution</p>	<ul style="list-style-type: none"> • Allergy testing subject to Pre-certification. See the Utilization Management section for details • Allergy services are covered only when ordered by a Physician 	<p>Allergy testing, shots and antigen: 80% PPO after Plan Year Deductible</p>	<p>Allergy testing, shots and antigen: 50% of U&C or 110% of the Medi Span AWP, (Average Wholesale Price) after Plan Year Deductible</p>

Plan Year 2018 Schedule of Medical Benefits
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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Ambulance Services</u> Ground vehicle transportation to the nearest appropriate health care facility as Medically Necessary for treatment of a Medical Emergency, acute Illness or inter-health care facility transfer</p> <p>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</p>	<p>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</p> <p>Pre-certification is required to establish Medical Necessity for all non-emergent care air transportation scheduled between facilities. Please see the Utilization Management (UM) Section for details on requesting Pre-certification. If the transportation between facilities is for emergent care, no Pre-certification is required; however, all transportation costs will be evaluated for reasonableness Note: For air ambulance only, the *Maximum Allowable Charge shall mean 250 percent of the applicable Medicare rate</p>	<p>80% PPO after Plan Year Deductible</p> <p>(Ground vehicle transport only)</p> <p>The lessor of 80% PPO or 80% of *Maximum Allowable Charge after Plan Year Deductible (air transport only)</p>	<p>80% U&C after Plan Year Deductible</p> <p>(Ground vehicle transport only)</p> <p>80% of the *Maximum Allowable Charge after Plan Year Deductible (air transport only)</p>

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<p><u>Autism Spectrum Disorders</u> Treatment of any neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.</p>	<p>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:</p> <p style="margin-left: 40px;">(a) Prescribed for a person diagnosed with an Autism Spectrum Disorder by a licensed Physician or licensed psychologist; and</p> <p style="margin-left: 40px;">(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</p> <p>Excludes coverage for reimbursement to an early intervention agency or school for services delivered through early intervention or school services</p>	<p>80% PPO after Plan Year Deductible</p>	<p>50% U&C after Plan Year Deductible</p>
<p><u>Behavioral Health Services</u> (Mental Health and Substance Abuse Treatment)</p> <p>Behavioral Health services payable by this Plan include:</p> <ul style="list-style-type: none"> • Outpatient Visits • Inpatient admission • Partial day care • Day treatment • Psychological testing <p>Pre-certification must be obtained from PEPP's Utilization Management Company for Inpatient, Partial, and Day treatment</p>	<p>See the specific Exclusions related to Behavioral Health Services, including learning disabilities, in the Exclusions section. Benefits are payable only for services of Behavioral Health Care Practitioners listed in the Definitions section</p> <p>The following Behavioral Health Practitioners are payable under the Plan: psychiatrist (MD or DO), psychologist (Ph.D.), Master's prepared counselors (e.g., MSW), licensed associate in social work, social worker, independent social worker or clinical social worker</p> <p>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. For instance, 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</p> <p>Outpatient Prescription Drugs for Behavioral Health payable under Drugs in this Schedule of Medical Benefits</p>	<p>Inpatient Admission, Inpatient Partial & Day Treatment: 80% PPO after Plan Year Deductible</p> <p>Outpatient: 80% PPO after Plan Year Deductible</p> <p>Psych Testing: 80% PPO after Plan Year Deductible</p>	<p>Inpatient Admission, Inpatient Partial & Day Treatment: 50% U&C after Plan Year Deductible</p> <p>Outpatient Services including Psych Testing: 50% U&C after Plan Year Deductible</p>

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<p><u>Blood Transfusions</u> Blood transfusions, blood products and equipment for its administration</p>	<ul style="list-style-type: none"> • Covered only when ordered by a Physician • Expenses related to Autologous blood donation (patient’s own blood) are covered 	80% PPO after Plan Year Deductible	50% U&C after Plan Year Deductible
<p><u>Breastfeeding Support</u></p>	<p>Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained Providers, as well as breastfeeding equipment in conjunction with each birth.</p>	Wellness/ Preventive: 100% No Deductible	50% U & C after Plan Year Deductible
<p><u>Chemotherapy</u> Chemotherapy drugs and supplies administered under the direction of a physician in a Hospital, health care facility, physician’s office or at home</p>	<ul style="list-style-type: none"> • Covered only when ordered by a Physician • Chemotherapy must be pre-certified by PEBP’s Utilization Management Company 	80% PPO after Plan Year Deductible	50% of U&C or 110% of the Medi Span AWP, after Plan Year Deductible
<p><u>Chiropractic Services</u> Office Visit and Spinal Manipulation services</p>	<ul style="list-style-type: none"> • 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 	80% PPO after Plan Year Deductible	50% U&C after Plan Year Deductible
<p><u>Clinical Trials</u> For example: Cancer or Chronic Fatigue syndrome clinical trials</p>	<ul style="list-style-type: none"> • 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 Definitions section • Pre-certification must be obtained from PEBP’s Utilization Management Company 	80% PPO after Plan Year Deductible	50% U&C after Plan Year Deductible

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<p><u>Diabetes Education Services</u> Diabetes training and education services are payable when requested by a Physician and Medically Necessary for the self-care and self-management of a person with diabetes</p>	<p>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</p> <p>Some diabetic supplies are payable under the Prescription Drug section of this Schedule of Medical Benefits. Please contact the Prescription Drug Plan Administrator for more information</p> <p>If a Participant or their Spouse/Domestic Partner or covered Dependent Child(ren) diagnosed with diabetes is actively engaged in the Diabetes Care Management Program some of their laboratory tests and Office Visits, Prescription Drugs and diabetic supplies are eligible for a Copayment and are not subject to Deductible. See the Diabetes Care Management section of this document for more information</p>	80% PPO after Plan Year Deductible	Not covered
<p><u>Dialysis</u> Hemodialysis or peritoneal dialysis and supplies</p>	<p>Covered when ordered by a Physician and administered in a Hospital, Health Care Facility, Physician's office or at home</p> <p>Outpatient, Inpatient or Home Dialysis must be pre-certified by PEBP's Utilization Management vendor. (See the Utilization Management section for details)</p>	80% PPO after Plan Year Deductible	50% U&C after Plan Year Deductible

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<p><u>Durable Medical Equipment (DME)</u> Rental only up to the allowed purchase price of the Durable Medical Equipment</p> <p>Purchase of standard models at the option of the Plan to include equipment maintenance agreements</p> <p>Repair, adjustment or servicing or Medically Necessary replacement of the Durable Medical Equipment due to a change in the covered person's physical condition, or if the equipment cannot be satisfactorily repaired</p> <p>Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration</p> <p>NOTE: Durable Medical Equipment must be pre-certified when the cost is expected to exceed \$1,000</p>	<p>See the Exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions section. To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions section</p> <p>Durable Medical Equipment is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner</p> <p>Certain blood glucose monitors are eligible for Benefits through PEBP's Prescription Drug Program; see the Prescription Drug Schedule of Benefits and the Diabetes Care Management sections of this document for more information</p> <p>Insulin pumps are eligible for purchase and must be pre-certified by PEBP's Utilization Management Company</p> <p>Rental is payable for certain Durable Medical Equipment but only up to the allowed purchase price of certain Corrective Appliances such as oxygen concentrators</p> <p>If the need for a certain durable medical device or Appliance is expected to be for a life time, the Plan encourages you to arrange for the purchase of the equipment as opposed to renting the equipment. 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</p> <p>Contact PEBP's third party administrator for the internet purchase of certain DME such as: CPAP machines or breast pumps</p>	<p>80% PPO after Plan Year Deductible</p>	<p>50% U&C after Plan Year Deductible</p>

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<p><u>Emergency Room & Urgent Care Services</u> Hospital Emergency room (ER) for a Medical Emergency</p> <p>Use of an Urgent Care Facility</p> <p>Ancillary charges (such as lab or x-ray) performed during the ER or Urgent Care Visit</p> <p>See also the Ambulance section of this schedule</p>	<p>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:</p> <p>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</p> <p>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</p>	<p>Emergency Room: Medical Emergency: 80% PPO after Plan Year Deductible</p> <p>Urgent Care Facility: 80% PPO after Plan Year Deductible</p>	<p>Emergency Room: Medical Emergency: 80% U&C after Plan Year Deductible</p> <p>Urgent Care Facility: 50% U&C after Plan Year Deductible</p>

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<p><u>Family Planning/Contraceptives (Females Only)</u></p> <p>Surgical sterilization- Females Only (e.g. tubal ligation)</p> <p>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)</p> <p>Follow up Visits for side effect management, compliance and maintenance and removal of any device or implant contraceptives covered under these guidelines is also covered at 100% as Wellness/Preventive as long as provided by in network facilities and Providers</p>	<p>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:</p> <ul style="list-style-type: none"> • Sterilization Surgery for women; • Surgical sterilization implant for women; • Intrauterine devices (IUDs) • Implantable rods; • Shots or injections; • Oral contraceptives, including emergency contraceptives (Plan B/morning after pill/oral medication) • Patches; • Vaginal contraceptive rings; • Spermicides; emergency contraceptives (Plan B/morning after pill/oral medication) • Diaphragm with spermicide; • Sponge with spermicide; • Cervical cap with spermicide; and • Female condoms 	<p>Wellness/ Preventive: 100% No Deductible</p>	<p>Wellness/ Preventive: 50% U&C after Plan Year Deductible</p>

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<p><u>Fertility, Sexual Dysfunction Services and Male Contraception</u></p> <p>Only diagnostic procedures for fertility and infertility are payable for the Employee and Spouse</p> <p>Medical or surgical treatment for sexual dysfunction</p> <p>Male contraception</p> <p>Male surgical sterilization</p>	<p>No coverage for the <u>treatment</u> of fertility or infertility. See the specific Exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Sexual Dysfunction Services in the Exclusions section</p> <p>Diagnostic procedures for fertility and infertility are subject to the Plan Year Deductible</p> <p>There are some limits on sexual dysfunction drugs such as Viagra or Muse (max 8 pills or injections/month) and are subject to the Plan Year Deductible</p> <p>Procedures related to sexual dysfunction as a result of a medical diagnosis or procedure to treat a medical diagnosis may be covered. See the Exclusions section of this document for more information</p> <p>Male contraception such as condoms are not covered under this Plan.</p> <p>Subject to Plan Year Deductible and Coinsurance</p>	80% PPO after Plan Year Deductible	50% U&C after Plan Year Deductible
<p><u>Gender Dysphoria</u></p>	<p>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 Pre-certification review and Case Management are covered</p> <p>Cosmetic related services such as hair removal are not covered</p> <p>Lifetime maximum Benefit for genital reconstruction Surgery: Participants or their covered Dependents are limited to one genital reconstruction Surgery while covered under the self-funded CDHP</p> <p>If gender reassignment Surgery is not pre-certified or the requirements of the Plan are not followed, Benefits payable for the services you failed to pre-certify will be reduced by 50% of the <u>Allowable charges</u>. 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</p>	80% PPO after Plan Year Deductible	50% U&C after Plan Year Deductible

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<p><u>Genetic Testing and Counseling</u></p> <ul style="list-style-type: none"> • amniocentesis, • non-invasive pre-natal testing for fetal aneuploidy, • chorionic villus sampling (CVS), • alpha-fetoprotein (AFP), • BRCA1 and BRCA2 • apo E <p>Notes</p> <ul style="list-style-type: none"> • This list is not all inclusive for what genetic tests may be covered • Contact the Utilization Management Company listed in the Contact Guide for coverage details and Pre-certification for covered genetic testing 	<p>See the Definitions section and the Exclusions section for Definitions and Exclusions relating to Genetic Testing and Counseling, including non-payment for pre-parental genetic testing</p> <p>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</p> <p>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</p> <p>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</p> <p>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</p>	80% PPO after Plan Year Deductible	50% U&C after Plan Year Deductible
<p><u>Hearing Aids</u></p>	<p>See the Corrective Appliances section of this chart. Hearing aids are considered Orthotic devices under this Plan</p>		

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<p><u>Home Health Care and Home Infusion Services</u> 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 shown in the Explanations and Limitations column</p> <p>Home services other than Skilled Nursing Care are not covered</p> <p>Enteral formulas for use at home</p>	<p>See the Exclusions related to Home Health Care and Custodial Care (including personal care and childcare) in the Exclusions section of this document</p> <p>Home Health Care and home infusion services are covered only when ordered by a Physician or Health Care Practitioner</p> <p>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</p> <p>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</p> <p>Enteral formula (including parenteral nutrition and nutritional supplements) are payable for use as mandated by law</p>	<p>80% PPO after Plan Year Deductible</p>	<p>50% of U&C or for infusion drug services, 110% of the Medi Span AWP, after Plan Year Deductible</p>
<p><u>Hospice</u> Hospice services and supplies are payable when the patient meets the criteria for receiving Hospice care as described under Hospice in the Definitions section to include:</p> <ul style="list-style-type: none"> • Inpatient Hospice care • Home Hospice services 	<p>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</p>	<p>80% PPO after Plan Year Deductible</p>	<p>80% U&C after Plan Year Deductible</p>

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<p><u>Hospital Services (Inpatient)</u> Room & board facility fees in a semiprivate room with general nursing services</p> <p>Specialty Care Units (e.g., intensive care unit, cardiac care unit)</p> <p>Lab/x-ray/diagnostic services</p> <p>Related Medically Necessary Ancillary Services (e.g., prescriptions, supplies)</p> <p>Newborn care and circumcision</p>	<p>Elective hospitalization is subject to Pre-certification. All hospitalization is subject to Concurrent Review. See the Utilization Management section</p> <p>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</p> <p>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</p> <ul style="list-style-type: none"> • 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 medical Plan. Refer to the Dental Benefits described in the PEBP Self-Funded PPO Dental Plan Master Plan Document <p>See the Eligibility section for how to properly enroll Newborns</p> <p>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</p> <p>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.</p> <p>Inpatient private duty nursing by a licensed Nurse (RN, LVN/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</p>	<p>80% PPO after Plan Year Deductible</p>	<p>50% U&C after Plan Year Deductible</p>

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<p><u>Laboratory Services (Outpatient)</u> Technical and professional fees Pre-Admission Testing</p>	<p>Covered only when ordered by a Physician or Health Care Practitioner</p> <p>Inpatient laboratory services are covered under the Hospital Services section of this Schedule of Medical Benefits</p> <p>Pre-Admission Testing: Laboratory 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 for which admission or Surgery is planned</p> <p>Outpatient laboratory services such as but not limited to cholesterol screening, glucose and PSA must be provided at a contracted free standing laboratory facility</p> <p>Outpatient laboratory services (except for Pre-Admission Testing, Urgent Care Facility or Emergency room) performed at an acute care Hospital facility will not be covered unless an exception is warranted and approved by the Plan Administrator or its designee</p> <p>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</p> <p>Refer to the wellness/preventive section for information regarding Benefits for screening tests and other preventive laboratory testing</p>	<p>80% PPO after Plan Year Deductible</p>	<p>50% U&C after Plan Year Deductible</p>

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<p><u>Maternity Services</u> Hospital and Birth (Birthing) Center charges and Physician and Midwife fees for Medically Necessary maternity services</p> <p>Termination of pregnancy - See the Genetic Testing section of this Schedule of Medical Benefits for additional information</p> <p>See the Section under Breastfeeding Support for information and Benefits related to this type of service</p> <p>Some preventive prenatal services such as obstetrical Office Visits, breastfeeding support, 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). Contact the Claims Administrator listed in the Participant Contact Guide section of this document for additional information</p>	<p>See the Exclusions related to Maternity Services in the Exclusions section</p> <p>See the Enrollment and Eligibility Master Plan Document for information regarding how to enroll a newborn Dependent Child(ren)</p> <p>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 Definitions section of this document).</p> <p>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)</p> <p>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.</p> <p>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</p>	<p>80% PPO after Plan Year Deductible</p>	<p>50% U&C after Plan Year Deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Medical Foods for Inherited Metabolic Disorders</u> Medical Foods (also called “Special Food Products”) are payable for persons with Inherited Metabolic Disorders (as those terms are defined in the Definitions section of this document) subject to certain conditions</p>	<p>Medical Foods (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:</p> <p>Must be prescribed by a Physician to treat a diagnosis of Inherited Metabolic Disorder</p> <p>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</p>	80% PPO after Plan Year Deductible, to the Benefit maximum	50% U&C after Plan Year Deductible, to the Benefit maximum
<p><u>Nondurable Supplies</u> Coverage is provided for up to a 31-day supply per month of:</p> <ul style="list-style-type: none"> • 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 the course of their required services 	<p>To determine what Nondurable Medical Supplies are covered, see the definition of Nondurable Supplies in the Definitions section</p> <p>Please see the Participant Contact Guide for information regarding the preferred diabetic supplies mail order program</p> <p>Diabetic supplies are also payable under the Prescription Drug Benefit, see the section on Prescription Drug Benefits in this document for more information</p>	80% PPO after Plan Year Deductible	50% of U&C or 110% of the Medi Span AWP after Plan Year Deductible

Plan Year 2018 Schedule of Medical Benefits
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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Outpatient Surgery Facility</u> Ambulatory (outpatient) Surgical Facility (e.g., surgical-center)</p> <p>Physician fees payable under the Physician services section of this Schedule of Medical Benefits</p>	<p>All Outpatient Surgery performed in a Surgery center or outpatient Hospital setting require Pre-certification 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</p> <p>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:</p> <p>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</p> <p>Patient has a documented Illness, such as hemophilia or prior tissue or organ Transplant that requires a Hospital environment to monitor vital signs</p> <p>Patient has a documented mental or physical impairment that requires general Anesthesia in a Hospital setting for the safety of the patient</p> <p>No payment is extended toward the dentist or any assistant Dental Provider fees under this medical Plan</p>	80% PPO after Plan Year Deductible	50% U&C after Plan Year Deductible
<u>Prosthetics</u>	See the Benefit in this Schedule entitled "Corrective Appliance"		

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Physician and Other Health Care Practitioner Services</u> 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:</p> <ul style="list-style-type: none"> • 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 	<p>“Primary Care Physician (PCP)” means a Physician in family practice, internal medicine, obstetrics and gynecology and pediatrics</p> <p>“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. Many specialists are licensed or certified in their area of clinical specialty</p> <p>Carpal Tunnel Surgery and foot Surgery subject to Pre-certification. See the Utilization Management section for details</p> <p>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 Definitions section</p> <p>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 (as that term is defined by this Plan in the Definitions section) is payable as an assistant surgeon</p> <p>No coverage is provided for Prophylactic Surgery or Treatment as defined in the Definitions section and as explained in the Exclusions section, unless otherwise specified in this document. No coverage for Homeopathic treatments, supplies, remedies or substances</p>	<p>PCP Office Visit: 80% PPO after Plan Year Deductible</p> <p>Specialist Office Visit: 80% PPO after Plan Year Deductible</p> <p>All Other Services 80% PPO after Plan Year Deductible</p>	<p>PCP or specialist services Inpatient or Outpatient: 50% U&C after Plan Year Deductible</p>
<p><u>Radiology (X-Ray), Nuclear Medicine & Radiation Therapy Services (Outpatient)</u> Technical and professional fees associated with diagnostic and curative services, including radiation therapy</p> <p>Pre-Admission Testing</p>	<p>Covered only when ordered by a Physician or Health Care Practitioner</p> <p>Refer to the wellness/preventive section of this document for information regarding Benefits for screening radiology services and other preventive radiology testing</p> <p>Pre-Admission Testing: Radiology 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 for which admission or Surgery is planned</p>	<p>80% PPO after Plan Year Deductible</p>	<p>50% PPO after Plan Year Deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Reconstructive Services and Breast Reconstruction After Mastectomy</u> 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:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	<p>See the Exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions section</p> <p>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</p> <p>Prophylactic Surgery is covered under certain circumstances:</p> <ul style="list-style-type: none"> • Must be pre-certified by PEBP’s Utilization Management Company • Women diagnosed with breast cancer at 45 years of age or younger; <i>or</i> • 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; <i>or</i> • 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); <i>or</i> • Women who possess BRCA1 or BRCA2 mutations confirmed by molecular susceptibility testing for breast and/or ovarian cancer; <i>or</i> • Women who received radiation treatment to the chest between ages 10 and 30 years, such as for Hodgkin disease; <i>or</i> • Women with a first or second degree male relative with breast cancer; <i>or</i> • Women with a first or second degree relative with a BRCA1 or BRCA2 mutation; <i>or</i> • Women with multiple primary or bilateral breast cancers in a first or second degree blood relative; <i>or</i> • Women with multiple primary or bilateral breast cancers; <i>or</i> • 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. 	<p>80% PPO after Plan Year Deductible</p>	<p>50% U&C after Plan Year Deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Rehabilitation Services (Cardiac)</u> Cardiac Rehabilitation is available to those individuals who have had cardiac (heart) Surgery or a heart attack (myocardial infarction or M.I.)</p>	<p>Cardiac Rehabilitation programs must be ordered by a Physician</p> <p>See also the definition of Cardiac Rehabilitation in the Definitions section of this document</p>	80% PPO after Plan Year Deductible	50% U&C after Plan Year Deductible
<p><u>Rehabilitation Services (Physical, Occupational, and Speech Therapy)</u> Short term active, progressive rehabilitation services (occupational, physical, or Speech Therapy) performed by licensed or duly qualified Therapists as ordered by a Physician</p> <p>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.</p>	<p>Inpatient rehabilitation admission requires Pre-certification (see the Utilization Management section for details)</p> <p>Maintenance Rehabilitation and coma stimulation services are not covered (see specific Exclusions relating to Rehabilitation Therapies in the Exclusions section)</p> <p>Rehabilitation services are covered only when ordered by a Physician</p> <p>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. Speech Therapy for functional purposes (including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin)</p>	Inpatient or Outpatient: 80% PPO after Plan Year Deductible	Inpatient or Outpatient: 50% U&C after Plan Year Deductible
<p><u>Second Physician Opinion</u> Includes only one Office Visit per opinion</p>	<p>For your Second Opinion, you may choose any In-Network, Board-certified specialist who is not an associate of the attending Physician</p>	80% PPO after Plan Year Deductible	50% U&C after Plan Year Deductible

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Skilled Nursing Facility (SNF) and Subacute Care Facility</u></p>	<p>Admission to a Skilled Nursing Facility or Subacute Care Facility requires Pre-certification (see the Utilization Management section of this document)</p> <p>Services must be ordered by a Physician</p> <p>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</p>	<p>80% PPO after Plan Year Deductible</p>	<p>50% U&C after Plan Year Deductible</p>
<p><u>Transplants (Organ and Tissue):</u></p> <ul style="list-style-type: none"> • 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 the donor when the receiver is a Participant under this Plan. Coverage is provided for organ or tissue procurement and acquisition fees, including Surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his/her plan will pay first and Benefits under this Plan will be reduced by that payable under the donor's plan. 	<p>Transplantation-related services require Pre-certification (see the Utilization Management section of this document for details)</p> <p>See the specific Exclusions related to Experimental and Investigational Services and Transplants in the Exclusions section</p> <p>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</p> <p>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</p> <p>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 section titled "Organ and Tissue Transplants" 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</p> <p>PEBP does not provide advance payment for travel expenses related to organ or tissue Transplants</p>	<p>80% PPO after Plan Year Deductible</p>	<p>50% U&C after Plan Year Deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<u>Vision Screening Exam*</u>	<p>One Annual preventive vision screening exam including refractive error testing per Plan Year.</p> <p>Hardware such as but not limited to, contact lenses, lenses and frames are not covered</p> <p>*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</p> <p>*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</p>	<p>Participant responsibility: \$25 Copay at time of service. PEBP will reimburse Provider up to \$95 once each Plan Year</p> <p>No Deductible Excess of this schedule not payable under the Plan</p>	<p>Participant responsibility: \$25.00 Copay at time of service. PEBP will reimburse Provider up to \$95 once per Plan Year</p> <p>No Deductible Excess of this schedule not payable under the Plan</p>
<u>Wellness/Preventive Benefit</u> For Example:	<p>Wellness/Preventive Benefits are healthcare services that are not provided as a result of Illness, Injury, or congenital defect. Your Physician may recommend a service that is not listed. Please contact the third-party administrator listed in the Participant Contact Guide for coverage information or refer to the wellness/preventive section of this document</p> <p>Deductible does not apply to these wellness/preventive Benefits. Unless coverage is mandated by law, you are responsible for any expenses incurred that are not listed in this documents or do not meet the definition of wellness/preventive services</p> <p>*The first billed procedure of the Plan Year for a colonoscopy or analog (film) mammogram will be considered preventive regardless of the diagnosis. If a digital breast tomosynthesis (“DBT” or “3-D mammogram”) is performed instead, the Plan will make the same payment as if an analog (film) mammogram had been performed because DBT does not meet the definition of wellness/preventive service. The difference between the Plan’s payment and any Provider billed charges is your responsibility. In addition, your payment toward the difference will not apply toward Your Deductible</p>	<p>Wellness/ Preventive: 100% No Deductible</p>	<p>Not covered</p>
<ul style="list-style-type: none"> • Physical exam, screening lab and x-rays • Well Child Visits and services • HPV vaccination • Prostate screening • Routine sigmoidoscopy or colonoscopy* • Adult immunizations • Screening analog (film) mammogram* • Pelvic exam and Pap smear lab test • Osteoporosis screening • Hypertension screening • Skin Cancer screening 			

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Wellness/Preventive Benefit (cont'd)</u> For Example:</p> <ul style="list-style-type: none"> • Routine hearing exam • Weight Loss program, medically supervised • Stress management programs • Breastfeeding support • Prenatal obstetrical Office Visits <p><u>For more information about wellness/preventive services, please refer to the wellness/preventive section of this document or contact the Claims Administrator listed in the Participant contact guide section of this document.</u></p>	<p>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 Exclusions section of this document. Weight loss program Benefits are not payable if provided Out-of-Network</p> <p>Outpatient newborn, Well Child Visits and routine childhood immunizations (<i>e.g.</i> DPT, Polio, MMR, HIB, hepatitis, chicken pox, tetanus). See also, the Special Rule for Coverage of Newborn Dependent Children in the Eligibility section</p> <p>Prescription and over-the-counter tobacco/smoking 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 Wellness/Preventive section of this document</p>	<p>Wellness/ Preventive: 100% No Deductible</p>	<p>Not covered</p>

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 limitations and Exclusions of the Plan. 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), 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 (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 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 in order 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 this document). 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 located 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 located 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

At least once each year, the PPO networks will generate an updated Directory of Health Care Providers who are members of their network. You can obtain network provider information by calling the applicable PPO 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 (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 find out if a Health Care Provider is a member of your network by calling the applicable PPO network at the telephone number listed in the Participant Contact Guide section of this document 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.

In Network Pricing Tool

PEBP's Claims Administrator and Statewide PPO Network provides an online pricing tool on the Claims Administrator's website that allows Participants to search for certain medical services (such as Physician Office Visits, laboratory, some inpatient procedures and radiology) and determine the estimated cost to you. You can access the online pricing tool by way of the single sign-on available on the PEBP website by logging in the E-PEBP portal at www.pebp.state.nv.us or by going directly to the Claims Administrator's website at www.healthscopebenefits.com.

Utilization Management (UM)

What is the Utilization Management Program

The Plan is designed to provide you and your eligible family members 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 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 Utilization Management 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 your own pocket.

Purpose of the Utilization Management Program

The Plan's Utilization Management program is administered by an independent professional Utilization Management company operating under a contract with the Plan (hereafter referred to as the UM company). The name, address and telephone number of the UM company appears in the Participant Contact Guide section of this document. The health care professionals in the UM company focus their review on the necessity and appropriateness of Hospital stays and the 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.

Elements of the Utilization Management Program

The Plan's Utilization Management program consists of:

- Pre-certification review – the review of proposed health care services before the services are provided;
- Concurrent (continued stay) review - 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/Sub-Acute Facility;
- Case Management - a process whereby the patient, the patient's family, Physician and/or other Health Care Providers work together with PEBP under the guidance of the Plan's independent UM company to coordinate a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, Providers and practices.

Just because Your Physician recommends Surgery, hospitalization, confinement in a Skilled Nursing/Sub-Acute Facility, or Your Physician or other Health Care 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 medical Plan.

The Utilization Management program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan Benefits. The UM company's certification that a service is Medically Necessary does not mean a Benefit payment is guaranteed. Eligibility for and actual payment of Benefits are subject to the terms and conditions of the Plan

as described in this 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.

All treatment decisions rest with you and Your Physician or other Health Care Provider. You should follow whatever course of treatment you and Your Physician, or other Health Care Provider, believe to be the most appropriate, even if:

- the UM company does not certify 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/Sub-Acute Facility because the UM company does not certify a proposed confinement.

NOTE: Benefits payable by the Plan may be affected by the determination of the UM company.

PEBP, the Claims Administrator and the UM company are ***not*** engaged in the practice of medicine and do not take responsibility for the quality of health care services actually provided (even if they have been certified 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 certified by the UM company as Medically Necessary.

Pre-certification Review

Pre-certification 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 or not the admission and length of stay in a Hospital or Skilled Nursing/Sub-Acute Facility, Surgery or other health care services are Medically Necessary and if the location of service is high quality and lowest cost. If the UM company requires you to travel more than 50 miles one way for a pre-certified service, PEBP may reimburse travel at GSA rates in accordance with State of Nevada travel policies as outlined in the State of Nevada's State Administrative Manual (SAM). Please see the travel section outlining the process later in this document. When services are required to be pre-certified (see list below), they must be approved for Medical Necessity and location of service before they are provided. Failure to obtain Pre-certification ***may*** result in Your Benefits being reduced (see the Failure to Follow Required Utilization Management Procedures section).

What Services Must Be Pre-certified:

- All elective Inpatient Hospital admissions, including planned use of a Hospital for a Dental purpose. (Exception: a pregnant mother does not need to notify the UM 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, Partial, and Day Treatment 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
- 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 interphalangeal joint
- Carpal tunnel Surgery
- Gender Dysphoria – any services related to the diagnosis of or treatment of Gender Dysphoria
- Genetic testing and/ or counseling for:
 - amniocentesis,
 - non-invasive pre-natal testing for fetal aneuploidy,
 - chorionic villus sampling (CVS),
 - alpha-fetoprotein (AFP),
 - BRCA1 and BRCA2
 - apo E
- For other types of genetic testing and/ or counseling, contact PEBP's third party administrator listed in the Participant Contact Guide
- Weight-loss Surgery (see more Plan restrictions for this service in the section below)
- All spinal surgeries, inpatient or outpatient, to include but not limited to: laminotomy, discectomy, stereotaxis and neurostimulators
- Dialysis- Inpatient and Outpatient
- Cardiac pace makers
- Illnesses requiring chemotherapy
- Any procedure that might be deemed to be Experimental and/or Investigational. See the Definition Section for information regarding Experimental and/or Investigational procedures.
- Durable Medical Equipment when the cost is expected to exceed \$1,000

Pre-certification 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 or their covered Dependent;
- Serious jeopardy to the health of an unborn Child;
- Serious impairment of a bodily function; or
- Serious dysfunction of any bodily organ or part.

Even though a Pre-certification 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 Utilization Management, such as concurrent (continued stay) review.

How to Request Pre-certification

It is your responsibility to ensure that Pre-certification occurs when it is required by this Plan. Any penalty for failure to obtain Pre-certification is your responsibility, not the Health Care Provider's. You or Your Physician must call the UM company at the telephone number shown in the Participant Contact Guide section of this document or available on the PEBP website (www.pebp.state.nv.us).

Calls for elective services should be made at least 14 days before the expected date of service. The caller should be prepared to provide all of 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 Health Care Provider that will be providing services
- the reason for the health care services or supplies
- the proposed date for performing the services or providing the supplies.

If additional information is needed, the UM company will advise the caller. The UM company will review the information and provide a determination to you, Your Physician, the Hospital or other Health Care Provider, and the Claims Administrator as to whether or not the proposed health care services have been certified as Medically Necessary. While industry and accreditation standards require a Pre-certification determination within 15 calendar days for a non-urgent case, the UM company will usually respond to Your Physician or other Health Care Provider by telephone within 3 Business Days of receipt of the request and any required medical records and/or information. 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 (see the section regarding Appealing a UM Determination).

Elective Inpatient and Outpatient Surgeries: You are required to obtain a Pre-certification 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 the Allowable charges. This provision applies to both In-Network and Non-Network Surgery expenses. Expenses related to the penalty will not be counted to meet Your Plan Year Deductible or Out-of-Pocket Maximum.

Concurrent (Continued Stay) Review

When you are receiving medical services in a Hospital or other Inpatient Health Care facility, the UM company will monitor your stay by contacting Your Physician or other Health Care Providers to assure that continuation of medical services in the health care 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 Health Care 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 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 (see the section regarding Appealing a UM Determination).

Emergency Hospitalization: You are not required to obtain a Pre-certification 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 1 Business Day so that the UM company can conduct a concurrent (continued stay) 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 the Allowable charges. This provision applies to both In-Network and Non-Network medical expenses. Expenses related to the penalty will not be counted to meet Your Plan Year Deductible or Out-of-Pocket Maximum.

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, Health Care Providers, PEBP's Claims Administrator and PEBP to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly and/or high-technology services, or when assistance is needed to guide the patient through a maze of potential Health Care Providers (see the section titled Restrictions and Limitations of the Utilization Management Program).

The Case Manager of the UM company will work directly with Your Physician, Hospital and/or other Health Care Provider to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Health Care Providers as needed. From time to time, the Case Manager may confer with Your Physician or other Health Care 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 of this document or on the PEBP website (www.pebp.state.nv.us).

Weight Loss Surgeries- Plan Restrictions

Weight loss Surgeries must be performed at an In-Network (PPO) 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 PEBP CDHP (or previous PEBP PPO Plans) 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 PEBP CDHP Plan, provided that all Pre-certification criteria are met.

For lap band adjustments, the Plan will consider any adjustments made in the 12 months following Surgery as long as the Participant remains compliant with their post-surgical agreement as verified by PEBP's UM company. Any adjustments to the lap band after the first 12 months post-Surgery will be subject to Pre-certification by PEBP's Utilization Management vendor.

It is the responsibility of the PEBP Participant to ensure that their Providers and facilities chosen to provide these services are in network in order for Benefits to be paid. Participants can verify the network status of any Provider or facility by calling PEBP's third party administrator.

The PEBP 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; *and*
2. Consultation with a dietician or nutritionist; *and*
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; *and*
4. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to Surgery, supervised by an exercise Therapist or other qualified professional; *and*
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.

This Plan allows for the reimbursement of certain travel and hotel accommodation expenses for the patient and one additional individual person (Spouse/Domestic Partner, family member or friend) when associated with medical treatment for bariatric Surgery that is performed at a Center of Excellence. See the section regarding travel expenses for more information.

If a Participant has started any type of program to meet the pre-Surgery criteria outlined below with an Out-of-Network facility/ Provider, those services will NOT be considered to be a part of the Plan's mandatory Pre-certification requirements. In order for the Plan to consider your bariatric Surgery at the in network Benefit level; you will have to begin the Pre-certification 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.

Pre-certification/ Pre-Surgery Criteria for Weight-Loss Surgery

The Participant or their Physician must contact PEBP's UM company to begin the process toward surgical intervention for obesity. The initial contact will include:

- Notification to the Participant that the Pre-certification process begins with the initial contact to the UM company.
- Notification to the Participant that Pre-certification requests presented to PEBP's UM company before the clinical criteria listed below has been completed will be denied. A Pre-certification request may be reconsidered upon completion of the clinical criteria.
- Informing the Participant of the requirement to access and participate in a weight management and nutrition program.
- Documenting Participant completion of the associated assessments required to be considered for the procedure.
- Educating the Participant on how to access wellness/preventive services and how to proceed with meeting the clinical indications listed below.
- PEBP's UM company can advise Participants of Centers of Excellence in bariatric Surgery Providers in their geographic area.

Clinical Criteria for Weight Loss Surgeries

- Treatment indicated by ANY ONE of the following:
 - Patient has a BMI exceeding 40 kg/m².
 - Patient's BMI is greater than 35 kg/m² and two or more clinically serious conditions exist (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension (high blood pressure), cardiomyopathy, musculoskeletal dysfunction, joint replacement, GERD, hypertriglyceridemia or hypercholesteremia, back pain, urinary incontinence, renal failure, arthritis).
- Surgical intervention indicated because patient has met all of following criterion:
 - 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 6 months (without a gap) within the 12 month period prior to the scheduled surgical intervention in a Physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record at each Visit. The Physician-supervised nutrition and exercise program must meet all of 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. Note: A Physician's summary letter is not sufficient documentation. Documentation should include medical records of the Physician's concurrent assessment of the patient's progress throughout the course of the nutrition and exercise program. 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; *and*
 - 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); *and*
 - Nutrition and exercise program(s) must be for a cumulative total of 6 months or longer in duration and occur within the 12-month period prior to the scheduled surgical intervention.
 - Patient has lost 10% of their initial weight per documentation in the medical record received from their supervising weight loss Physician.

NOTE: The PEBP Participant will sign a contract of agreement to attend monthly support meetings for 1-year post Surgery (provided by Participating 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 to 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
- Inability to comply with nutritional requirements including life-long vitamin replacement

Ambulance (Air/ Flight Services)

All flight-based inter-facility patient transport services require Pre-certification from the Plan Administrator.

The Plan Administrator or its designee may discuss with the Physician and/or Hospital/facility the diagnosis and the need for inter-facility patient transport versus alternatives. Failure to obtain a Pre-certification number may, solely in the Plan Administrator's discretion, result in a reduction or denial of benefits for charges arising from or related to flight-based inter-facility patient transport. Non-compliance penalties imposed for failure to obtain Pre-certification will not be included as part of the Annual Out-of-Pocket Maximum.

The Plan Administrator retains the discretionary authority to limit benefit availability to alternative Providers of inter-facility patient transport if and when a Provider fails to comply with the terms of the Plan, or proposed charges exceed the Maximum Allowable Charge in accordance with the terms of the Plan.

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 Pre-certification through the Utilization Management (UM) company. The UM company will make a Pre-certification determination based on type of Surgery, covered benefits, Medical Necessity, Provider quality, cost, and location. If You choose to receive healthcare services from a non-Exclusive Provider/facility Your benefits will be limited to the Reference Based Pricing for the services as determined by the Plan Administrator. This provision applies to healthcare services received from both In-Network and Out-of-Network Providers. **For this section only You may be balanced billed for amounts exceeding the Referenced Based Price including Your Plan Year Maximum Out-of-Pocket.**

Failure to Follow Required Utilization Management Procedures

If you do not follow the required Pre-certification Review process described in this section, Benefits payable for the services you failed to Pre-certify 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.

NOTE: PEBP's Utilization Management (UM) Company must be notified of the Emergency Hospital admission within 1 Business Day so that the UM company can conduct a concurrent (continued stay) review. Your Physician or the Hospital should call the UM company to initiate the Concurrent Review. If you do not follow the required UM process in regards to Concurrent Review, benefits payable for the services may 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.

If you wish to appeal a decision made by the Utilization Management Company, please refer to the section called "Appealing a UM Determination" in the Self-Funded Claims Administration section of this document.

Travel expenses for Organ and/or Tissue Transplant and Obesity Surgery services

This Plan requires Participants to use a PPO Center of Excellence for organ and tissue Transplants and obesity Surgery. To locate a PPO Center of Excellence, please contact or have Your Physician contact PEBP's National PPO Network or Third Party Claims Administrator.

This Plan allows for the reimbursement of certain travel and hotel accommodation expenses for the patient and one additional individual (Spouse/Domestic Partner, family member or friend) when associated with medical treatment for organ and tissue Transplants or bariatric weight loss Surgery performed at a Center of Excellence. This Benefit is subject to certain conditions, as described below.

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

This Plan incorporates the travel expense reimbursement guidelines established in the Nevada State Administrative Manual (SAM) 0200 (with certain exclusions outlined below) as well as the guidelines adopted by the PEBP Board and outlined in the PEBP Board Duties, Policies and Procedures manual.

Travel expenses for Elective Inpatient and Outpatient Surgery services performed at Exclusive Hospital/Ambulatory Surgical Facility for CDHP members residing in Nevada

This Plan requires Participants who reside in Nevada to use Exclusive Hospitals/Ambulatory Surgical Facilities for certain non-emergent/elective Inpatient and Outpatient Surgeries as determined by PEBP's Utilization Management company.

This Plan allows for the reimbursement of certain travel and hotel accommodation expenses for the patient and one additional individual (Spouse/Domestic Partner, family member or friend) for certain elective (non-emergent) Inpatient and Outpatient Surgeries as determined by PEBP's UM company and only when surgery services are performed at Exclusive Hospitals/Ambulatory Surgery Facilities. This benefit is subject to certain conditions, including Pre-certification by PEBP's Utilization Management company.

PEBP has full authority to approve or deny all or part of your travel expenses. The denial of travel expenses cannot be appealed.

This Plan incorporates the travel expense reimbursement guidelines established in the Nevada State Administrative Manual (SAM) 0200 (with certain exclusions outlined below) as well as the guidelines adopted by the PEBP Board and outlined in the PEBP Board Duties, Policies and Procedures Manual.

In state travel (Nevada) – SAM 0212

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

Participants are required to use the least expensive method of transportation. Participants who use their personal vehicle to travel to a Center of Excellence or to an Exclusive Hospital/Ambulatory Surgical Facility will be compensated for miles to and from the Center of Excellence or Exclusive Hospital/Ambulatory Surgical Facility (based on an objective source such as Google Maps) at the standard mileage reimbursement rate for which a deduction is allowed for travel for federal income tax or the personal convenience mileage reimbursement rate depending on the circumstances and the cost of other methods of travel.

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> and the link "Per Diem Rates" for the most current rates.

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

The Board Duties, Policies and Procedures of PEBP outline when meals are eligible for reimbursement:

- 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.

- Dinner- must depart before 5:00 p.m. or return after 7:00 p.m.

The PEBP Board has adopted the following additional restrictions relating to travel associated with medical treatment for organ and tissue Transplants or bariatric weight loss Surgery performed at a Center of Excellence and non-emergent elective Surgeries performed at Exclusive Nevada Hospitals/Ambulatory Surgical Facilities:

- Travel expenses are covered only when the distance to the Center of Excellence or Exclusive Nevada Hospital/Ambulatory Surgical Facility 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 (non-emergent) Surgery performed at an Exclusive Nevada Hospital/Ambulatory Surgery Facility approved by PEBP's Utilization Management company (including pre-Surgery evaluations) and for one year after Surgery for follow-up Visits as required by the patient's surgeon.
- 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 PEBP or its designee will not be covered. Travel expenses related to an Inpatient or Outpatient Surgery that is not determined to be an Exclusive Hospital/Ambulatory Surgical Facility by PEBP's UM company will not be covered. There are no exceptions.
- Eligible travel expenses includes:
 - 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.).
 - 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
 - Vehicle insurance
 - Flight insurance
 - Cards, stationery, stamps
 - Clothing
 - Dry cleaning
 - Entertainment (cable televisions, books, magazines, movie rentals)
 - Flowers
 - Household products
 - Household utilities, including cell phone charges, 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
 - Travel expenses incurred on or after one year following Surgery are not eligible for reimbursement.
- Travel expenses are subject to the Annual Deductible and Coinsurance amount.
 - 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 make arrangements for 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's third party Claims Administrator 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.).

Gender Dysphoria

Benefits for individuals diagnosed with gender dysphoria are effective July 1, 2015. Only medical services rendered on or after July 1, 2015 are covered. If the transition from one sex to another was started prior to July 1, 2015, only services rendered after the effective date of this benefit would be covered.

This Plan provides certain Benefits to individuals who are seeking medical services for the treatment of Gender Dysphoria to include related mental health therapy, hormone therapy, prescription drug therapy and genital reconstruction Surgery under the condition that the Participant or their covered Dependent adheres to the requirements listed in this Plan document such as Pre-certification review and Case Management. Other mandatory requirements include a mental health evaluation and mental health treatment to confirm a diagnosis of gender disorder/dysphoria.

Pre-certification requirement

All services related to gender dysphoria (excluding mental health services) must be pre-certified by PEBP's Utilization Management Company to determine the appropriateness of care and medical necessity. The Pre-certification requirement applies to medical treatment related to hormone therapy, prescription drug therapy and genital reconstruction Surgery. If you do not follow the required Pre-certification review process described in the Utilization Management section of this document, Benefits payable for the services you failed to have pre-certified will be reduced by 50% of the Allowable charges. Please discuss this requirement with Your medical professionals prior to receiving any treatment for gender identity disorder. This provision applies to both In-Network and Non-Network medical expenses. Expenses related to the penalty will not be counted towards Your Annual Deductible or Annual Out-of-Pocket Maximum.

When reviewing services for appropriateness of care and medical necessity, the Utilization Management 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

Case Management services are mandatory for those who are seeking treatment of gender reassignment Surgery. PEBP requires Case Management to help the Participant, Providers and other PEBP vendors to work together for successful outcomes.

The Participant or their Physician must contact PEBP's UM company to begin the process toward surgical intervention of Gender Dysphoria. The initial contact will include:

- Notification to the Participant that the Pre-certification process begins with the initial contact to the UM company.
- Documenting that the Participant meets all criteria specified in the Mental Health Coverage and the Hormone Therapy Coverage sections below.
- PEBP's UM company can advise Participants of Providers who specialize in this type of treatment to include genital reconstruction.

This service is provided by the Utilization Management Company and will be initiated upon the first call for a Pre-certification. 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.

Limitations and Exclusions

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 previous PEBP PPO Plan. Contact PEBP's Utilization Management Company to discuss other procedures not listed in this section.

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: Please be advised that PEBP's Utilization Management Company has full authority to determine if a procedure is cosmetic.

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 disorder/dysphoria services

Mental Health Coverage

Mental Health services do NOT require Pre-certification.

Benefit coverage includes Transgender and associated co-morbid psychiatric diagnoses provided as any other outpatient Mental Health Service under the Plan.

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.

Hormone Therapy Coverage

Hormone therapy coverage requires Pre-certification 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 as described in the Prescription Drug Benefits section of this document.

Hormone therapy for individuals preparing for gender reassignment Surgery is Medically Necessary when all of 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 disorder/dysphoria (usually a minimum of three months).

Gender Reassignment Surgery to include other preparatory procedures

- Gender reassignment Surgery must be pre-certificated 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.
- This Plan provides Benefits for gender reassignment Surgery referred to also as genital reconstruction.
- This Plan limits an individual to one gender reassignment Surgery in an individual's lifetime while covered under the PEBP CDHP. In other words, if an individual previously had Surgery to change from female to male and PEBP paid for the procedure and later while still covered under the PEBP CDHP, requests to change back from male to female, PEBP would not pay for the second procedure.
- In preparation for genital reconstruction, other procedures are also covered such as total hysterectomies and orchiectomies.
- To determine which procedure may or may not be covered, the Participant or their covered Dependent should consult with their Case Management Nurse who works for PEBP's Utilization Management Company.

Living Wills

A living will, also called an advance directive, is a written legal document that allows a patient to give clear instructions about their medical treatment if the patient is terminally ill or permanently unconscious. A living will (advance directive) extends the principle of consent, whereby a patient must agree to any medical intervention before doctors can proceed. It allows the patient to guide his/her own health care for the future when he/she may be too ill to make decisions concerning care. It may be revoked by the patient at any time. For many, the living will preserves personal control and eases the decision-making burden of family members.

The Nevada Secretary of State through NRS 449.925; provides information regarding how to register an advance directive through their office. Please refer to the Participant Contact Guide for more information.

Disease Management

Diabetes Care Management

The Diabetes Care Management (DCM) program is a disease management program open to all primary CDHP self-funded Participants, their covered Spouses or Domestic Partners and their covered Dependent Children diagnosed with diabetes.

The DCM program is voluntary and considered an “opt-in” program. To join the DCM program contact the third-party administrator listed in the Participant Contact Guide section of this document. Your effective date will be determined by PEBP and the third party administrator, but generally, will occur on the 1st day of the month following the completion of Your enrollment with the third party administrator.

The information described in this section provides a summary of the program’s functions. For more detailed information, please contact PEBP’s third party administrator. Contact information for PEBP’s third party administrator is located in the Participant Contact Guide section of this document.

Primary Participants and their covered Spouses or Domestic Partners and Dependents will be required to adhere to the following requirements:

- Submit a completed DCM form signed by both the DCM member and their healthcare provider on or before June 30, 2018. Completed forms must be mailed (postmarked on or before June 30, 2018) or faxed on or before June 30, 2018 to the third party administrator located in the Participant Contact Guide.
- At least 2 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 PEBP’s third party administrator.
- Adherence to appropriate laboratory testing as prescribed by their Physician.

Participants, their covered Spouses or Domestic Partners and their covered Dependent Children 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 Copayment 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 Copayment.
- Copayments made under this benefit will not apply to the Deductible but will apply Annual Out-of-Pocket Maximum.

If, at any time, PEBP's third party administrator deems a Participant, covered Spouse, covered Domestic Partner or covered Dependent Child(ren) to be non-compliant or no longer engaged, the Participant, any covered Spouse or covered Domestic Partner and any covered Dependent Child(ren) will return to the standard CDHP/PPO Benefits where the Annual Deductible and Coinsurance will apply to the medical services listed in this section of the MPD. The effective date of the return to the standard CDHP/PPO Benefits will be the first day of the month following the non-compliance notification from PEBP's third party administrator.

Plan Year 2018 Schedule of Benefits for Diabetes Care Management Program

This chart explains the benefits payable by the wellness benefit of the Self-funded Plan while engaged in Care Management.

All benefits are subject to the Deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network
Routine Office Visits and routine laboratory testing	<ul style="list-style-type: none"> • 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 	<p>100% of PPO contracted rate. No Deductible.</p> <p>Limit of two Visits per year.</p>	<p>Not covered under wellness/preventive.</p> <p>Subject to 50% Coinsurance and Annual Deductible.</p>
Diabetic Supplies Mail Order Benefit	<ul style="list-style-type: none"> • This is a preferred mail order service for diabetic supplies for Participants. To enroll in this Benefit, contact the diabetes mail order Benefit program whose name and phone number is listed in the Participant Contact Guide section of this document • You may receive up to a 90-day supply (with the exception of the blood glucose monitor) of each eligible diabetic supply item • Diabetic supplies must be coordinated through the Pharmacy Benefit Manager's mail order service to receive the Benefit • Diabetic supplies not coordinated through the preferred mail order service will be subject to normal Plan Benefits e.g. Deductible and Coinsurance • Must be actively engaged in the Diabetes Care Management program 	<p>\$50 Copay applies to <u>each</u> 90-day diabetic supply item. If the actual cost is less than \$50, you will pay the actual cost</p> <p>There is no cost to you for one blood glucose monitor per Plan Year</p> <p>Once enrolled, you are able to receive up to a 90-day supply of the following items: test strips, insulin syringes, alcohol pads, and lancets.</p>	<p>Not covered</p>

Plan Year 2018 Schedule of Benefits for Diabetes Care Management Program

This chart explains the benefits payable by the wellness benefit of the Self-funded Plan while engaged in Care Management.

All benefits are subject to the Deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network
<p>Diabetes related medications such as insulin and Metformin</p>	<p>Diabetes related medications will be identified by PEBP's Prescription Drug Administrator.</p> <p>Other Limitations</p> <ul style="list-style-type: none"> • Copayments for diabetes related drugs are not applied to meet the medical and Prescription Drug Deductible but are applied to the Out-of-Pocket Maximum • This Plan does not coordinate Prescription Drug plan Benefits • Must be actively engaged in the Diabetes Care Management program • Copayment at 90 day supply retail: Subject to three times the listed 30 day retail Copayment <p>Specialty Medications: Specialty Medications are not covered under this program and are subject to the Annual Deductible and Out-of-Pocket Maximums described in the Summary of Self-Funded Components section of this document. For more information about specialty medications, please contact the Prescription Drug Plan Administrator listed in the Participant Contact Guide.</p>	<p>In-Network Retail: 30 or 90 day supply only</p> <ul style="list-style-type: none"> • Tier 1 Generic: \$5 Copay • Tier 2 Preferred Brand: \$25 Copay • Tier 3 Non Preferred Brand: 100% Copay* <p>Mail Order Services 30 or 90 day supply only</p> <ul style="list-style-type: none"> • Tier 1 Generic: \$15 Copay • Tier 2 Preferred Brand: \$75 Copay • Tier 3 Non Preferred Brand: 100% Copay* <p>*Tier 3 Non-preferred name brand drugs: Participant is responsible for 100% of the Preferred Contract Rate. Deductible credit is not applied.</p>	<p>Not covered</p>

Obesity and Overweight Care Management

The Obesity and Overweight Care Management program is open to all primary CDHP Participants, their covered Spouses or Domestic Partners and their covered Dependent Children who have been diagnosed as obese or overweight by their Physician.

For enrollment information, please contact PEBP's third party administrator listed in this document under the Participant Contact Guide. When you enroll in the program, your effective date will typically be the 1st of the month following your enrollment in the program. The effective date will be determined by PEBP.

The information described in this section provides a summary of the program's functions. For more detailed information, please contact PEBP's third party administrator. Contact information for PEBP's third party administrator is located in the Participant Contact Guide section of this document.

The Obesity and Overweight Care Management program is optional and considered an "opt-in" program. To be eligible for the enhanced wellness Benefits, Participants and/or their covered Dependents must meet certain criteria and adhere to certain participation requirements.

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

PEBP's third party administrator 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:
 - A. Services must be provided by:
 - An In-Network provider who specializes in weight loss services according to PEBP'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 American Board of Bariatric Medicine (ABBM); or
 - If no Provider as described above is available within 50 miles of a Participant's residence, any In-Network Provider.
 - B. The patient's BMI must be greater than 30 kg/m², with or without any co-morbid conditions present, or greater than 25 kg/m² (or waist circumference greater than 35 inches in women, 40 inches in men) if one or more of the following co-morbid conditions are present:
 - Coronary artery disease;

- Diabetes mellitus type 2;
 - Hypertension (Systolic Blood Pressure greater than or equal to 140 mm Hg or Diastolic Blood Pressure greater than or equal to 90 mm Hg on more than one occasion)
 - Obesity-hypoventilation syndrome
 - Obstructive sleep apnea;
 - Cholesterol and fat levels measured (Dyslipidemia):
 - a. HDL cholesterol less than 35 mg/dL ; *or*
 - b. LDL cholesterol greater than or equal to 160 mg/dL; *or*
 - c. Serum triglyceride levels greater than or equal to 400 mg/dL.
- For Children 2 to 18 years
- Services must be provided by an In-Network Provider who specializes in childhood obesity;
 - Child must present a BMI \geq 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. Actively engaged is defined as:

1. Participation in regular Office Visits with your weight loss medical Provider. The frequency of the Office Visits will be determined by your weight loss medical Provider who will in turn report this information to PEBP’s third party administrator for monitoring.
2. Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss medical 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 PEBP’s third party administrator who will review monthly progress reports submitted by the Provider.
3. Losing weight at a rate determined by the weight loss medical Provider.

Monitoring Engagement

PEBP’s third party administrator will assist your weight loss medical 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 PEBP’s third party administrator, your Benefits under this program will end and your coverage will return to the standard CDHP/PPO Benefits where the Annual Deductible, Coinsurance and other plan limitations will apply. The effective date of the return to the standard PPO Benefits will be the first day of the month following the non-compliance notification received from PEBP’s third party administrator.

How to Enroll in the Obesity and Overweight Care Management Program

- Step 1:** Contact PEBP's third party administrator for a list of participating weight loss Providers. This information is located on the third party administrator's website by logging into the E-PEBP Portal.
- Step 2:** Make an appointment with a participating weight loss Provider. You may consider the physical location of the Provider when considering which Provider may work best with you. PEBP's third party administrator can also help you identify which Participating Provider may best meet your needs, based on geography or other specialized needs you may have.
- Step 3:** When you make an appointment with your participating weight loss Provider, before you go, be sure to take an Obesity and Overweight Care Management Program enrollment form with you. This form is located on the third party administrators' website under forms.
- Step 4:** Have your participating weight loss Provider complete the enrollment form and submit (by mail or fax) the completed form to PEBP's third party administrator. Their name, address and fax number are provided on the enrollment form.
- Step 5:** PEBP's third party administrator will review the information submitted by your Provider and if the information indicates that you meet the criteria for the weight loss program Benefits, PEBP's third party administrator will enroll you in the program. The third party administrator will notify PEBP and PEBP's Pharmacy Benefits Manager of your enrollment. If you do not meet the criteria for weight loss Benefits, PEBP's third party administrator will notify you of the denial of Benefits.
- Step 6:** Engagement in the program.

NOTE: Once you have met your final weight loss goal as determined by your weight loss Provider in a medically supervised weight loss program, Benefits under the Obesity and Overweight Care Management program will end. This Plan does not provide Benefits for ongoing Maintenance Care. If you choose to receive ongoing Maintenance Care, you will be responsible for the cost of receiving services.

Plan Year 2018 Schedule of Benefits for Obesity and Overweight Care Management Program

This chart explains the Benefits payable by the wellness Benefit of the Self-funded Plan while engaged in Care Management.

All Benefits are subject to the Deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network
<p>Certain obesity medications</p> <p>To find out if a certain medication is covered under this benefit, please contact PEBP's Prescription Drug Plan Administrator listed in the Plan Contacts section of this document.</p>	<p>Medications related to the treatment of overweight or obesity will be identified by PEBP's Prescription Drug Plan Administrator. Before you begin your medication weight loss treatment, please contact PEBP's Prescription Drug Plan Administrator to make sure the medication your Provider has prescribed is covered under the current Formulary.</p> <p>Other Limitations</p> <ul style="list-style-type: none"> • Copayments for obesity related drugs are not applied to the medical and Prescription Drug Annual Deductible or Out-of-Pocket Maximum. • 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. 	<p>In-Network Retail:</p> <ul style="list-style-type: none"> • Tier 1 Generic: \$5 Copay • Tier 2 Preferred Brand: \$25 Copay • Tier 3 Non Preferred Brand: 100% Copay* <p>Mail Order Services:</p> <ul style="list-style-type: none"> • Tier 1 Generic: \$15 Copay • Tier 2 Preferred Brand: \$75 Copay* • Tier 3 Non Preferred Brand: 100% Copay* <p>*Tier 3 Non-preferred name brand drugs: Participant Responsibility: 100% of the Preferred Contract Rate. Deductible credit and out of pocket maximum credit is not applied</p>	<p>Not covered</p>

Plan Year 2018 Schedule of Benefits for Obesity and Overweight Care Management Program

This chart explains the Benefits payable by the wellness Benefit of the Self-funded Plan while engaged in Care Management.

All Benefits are subject to the Deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network
Office Visits	<p>Office Visits must be provided by:</p> <ul style="list-style-type: none"> • An In-Network Provider who specializes in weight loss services according to PEBP’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 	100% of PPO contracted rate under the wellness/preventive benefit.	<p>Not covered under wellness/ preventive benefit.</p> <p>Subject to 50% Coinsurance, Annual Out-of- Network Deductible and Out-of- Pocket Maximum. U&C Allowable applies.</p>
Laboratory test	<p>Laboratory test must be provided by an In-Network Provider</p> <p>Participant and/or cover Dependent must meet criteria stated in the Obesity and Overweight Care Management section of this document</p> <p>Participant and/or cover Dependent must be actively engaged in the Obesity and Overweight Care Management Program</p> <p>Participant and/or cover Dependent must remain actively engaged in a medically supervised weight loss program to receive this Benefit</p> <p>Please refer to the Obesity and Overweight Care Management section of this document for more information about this program</p>		
Nutritional counseling services	The frequency of nutritional counseling services will be determined by PEBP’s third party administrator and will be based on medical necessity		

Plan Year 2018 Schedule of Benefits for Obesity and Overweight Care Management Program

This chart explains the Benefits payable by the wellness Benefit of the Self-funded Plan while engaged in Care Management.

All Benefits are subject to the Deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network
Meal replacement therapy	<p>Benefit is for individuals who are diagnosed as morbidly obese only</p> <ul style="list-style-type: none"> • 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, NutriSystem, Atkins or other similar prepared meals or meal replacements. • Meal replacement costs do not apply to the Annual Deductible or Out-of-Pocket Maximum. <p>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</p> <p>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</p>	50% of the cost to the Participant, up to a maximum Benefit of \$50 per month.	Not covered.
Gym membership	Gym membership is not included in this Benefit	Not Covered	Not Covered
Exercise equipment	Exercise equipment is not included in this Benefit	Not Covered	Not Covered
Bariatric weight loss Surgery	Bariatric weight loss Surgery is not included in this Benefit	Not Covered	Not Covered

Wellness/Preventive Services

The safest and most effective way to treat an illness is to prevent it from happening. An important PEBP Self-funded Consumer Driven Health Plan (CDHP) Benefit is coverage of wellness/preventive services and lifestyle education in order to aid Participants in working with their Physicians to maintain good health. PEBP has made several tools available to Participants for customizing their care and providing opportunities to achieve goals and success in healthcare.

As the average Participant age increases, wellness/preventive screening tests such as colonoscopies, hearing tests, skin cancer examinations, and hypertension evaluation should be considered as part of your preventive medicine schedule. Participants should consult with their Physicians to determine their individual screening needs.

The Plan covers Benefits mandated through the Affordable Care Act legislation for Preventive Care such as immunizations, screenings, and other services that are listed as 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).

See www.uspreventiveservicestaskforce.org or www.healthcare.gov/preventive-care-benefits/ for more details.

Important Note: The Preventive Care services identified through these links are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered.

Preventive and Wellness Services for Adults and Children – In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive and Wellness Services can be found at:
www.healthcare.gov/preventive-care-benefits/.

Women's Preventive Services – With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

- a. Well-woman visits;
- b. Gestational diabetes screening;

- c. HPV DNA testing;
- d. Sexually transmitted infection counseling;
- e. HIV screening and counseling;
- f. FDA-approved contraception methods and contraceptive counseling;
- g. Breastfeeding support, supplies and counseling; and
- h. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at:

<https://www.hrsa.gov/index.html> or at www.healthcare.gov/preventive-care-benefits/.

NOTE: Participants should consult with the third party administrator (TPA) listed in the Participant Contact Guide to learn if a particular screening test, wellness/preventive evaluation or lifestyle education course is covered. For information about breastfeeding support and supplies, including breast pumps, please contact the customer service number on the back of the member ID card.

Unless otherwise noted, wellness/preventive Benefits are only available when participating PPO Providers such as Physicians, pharmacies, radiologist and laboratories are used.

- Typically, wellness/preventive screening Benefits are for well care only, meaning that any Office Visit, test or procedure done that is related to a known or present medical condition may be considered as a regular medical claim and processed accordingly with Deductible and Coinsurance.
- Your Physician or other healthcare Provider must submit a wellness/preventive screening diagnosis code as the primary diagnosis for the claim to be considered a wellness/preventive medical service.
- If Your healthcare Provider does not submit the claim to the TPA with a wellness/preventive diagnosis as the primary reason for the Visit or medical service, the claim may be processed under the Annual Deductible and Coinsurance.

Preventive Drug Benefit Program

Wellness and good health depend on taking and finishing your preventive medications prescribed to you by Your Physician. The Preventive Drug benefit program provides Plan Participants access to certain preventive medications 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 maximum Out-of-Pocket costs. The medications covered under this Benefit include categories of Prescription Drugs that are used for preventive purposes for conditions such as hypertension, asthma, or high cholesterol. A list of eligible preventive drugs covered under this Benefit can be found by visiting www.pebp.state.nv.us or by contacting the Pharmacy Benefit Manager located in the Participant Contact Guide Section of this document.

Many vaccines may also be administered through the Prescription Drug Benefit with certain pharmacies. Contact the Prescription Drug Plan Administrator listed in the Participant Contact Guide of this document and ask for a list of participating pharmacies to include the types of immunizations they administer or contact your local Pharmacy for immunization information.

For more information regarding wellness/preventive care recommendations and immunizations for you and your family, please visit www.vaccines.gov.

Tobacco/ Smoking Cessation

Tobacco/smoking cessation products are covered under the Prescription Drug program.

- You may obtain over-the-counter 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); submit the form, written prescription and your receipt to the Pharmacy Benefits Manager whose name and address is located in the Participant Contact Guide Section of this document. 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.

NOTE: PEBP does not pay Benefits for the use of electronic cigarettes.

Health Savings Accounts for CDHP Participants

Active Employees Only

This section of PEBP's Master Plan Document provides summary information only. For more detailed information regarding this important Benefit, see Internal Revenue Service (IRS) Publications 502 and 969 or contact PEBP's Claims Administrator listed in the Participant Contact Guide located in the front of this document.

The PEBP Health Savings Account (HSA) provides a mechanism that allows Employees to set aside and spend pre-tax dollars on qualified medical expenses in accordance with applicable Internal Revenue Service (IRS) provisions.

The PEBP Consumer Driven Health Plan (CDHP) is an "HSA-friendly" health plan, which means that it complies with federal requirements regarding Deductibles, Out-of-Pocket Maximums, and certain other features. Because the CDHP meets these requirements, active Employees in the CDHP are eligible to establish and contribute to an HSA while covered under the CDHP (subject to certain limitations described below). Retirees and HMO Participants are not eligible to establish or contribute to an HSA.

PEBP contributions will be placed in the Employee's HSA each Plan Year. Employees may also fund their HSA through voluntary pre-tax payroll deductions. Funds in the HSA may be used to pay for any qualified medical expense as defined by the IRS (see IRS Publications 502 & 969), including payment of Deductibles, Coinsurance, dental costs or vision costs incurred by the Participant, the Participant's Spouse or any other Dependent claimed on the Participant's annual tax return. 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 PEBP provides coverage for the Dependent. 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.

Distributions from the HSA are tax-free when used for the reimbursement of qualified medical expenses. Use of HSA funds for other than qualified medical expenses can result in taxes and penalties being imposed by the IRS.

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.

(See next page for HSA contribution table)

CDHP HSA Contributions – State and Non-State Employees			
State and Non-State Employees	Base Contribution	Preventive Program Contribution*	Total Base and Preventive Program Contribution
Participant Only	\$700	\$200	\$900
Dependents	\$200 per Dependent, maximum 3 Dependents	Not Applicable	\$200 per Dependent, maximum 3 Dependents

*The Preventive Program contribution only applies to primary Participants covered under the CDHP on July 1, 2017. Preventive Program contribution is contingent upon the primary Participant completing a series of wellness activities during the Plan Year (July 1, 2017 – June 30, 2018). Participants must receive a Dental exam, Dental cleaning, one physical exam with their primary care Provider and have one blood draw for the purposes of wellness and screening. The standard Plan exclusions regarding lab draw stations applies. Participants will not be awarded the \$200 Preventive Program contribution until the third-party administrator confirms all required activities have been completed.

New hires effective August 1, 2017 and later receive a pro-rated base contribution (Participant and Dependents) based on their CDHP coverage effective date.

Calendar Year 2017 HSA Contribution Limits	
Individual	Family (two or more HSA eligible family members)
\$3,400	\$6,750
<p>The total contributions (combined Employee/Employer) cannot exceed the 2017 calendar year limit.</p> <p>Family maximum is based on an Employee's family status as reported to the IRS. To contribute the family maximum, the Employee and at least one Dependent claimed who is also claimed as a federal tax return must be eligible for the HSA. 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 \$6,750.</p> <p>Employees age 55 years and older at the end of the tax year may contribute an additional \$1,000 to the HSA.</p>	

In order to contribute more than the IRS individual HSA maximum amount up to the family maximum, the Employee and at least one other Dependent must be covered under a High Deductible Health Plan and not covered under any of the items listed under the Note below.

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). There is no maximum

balance. 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 with the State or other entity covered by PEBP.

Unlike the Flexible Spending Account, Employees cannot be reimbursed from funds that have not yet been added to the HSA. Any reimbursement from the HSA will be the lesser of the available HSA balance or the claim amount paid to the Provider.

PEBP has selected Healthcare Bank as the single 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.

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
- 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) in order to receive PEBP contributions as described below. PEBP's third-party administrator reserves the right to verify Medicare eligibility with the Centers for Medicare and Medicaid Services (CMS).

Health Reimbursement Arrangement for CDHP Participants

Active Employees and Retirees

This section of PEBP's Master Plan Document provides summary information only. For more detailed information regarding this important Benefit, see Internal Revenue Service (IRS) Publication 502 or contact PEBP's Claims Administrator listed in the Participant Contact Guide located in the front of this document.

For Participants who are on the PEBP CDHP and who are not eligible for an HSA, or who fail to establish an HSA, a CDHP Health Reimbursement Arrangement (HRA) account will be established in the Participant's name. CDHP HRAs are not available for PEBP's 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, Dental costs or vision costs.

The CDHP's HRA may only be used to pay or reimburse qualified Out-of-Pocket medical 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 2018 will be available for use at the beginning of the Plan Year on July 1, 2017 (subject to certain limitations). Participants and Dependents who become eligible for PEBP coverage after July 1, 2017 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. However, in future years, PEBP may establish a limit on the balance that can be rolled over from one year to the next.

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 back 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 as long as 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.

Timely Filing of HRA Claims

In accordance with NAC 287.610, all claim requests must be submitted to the third party 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.

HRA Contributions

For Eligible State Retirees, State Active Employees and Non-State Active Employees Enrolled in the CDHP			
State and Non-State Retiree/Employee	Base Contribution	Preventive Program Contribution*	Total Base and Preventive Program Contribution
Participant Only	\$700	\$200	\$900
Dependent	\$200 per Dependent, maximum 3 Dependents	Not Applicable	\$200 per Dependent, maximum 3 Dependents

*The Preventive Program contribution only applies to primary Participants covered under the CDHP on July 1, 2017. Preventive Program contribution is contingent upon primary Participant completing a series of wellness activities during the Plan Year (July 1, 2017 – June 30, 2018). Participants must receive a dental exam, dental cleaning, one physical exam with their primary care provider, and one blood draw for the purposes of wellness and screening. (The standard Plan exclusions regarding lab draw stations applies.) Participants will not be awarded the \$200 Preventive Program contribution until the third-party administrator confirms all required activities have been completed.

New hires effective August 1, 2017 and later receive a pro-rated base contribution (Participant and Dependents) based on their CDHP coverage effective date.

Medical Exclusions

The following is a list of services and supplies or expenses not covered by the Medical CDHP Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these Exclusions and terms of the Plan, and determines eligibility and entitlement to Plan Benefits. General Exclusions are listed first followed by specific medically related Plan exclusion(s).

General Exclusions

(Applicable to all medical services and supplies)

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

Complications of a non-covered service: Expenses for care, services or treatment required as a result 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 in order to have access to the medical services provided by the concierge medical practice.

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

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 of this document.

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 Definitions section of this document).

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 tortuous or wrongful act of that third party (see the provisions relating to Third Party Liability in the Subrogation section in this document 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 medical program or after the date the patient's coverage ends, except under those conditions described in the COBRA section of this document.

Experimental and/or Investigational Services: Unless mandated by law, expenses for any medical services, supplies, drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational services as defined in the Definitions section of this document.

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.

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.

Illegal Act: Expenses incurred by any Covered Individual for injuries resulting from commission (or attempted commission by the Covered Individual) of an illegal act the Plan Administrator determines involved violence or the threat of violence to another person, or in which any weapon or explosive is used by the Covered Individual. 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 PEBP Provider network.

Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary, as defined in the Definitions section of this document.

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required as a result 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-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care 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 PEBP's Utilization Management 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 in the course of employment if the Injury, Illness or condition is subject to coverage, in whole or in part, under any Workers' Compensation, or occupational disease (or similar) law.

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

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.

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.

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

Telephone Calls: Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management vendor; or any representative of the Plan for any purpose whatsoever.

War or Similar Event: Expenses incurred as a result of an Injury or Illness due to You or your covered Dependents participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Additional Exclusions and Plan Limitations

Alternative/Complementary Health Care Services 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.

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/art therapy, developmental disabilities; dyslexia, gambling addiction, 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**.

Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions

- Expenses for any items that are not Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment (as each of those terms is defined in the Definitions section of this document), 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.
- Orthopedic shoes and foot Orthotics are not a covered Benefit unless the foot Orthotic is permanently attached to a brace.
- Expenses for replacement of lost, missing, or stolen, duplicate or personalized Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.
- Expenses for Corrective Appliances and Durable Medical Equipment to the extent they exceed the cost of standard models of such Appliances or equipment.
- Expenses for occupational therapy (Orthotic) supplies and devices needed to assist a person in performing Activities of Daily Living, including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing.

- Expenses for Nondurable Supplies, except as payable under Nondurable Supplies in the Schedule of Medical Benefits.

Cosmetic Services Exclusions

Expenses related to Surgery or medical treatment to improve or preserve physical appearance, but not physical function, and complications thereof. 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. To determine the extent of this coverage, see Reconstructive Services in the Schedule of Medical Benefits. Participants should use the Plan's Pre-certification procedure to determine if a proposed Surgery or service will be considered Cosmetic Surgery or Medically Necessary reconstructive services.

Custodial Care Exclusions

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

Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are not considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are not covered, even if they are Medically Necessary.

Dental Services Exclusions

- 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 period will be considered under the Dental Benefits described in the PEBP Self-Funded Dental PPO Plan Master Plan Document.
- 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 Exclusions

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been Prescribed for a Medically Necessary Indication as defined in the Definitions section of this document; or are Experimental and/or Investigational (as defined in the Definitions section of this document).
- 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 Definitions section of this document) unless noted as payable in the Schedule of Medical Benefits.
- Medical Foods (as defined in the Definitions section of this document), 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 anorexiant (phentermine, Xenical), except those anorexiant 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 Wellness/Preventive 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 Wellness/Preventive 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 Exclusions

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

Fertility and Infertility Services Exclusions

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 Exclusions

- 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 pre-certified).
- 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 is payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

Genetic Testing and Counseling Exclusions

- Genetic Testing: 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 alphafetoprotein (AFP) analysis in pregnant women.
- Participants should contact the Plan's Utilization Management vendor or Third Party 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 wellness/preventive section of this document.

Hair Exclusions

- 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 Exclusions

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

Home Health Care Exclusions

- 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.

Maternity/Family Planning Exclusions

- 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 cryostorage of umbilical cord blood or other tissue or organs.
- For Nondurable Supplies.

Prophylactic Surgery or Treatment Exclusions

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 Definitions section of this document), when the services, procedures, Prescription of Drugs, or Prophylactic Surgery is prescribed or performed for the purpose of:

- 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 Utilization Management 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 PEBP's Utilization Management vendor or PEBP's third party Claims Administrator.

Provider Error and Negligence Exclusions

- Error: That are required to treat Injuries that are sustained or an Illness that is contracted, including infections and complications, while the Participant was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense;
- Negligence: For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

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 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.

Smoking Cessation or Tobacco Withdrawal Exclusions

- 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 Wellness/Preventive section of this document.

Transplant (Organ and Tissue) Exclusions

- 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 Transplantation 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 Exclusions

Any vision care services in excess of the Vision care Benefit maximums. Vision therapy (orthoptics) unless prior approved by PEBP or PEBP's third party Claims Administrator, elective corrective eye surgeries (such as lasik Surgery), materials and supplies.

Weight Management and Physical Fitness Exclusions

- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs and Prescription Drugs, except those services payable under the Wellness (Prevention) section of the Schedule of Medical benefits. Surgery for weight reduction is payable only if pre-certified 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 Pre-certification Review process for weight reduction Surgery, Benefits payable for the services you failed to pre-certify 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, NutriSystems, 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.

Prescription Drug Benefits

Eligible Benefits

Benefits for Prescription Drugs are provided through the Prescription Drug Plan. 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 Health Care Practitioner.

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

- Prenatal & pediatric Prescription vitamins;
- Prescription female oral contraceptives;
- Insulin, and insulin injecting devices;;
- Diabetic supplies;
- Influenza and Pneumonia vaccines;
- HPV vaccine;
- Herpes Zoster vaccine;
- 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 Female Contraception section of the Explanation of Medical Benefits for more information or call the Prescription Drug Plan Administrator, whose contact information is in the Participant Contact Guide.

The Plan provides coverage for Plan 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.

Prescription Drug Deductible

Unless otherwise noted in this document, each Plan Year You are responsible for paying all of Your eligible medical and Prescription Drug expenses until You satisfy the Plan Year Deductible. Eligible medical and Prescription Drug expenses are applied to the Plan Year Deductible in the order received by the Claims Administrator or the Prescription Drug Plan Administrator. Deductibles under this Plan are accumulated on a Plan Year basis. Only eligible medical and Prescription Drug expenses can be used to satisfy the Plan Deductible requirements.

Some OTC drugs and some Prescription Drugs are eligible to be covered under the Plan's wellness/preventive 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
- Female oral contraceptives

The Plan also offers a number of generic and preferred-brand preventive medications where the Deductible is waived and only a Coinsurance applies. Examples of preventive medication categories are shown below and include both prescriptions and OTC medications.

- Blood pressure lowering medications
- Cholesterol lowering medications
- Agents to prevent osteoporosis
- Asthma medications
- COPD medications

Visit the PEBP website at www.pebp.state.nv.us or [log on to express-scripts.com](http://log.on.to/express-scripts.com) to see a [list of common preventive medications 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 in order for the medication to qualify as preventive under the Plan.

For more information on the Plan's Deductible, refer to the CDHP Plan Overview section of this document.

PEBP's Prescription Drug Plan Administrator 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 menu option displays clinically equivalent lower cost options along with any applicable coverage alerts (such as "prior authorization required"). See the Participant Contact Guide section of this document or go to the PEBP website at www.pebp.state.nv.us.

Prescription Retail Drugs

30-Day at Retail Program

To obtain a 30-day supply of medications, 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" menu option.

90-Day Retail Program

Through the 90-day retail program You can receive a 90-day supply of Your long-term maintenance prescription medications at select retail pharmacies. Maintenance medications 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).

Preventive Drug Benefit Program

Wellness and good health depend on taking and finishing your preventive medications prescribed to You by Your Physician. The Preventive Drug benefit program provides Plan Participants access to certain preventive medications 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 the Pharmacy Benefit Manager located in the Participant Contact Guide Section of this document.

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 of this document and ask for a list of participating pharmacies to include the types of immunizations they administer or contact your local Pharmacy for immunization information.

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 medications and have them mailed directly to You with free standard shipping. Not all medicines are available via mail order. Check with the Prescription Drug Plan Administrator for further information on the availability of Your particular prescription medication.

Home delivery order forms are available at express-scripts.com or contact the Prescription Drug Plan Administrator. 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 Express Scripts pharmacy for processing.
- Phone: Call the Prescription Drug Plan Administrator and request that Your prescription medication 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 with a click of a button from the home page
- 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. Members are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. Check with the Prescription Drug Plan Administrator 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 Disease Management vendor 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.

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 Plan 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 have to 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 of time, 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, 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.

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.

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 Exclusions section of this document.

Schedule of Prescription Benefits

The following schedule of Prescription Drug Benefits provides information regarding the Benefits offered by the self-funded Plan.

Plan Year 2018 Schedule of Prescription Drug Benefits

This chart explains the Benefits payable by the Self-funded Plan.

All Benefits are subject to the Deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	Participant Responsibility
<p><u>Prescription Drug Plan</u> Coverage is provided only for medications approved by the Food and Drug Administration (FDA) 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.</p> <p>Coverage is also provided for:</p> <ul style="list-style-type: none"> • Prenatal & pediatric prescription vitamins; • Female Oral Contraceptives; • Insulin, and insulin injecting devices; • Diabetic supplies. 	<p>The Plan provides a mandatory Generic Drug program meaning that if a brand name drug is dispensed in place of a Generic, regardless of whether or not the Participant or the Physician requests it, you will pay 100% of the discounted rate. Deductible and out of pocket credit is not applied.</p> <p>Retail Drugs: To obtain a 30-day or 90-day supply of medication, present Your ID card to any In-Network retail Pharmacy. Contact the Prescription Drug Plan Administrator for locations of In-Network retail pharmacies.</p> <p>Preventive Drug Program The Preventive Drug Program Benefit provides Plan Participants access to certain preventive medications 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 the Out-of-Pocket Maximum. The medications covered under this Benefit include categories of Prescription Drugs that are used for preventive purposes or conditions such as hypertension, asthma, or high cholesterol. To see the Preventive Drug list, visit the Prescription Drug Plan Administrator’s website.</p> <p>Specialty Medications: Certain medications fall into a category called ‘specialty medications’. Specialty medications are available only through Accredo Specialty Pharmacy (see the Participant Contact Guide) and prescriptions are limited to a 30-day supply. Contact the Prescription Drug Plan Administrator or log on to their website to determine if a medication you take is considered a specialty drug.</p> <p>Home Delivery Drug Service through Express Scripts Pharmacy: You may use Express Scripts Pharmacy (see the Participant Contact Guide) to receive up to a 90-day supply of non-Emergency, extended-use "maintenance" Prescription Drugs, such as for high blood pressure or diabetes. Refer to the Home Delivery Drug Program section for more information on how to move Your prescriptions to home delivery. NOTE: not all medicines are available via home delivery. Check with the Prescription Drug Plan Administrator for further information, or log onto their website.</p> <p>For a list of drugs classified as Tier 2 Brand and Tier 3 Non-Preferred Brand, contact the Prescription Drug Plan Administrator, or log onto their website for more information.</p>	<p>In-Network Retail :</p> <ul style="list-style-type: none"> • 20% Coinsurance after Plan Year Deductible <p>Preventive Drug Program: Drugs purchased under this program are subject to 20% Coinsurance.</p> <p>Specialty Medications:</p> <ul style="list-style-type: none"> • 20% Coinsurance after Plan Year Deductible <p>Home Delivery Services:</p> <ul style="list-style-type: none"> • 20% co-insurance after Plan Year Deductible <p>*Non-preferred name brand and non-preferred Generic Drugs Participant is responsible for 100% of the Preferred Contract Rate. Deductible credit and Out-of-Pocket credit is not applied.</p>

Plan Year 2018 Schedule of Prescription Drug Benefits

This chart explains the Benefits payable by the Self-funded Plan.

All Benefits are subject to the Deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	Participant Responsibility
<p><u>Prescription Drug Plan</u> (continued)</p> <p>Prior Authorization is required from the Prescription Drug Plan Administrator for some medications. See the Prescription Drug Plan Administrator’s website for details.</p> <p>Some medications may have quantity limits per month like:</p> <ul style="list-style-type: none"> • 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 	<p>Diabetes Supplies Home Delivery Benefit through Express Scripts Pharmacy: This is a preferred mail order service for diabetic supplies for Participants. Refer to the Home Delivery Drug Program section on how to fill Your diabetic supplies through home delivery. Once enrolled, You are able to receive up to a 90-day supply of the following items subject to deductible and Coinsurance, unless You are enrolled in the Diabetes Care Management Program: blood glucose monitors, test strips, insulin syringes, alcohol pads, and lancets. Participants who are enrolled in the Diabetes Care Management Program can receive these supplies by paying a Copayment that is not subject to Deductible and Coinsurance. Diabetic medication benefits are also available to Participants enrolled in the Diabetes Care Management Program and are not subject to Deductible and Coinsurance. See the Diabetes Care Management section of this document for more information.</p> <p>Tobacco/Smoking Cessation Products: The Plan waives the Deductible for prescription and over-the-counter smoking cessation products. Contact the Prescription Drug Administrator for eligible medications and products.</p> <p>Vaccine Coverage: The Plan waives the Deductible for certain vaccine services, see the Eligible Benefits section for more information.</p> <p>Out-of-Network Pharmacy, Out-of-country Pharmacy, or extended absence Benefits: See the Prescription Drug Plan Administrator section of this document for detailed information.</p> <p>Other Limitations:</p> <ul style="list-style-type: none"> • The Medical and Prescription Drug Annual Deductible is based on Your selected coverage tier. Refer to the CDHP Plan Overview section of this document. 	<p>In-Network Retail :</p> <ul style="list-style-type: none"> • 20% Coinsurance after Plan Year Deductible <p>Home Delivery Services:</p> <ul style="list-style-type: none"> • 20% Coinsurance after Plan Year Deductible <p>Tobacco/Smoking Cessation Products:</p> <ul style="list-style-type: none"> • Some products are paid at 100% <p>Preventive Vaccines</p> <ul style="list-style-type: none"> • Most preventive vaccines are paid at 100% <p>*Non-preferred name brand and non-preferred Generic Drugs Participant is responsible for 100% of the Preferred Contract Rate. Deductible credit and out of pocket credit is not applied.</p>

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 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 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 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 third party 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 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 of 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 third party 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 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.
- For Providers such as Hospitals and facilities that bill for items such as orthopedic devices/implants or other types of biomaterial, the Plan has the right to request a copy of the invoice from the organization that supplied the device/implant/biomaterial to the Hospital or facility. The Plan has the right to deny payment for such medical devices until a copy of the invoice is provided to the Plan's Claims Administrator.

NOTE: Claims are processed by PEBP's third party administrator in the order they are received. If a claim is held or "soft denied" that means that PEBP's third party 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 is held or soft denied may be paid or processed even though they were received at a later date.

NOTE: It is Your responsibility to maintain copies of the Explanation of Benefits provided to You by PEBP's third party administrator or Prescription Drug administrator. Copies of Explanation of Benefits documents are available on the third party administrator's website but cannot be reproduced. PEBP and its third party administrator do not provide printed copies of Explanation of Benefits outside of the original mailing.

Where to Send the Claim Form

Send the completed claim form, the bill You received (You keep a copy, too) and any other required information to the third party administrator at the address listed in the Participant Contact Guide in this document.

CDHP Claim Appeal Process

What can be Appealed? You have the right to ask the Plan Administrator 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 Plan Administrator and Designee

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

Internal Appeals

Written Notice of Adverse Benefit Determination

The Plan or its designee, typically the third party claims administrator, will notify You in writing of an Adverse Benefit Determination resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. 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 an appeal of the Adverse Benefit Determination. When applicable, the notice will explain what additional information is required from You and why it is needed. Your request for appeal must be made in writing to the office where the claim was originally submitted (the claims administrator) within 180 days after You receive a notice of Adverse Benefit Determination. 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, Dental, vision, and rescission of benefits)

If Your claim is denied, or if you disagree with the amount paid on a claim, You may request a review from the third party claims administrator within 180 days of the date You received the Explanation of Benefits (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 the Plan Administrator determines that the failure was acceptable. The written request for appeal must include:

- The name and social security number, or member 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. The Claims Administrator will review Your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process Your request for appeal, it will be requested promptly. A Level 1 Appeal that is not filed

in a timely manner will be deemed waived with respect to Adverse Benefit Determination to which they relate.

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 appeal 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. 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, Dental, vision, and 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 Plan Administrator's section of the Participant Contact Guide in this document 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 must include a copy of:

- The Level 1 review request;
- A copy of the decision made on review; and
- Any other documentation provided to the third party claims administrator 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, third party administrator, Prescription Drug administrator, Internet, and the PEBP Master Plan Document 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 appeal 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. [NAC 287.680](#)

Appealing a UM Determination

You may request an appeal of any Adverse Determination made during the Pre-certification, Concurrent Review, Retrospective Review, Case Management or Second Opinion review process described in this section.

The appeal process for determinations made by the UM 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 levels of appeal review:

- Expedited Appeal, and
- Standard Appeal
 - Qualifications of Reviewer

- A Physician (other than the Physician who rendered the original decision) is utilized to complete 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 UM company is in the Participant Contact Guide section of this document and on the PEBP website (pebp.state.nv.us).

Expedited Appeal Process - You may obtain an expedited medical review of a denied Pre-certification (pre-service) 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 UM company that will ensure the timely receipt of the information required to complete the appeal process. If Your Physician requests a consultation with the reviewing Physician, this will occur within 1 Business Day. The UM company will make a determination 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 Claims Administrator. Upon receipt of a request, the UM 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 Pre-certification request (or a denial/non-certification at any other level of UM review such as Concurrent Review, Retrospective Review, Second Opinion or Case Management issue) and You do not qualify for an Expedited Appeal, You may request a Standard Appeal Review. Requests for Standard Appeal Review may be made by writing to the UM company.

Appeals 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 will be completed by a Physician within 15 days of the request. Appeals for post-service treatment will be completed within 20 days of the request. The results of the determination of a Standard Appeal will be provided in writing to the patient, managing Physician, facility and Claims Administrator.

A Participant or their designee can choose to bypass this appeal process and request a review by an External Review board. To request a review by the External Review board, please refer to the section of this document called External Appeals (Medical claims only).

External Appeals (Medical claims only)

An External Appeal may be requested by a Participant and/or the Participant's treating Physician after you have exhausted the internal claim appeal review process (please refer to the section in this document titled "CDHP Appeal Process". This means that You may have a right to have PEBP's decision reviewed by independent health care professionals if PEBP's decision 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.

NOTE for Utilization Management (UM) Appeals only: A Participant or their designee can choose to bypass the UM expedited and standard appeal processes 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 4 months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. A standard External Review request form can be found on the PEBP website at www.pebp.state.nv.us.

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

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 appeal of PEBP's denial. If PEBP's 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 our denial. Please refer to the section in this document titled "Experimental and 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 Health Care Provider certifies that adherence to the time frame for the standard External Review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person'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 Health Care Provider for Expedited Consideration of a Patient's External Review."

Experimental and Investigational External Review

If You have had a service such as drug therapy, durable medical device, procedure or other therapy denied because PEBP or its designee (third party administrator, Prescription Drug Administrator or 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. See the Definitions section for Clinical and Administrative Coverage Reviews.

Clinical Coverage Review

The Clinical Coverage Review is a request for coverage or medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

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 the Prescription Drug Administrator at 1-800-753-2851 or the prescriber may submit a completed Initial Coverage Review form obtained online at www.express-scripts.com/services/physicians/ or via fax to 1-877-329-3760. (Home Delivery coverage review requests are automatically initiated by the Home Delivery Pharmacy as part of filling the Prescription.)

Administrative Coverage Review

The 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 the Pharmacy Benefit Manager to the attention of the Benefit Coverage Review Department (see Participant Contact Guide).

In order to make an initial determination for a Clinical Coverage Review request, the prescribing Physician must submit specific information for review. For an Administrative Coverage Review request, the Participant must submit information to the Pharmacy Administrator 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 the Pharmacy Administrator at 1-800-753-2851.

If the necessary information is provided to the Pharmacy Benefit Manager 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 5 days for home delivery
- Standard Post-Service: 30 days

Level 1 Appeal or Urgent Appeal After Initial Clinical or Administrative Coverage Review has been denied

When an initial coverage review has been denied, a request for appeal may be submitted by the Participant within 180 days from receipt of notice of the initial Adverse Benefit Determination. To initiate an appeal, the following information must be submitted by mail or fax to the Pharmacy Benefit Manager's Benefit Coverage Review Department.

- Name of patient
- Participant ID number
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial Adverse Benefit Determination
- 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 the Pharmacy Benefit Manager. Claims appeals submitted by mail will not be considered urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

The Pharmacy Benefit Manager completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are by the Pharmacy Benefits Manager's pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or an independent third party utilization management company.

Level 1 Appeal Decisions and Notifications

The Pharmacy Benefit Manager will render Level 1 Appeal determinations within the following timeframes:

- Standard Pre-Service: 15 day
- Standard Post-Service: 20 days
- 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 287.670](#)]

Level 2 Appeal After a Level 1 Appeal has Been Denied

When a Level 1 Appeal has been denied, a request for a Level 2 Appeal may be submitted by the Participant within 90 days from receipt of notice of the Level 1 Appeal denial. To initiate a Level 2 Appeal, the following information must be submitted by mail or fax to the appropriate department for Clinical Coverage or Administrative Coverage Review Requests.

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 department (see the Participant Contact Guide). Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Level 2 Appeal Decisions and Notifications

The Pharmacy Benefit Manager will render Level 1 and 2 Appeal determinations within the following timeframes:

- Standard Pre-Service: 15 day
- Standard Post-Service: 30 days
- 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](#)]

When and How to Request an External Review

The right to request an independent External Review may be available for an Adverse Benefit Determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that 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 fax 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 (COB)

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 of 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 PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and Dental Deductibles.

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

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

Examples of what is not an allowable expense include:

- the difference between the cost of a semi-private room in the Hospital and a private room;
- when both plans use usual and customary (U&C) fees, any amount in excess of the highest of the U&C fee for a specific benefit;
- when both plans use negotiated fees, any amount in excess of the highest negotiated fee is not an allowable expense (with the exception of 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.

NOTE: If the Spouse or Domestic Partner of a primary PEBP Participant is eligible for health insurance coverage from their employer, that Spouse or Domestic Partner is not eligible for PEBP coverage whether they have enrolled in their employer sponsored health insurance or not. This includes Spouses or Domestic Partners who are eligible for PEBP coverage.

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 as a result of

the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

- secondary to the plan covering the person as a dependent;
- primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);
- then the order of benefits is reversed, so that the plan covering the person as a dependent pays 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 pays 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 or not 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 of time pays first, and the plan that has covered the other parent for the shorter period of time pays second.
- The word “birthday” refers only to the month and day in a calendar year; not the year in which the person was born.

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

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

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

Rule 3: Active/Laid-Off or Retired Employee

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

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

Rule 4: Continuation Coverage

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

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

Rule 5: Longer/Shorter Length of Coverage

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

Administration of COB

To administer 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 to be 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 Participants 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 Master Plan Document for more information regarding enrollment in the Medicare Exchange.

Entitlement to Medicare Coverage

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.

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

This Plan will pay as primary for services that would have been covered by Part A when You are not eligible for Premium Free Medicare Part A. However, You must enroll in Medicare Part B and PEBP will be the secondary payer for Medicare Part B services. This Plan will always be secondary to Medicare Part B, whether 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

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 pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins, or the first month in which the individual receives a kidney Transplant. Then, starting with the 31st month after the start of Medicare coverage or the first month after the individual receives a kidney Transplant, Medicare pays first and this Plan pays second.

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 section of this document.

How Much This Plan Pays When It Is Secondary to Medicare

When the Participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays as secondary to Medicare, with the Medicare negotiated Allowable fee taking precedence. If a service is not covered under Medicare but is covered under this Plan, this Plan will pay as Primary with the Plan's Allowable fee for the service taking precedence.

When the Retiree or the Retiree's covered Spouse or Domestic Partner is enrolled in Medicare Part B: This Plan will always be secondary to Medicare Part B. If eligible Retirees or their covered Spouses or Domestic Partners are not enrolled in Part B, This Plan will estimate Medicare's Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

When the Participant Enters Into a Medicare Private Contract: a Medicare Participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that NO claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare Participant enters into such a contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare Participant receives pursuant to it.

Coordination with Other Government Programs

Medicaid

If a Covered Individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

Tricare

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

NOTE: Spouses that are eligible for health coverage, including Tricare, through their current employer are typically not eligible for coverage under the PEBP Plan. If Your Spouse's employer-sponsored health coverage satisfies PEBP's definition of "significantly inferior coverage", you may be able to enroll or continue Your Spouse's coverage under PEBP. Please refer to the Enrollment and Eligibility Master Plan Document for a definition of "significantly inferior coverage"

Veterans Affairs Facility Services

If a Participant receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related Illness or Injury, Benefits are not payable by the Plan. If a Covered Individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related Illness or Injury, Benefits are payable by the Plan at the In-Network benefit level at the Usual and Customary Charge, only to the extent those services are Medically Necessary and are not excluded by the Plan.

Worker's Compensation

This Plan does not provide benefits if the expenses are covered by workers' compensation or occupational disease law. If a Participant contests the application of workers' compensation law for the Illness or Injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a Workers' Compensation or occupational disease law. However, before such payment will be made, You and/or Your covered Dependent must execute a Subrogation and reimbursement agreement (described in the Third Party Liability section of this document) that is acceptable to the Plan Administrator or its designee.

Third Party Liability

Subrogation and Rights of 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 "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 injury 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 Rights of Recovery provision allows for the right of recovery for certain payments made by the Plan, irrespective of fault, wrongdoing, or negligence. Any and all payments made by the Plan relating in any way to the Injury may be recovered directly from the other person or from any judgment or settlement obtained by the Participant in relation to the Injury.

By accepting coverage under the Plan, the Participant automatically assigns to the Plan any and all rights the Participant may have to recover damages or payments from any other person arising from or relating in any way to the Injury. This includes payments made or to be made to or for the Participant from another insurance company, including the Participant's own insurance policy. The Plan Administrator may act as the substitute for the Participant in the event any payment made by this Plan for health care or other Benefits, including any payment for a known pre-existing condition, may be the responsibility of another person. Such payments shall be referred to as Reimbursable Payments. This express assignment allows the Plan to directly pursue any claim that the Participant may have, whether or not the Participant chooses to pursue that claim. The Plan or Plan Administrator may pursue any such claims on behalf of the Participant and/or in the Participant's own name, as if the Participant were pursuing the claim on his/her own behalf. This includes the right to sue the other person in order to recover any and all payments made by the Plan relating in any way to the Injury.

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

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

Right of Reimbursement and Recovery

By accepting Coverage under the Plan, the Participant agrees that if they or someone else receive a recovery of any kind in the form of a judgment, settlement, payment, or other compensation, irrespective of fault, wrongdoing, or negligence, the Plan has the unequivocal right to recover its Subrogated Payments from the Participant and from any other person, including but not limited to the following:

- (1) a Tortfeasor;
- (2) a Tortfeasor's insurance company; and
- (3) any other source, including but not limited to: any form of first-party insurance coverage carried by the Participant; uninsured or underinsured motorist coverage; any medical payments coverage; no-fault coverage; school insurance coverage; workers' compensation coverage; premises liability coverage, including homeowners' and boating coverage; any medical malpractice recovery; or any other form of insurance coverage, whatever kind.

The Plan has an equitable lien against the Recovery rights of the Participant, and has the right to be paid from any such Recovery, or potential Recovery, an amount not to exceed the total amount of benefits paid or to be paid by the Plan, irrespective of whether or not the Participant has been "made whole" for the injuries received. In its sole discretion, PEBP has the right (but is not required) to consider reducing the subrogated amount (lien) by any attorney's fees or costs incurred (e.g. Deductible or Co-insurance) by the participant or their covered Dependent in the collection of damages.

The Plan's right to subrogation applies on a first-dollar basis, and has priority over all other rights or claims, including the Participant's attorney fees. The Plan's right of subrogation applies irrespective of whether the funds paid to (or for the benefit of) the Participant constitute a full or partial recovery, and applies to funds paid for non-health care charges or attorney fees, or other costs and expenses. The Plan's first priority right of subrogation in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Participant or any other person or entity attempts to designate or characterize the Recovery, including but not limited to claims for loss of consortium, and irrespective of whether the Recovery itemizes or identifies an amount recovered, adjudicated, or characterized specifically as medical expenses, or is specifically linked to certain kinds of damages or payments.

The Plan's first priority right of Subrogation extends to any and all recoveries arising from or related in any way to the Injury, including but not limited to any recovery obtained by the Participant's estate, or obtained by the Participant's heirs, successors, assigns, dependents, and/or the like, or irrespective of whether the claim is characterized as a wrongful death claim or a survivorship claim.

The Plan's first priority right of Subrogation extends to the Participant's attorney and/or other agents, successors, and assigns of the Participant.

Payment of the Subrogated Amount to the Plan shall be made without reduction, set-off, or abatement for attorney's fees or costs incurred by the Participant in the collection of a Recovery.

The Plan shall be entitled to seek any equitable remedy or any legal remedy to recover money damages against any party possessing or controlling such monies or properties. At the discretion of the Plan and/or the Plan Administrator, the Plan may reduce any and all Eligible Medical Expenses, or deny any and all claims, otherwise available to the Participant under the Plan by an amount up to the total Subrogated Amount that is subject to the Plan's right of Subrogation. The Plan's right to reduce Eligible Medical Expenses and deny claims applies to all Eligible Medical Expenses and claims, irrespective of whether such Eligible Medical Expenses and claims bear any relation to the Injury. All rights of the Plan's recovery will be limited to the amount of payments made under this Plan, plus the Plan's reasonable attorney fees and costs incurred to enforce the terms and conditions of the Plan.

The Plan's equitable lien shall also attach to any money or property that is obtained, held, or to be paid by any person, including but not limited to the Participant, the Participant's attorney, an insurance company, and/or a trust for the direct or indirect benefit of the Participant or for his/her "special needs," as a result of an exercise of the Participant's rights of Recovery.

The Plan may require the Participant or the Participant's attorney or substitute, as a pre-condition to receiving benefit payments, to sign a subrogation agreement or acknowledgment and to agree in writing to assist the Plan and to protect the Plan's right to payment of the Subrogated Amount from any person including the Participant. In the event that the Plan does not receive, the following provisions also apply to the Plan's right of Subrogation, reimbursement, and creation of an equitable lien:

1. **"Pay and Pursue."** The Plan Administrator, in its sole discretion, may elect to process claims under the "pay and pursue" option. If the Plan Administrator elects to "pay and pursue," Benefit payments will be made prior to necessarily applying the Subrogation, reimbursement and lien rights under the Plan. This is at the sole discretion of the Plan Administrator, and remains subject to the Participant's required cooperation with and protection of the Plan's right of Subrogation.
2. **Scope of Subrogation, Reimbursement and Lien Rights.** The Subrogation, reimbursement and lien rights apply to any and all Benefits paid by the Plan on behalf of the Participant arising from or related in any way to the Injury, and apply to all of the following, enumerated without limitation:
 - a. Any no-fault insurance.
 - b. Medical benefits/payments coverage under any automobile insurance coverage. This includes the Participant's insurance plan or any third person's insurance policy under which the Participant may be entitled to benefits.
 - c. Under-insured and uninsured motorist coverage, and any other first-party insurance coverage.
 - d. Any automobile medical payments and personal injury protection ("PIP") benefits.
 - e. Any third person's liability insurance, whether automobile coverage or other;
 - f. Any premises/guest medical payments coverage, including homeowner's insurance.
 - g. Any medical malpractice recovery or insurance policies covering medical malpractice;
 - h. Workers' compensation benefits or claims.
 - i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds), to the extent permitted by law.
 - j. Restitution in a criminal matter.

3. **Reimbursable Payments.** The term “Reimbursable Payments” refers to any Benefit payments made by the Plan that are eligible for recovery from any other person as described hereinabove.
4. **“Make Whole” and “Common Fund” Rules Do Not Apply.** The Plan’s right of Subrogation, reimbursement, equitable liens, and other legal and equitable remedies are specifically intended to supersede the applicability of any and all common law doctrines and/or any and all local, state, and federal laws, including but not limited to the “make whole” rule and the “common fund” rule, to the extent permitted by law.

General Provisions and Notices

General Provisions

Name of the Plan

Public Employees' Benefits Program (PEBP)

Plan Administrator

Public Employees' Benefits Program (PEBP)

901 South Stewart Street, Suite 1001

Carson City, NV 89701

Phone: (775) 684-7000 or (800) 326-5496

Tax Identification Number (TIN)

88-0378065

Type of Plan

Group Health Plan including medical expense Benefits.

Type of Administration

PEBP is liable for all expenses associated with the benefits of the CDHP medical and Dental Plans outlined in this document. An independent Claims Administrator administers the Benefits for the CDHP and the Self-funded PPO Dental Plan. Refer to the Participant Contact Guide in this document for the name and address of the Claims Administrator.

Per NRS 287.0485 no officer, Employee, or Retiree of the State has any inherent right to Benefits provided under the PEBP.

Agent for Service of Legal Process

For disputes arising under the Plan, service of legal process may be made on the Plan Administrator, and must comply with the Nevada Revised Statute 41.031, in care of:

Public Employees' Benefits Program (PEBP)

901 South Stewart Street, Suite 1001

Carson City, NV 89701

Phone: (775) 684-7000 or (800) 326-5496

Plan Year

The Plan’s CDHP and Self-Funded Dental PPO Plan Benefits are administered on a Plan Year typically beginning July 1 and ending June 30. PEBP has the authority to revise the Benefits and premium 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. Fiscal records are kept on a 12-month period basis beginning on July 1 and ending on June 30.

Plan Amendments or Termination of Plan

PEBP reserves the right to amend or terminate these plans, or any parts of them at any time. Amendments may occur on the approval of the PEBP Board, or on such other date as may be specified in the document amending the Plan. These Plans or any coverage under them may be terminated by the PEBP Board, and new coverages may be added by the PEBP Board.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plans, the Plan Administrator and its designees have discretionary authority to interpret the terms of the Plans and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plans. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Such interpretations or determinations regarding Benefits should be guided by evidence based practice of medicine and Medical Necessity.

No Liability for Practice of Medicine

The Plan Administrator and its designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan Administrator nor any of its designees will have any liability whatsoever for any loss or Injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Right of Plan to Require a Physical Examination

The Plan reserves the right to have the person who has a total Disability, or who has submitted a claim for Benefits and is undergoing treatment under the care of a Physician, to be examined by a Physician selected by the Plan Administrator or its designee at any time during the period that Benefits are extended under this provision. The cost of such an examination will be paid by the Plan.

When You Must Repay Plan Benefits

If it is found that Plan Benefits paid by the Plan are too much because:

- some or all of the medical expenses were not paid or payable by You or Your covered Dependent; or
- You or Your covered Dependent received money to pay some or all of those expenses from a source other than the Plan; or
- You or Your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or Injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the expenses for which Plan Benefits were paid; or
- the Plan erroneously paid Benefits to which you were not entitled under the terms and provisions of the Plan.

The Plan will be entitled to a refund from you (or Your Health Care Provider) of the difference between the amount actually paid by the Plan for those expenses, and the amount that should have been paid by the Plan for those expenses, based on the actual facts (see also the Subrogation section of the Coordination of Benefits section).

Privacy Notice

Disclosure and Access to Medical Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with PEBP to its Participants and their covered Dependents. This Notice describes how PEBP collectively as we, us, or our may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

PEBP is declared a hybrid entity, the Plan is an affiliated covered entity and this Notification of Privacy Practice serves as notification for all health care components, Your health information may be shared between health plans for continuum of care.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health Plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all Participants and posted on the PEBP website.

Privacy Notice Definitions

Group Health Plan means, for purposes of this Notice, all health care components offered by PEBP to our Participants and their covered Dependents.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Uses and Disclosures of Your Protected Health Information

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Uses and Disclosures with Your Permission - We will not use or disclose Your medical information for any other purposes unless You give us your written authorization to do so.

For example, in general and subject to specific conditions, we will not use or disclose Your psychotherapy notes, will not use or disclose Your protected health information for marketing, or fundraising, unless You give us a written authorization. If you give us written authorization to use or disclose Your medical information for a purpose that is not described in this notice, in most cases, You may revoke it in writing at any time. Your revocation will be effective for Your medical information we maintain, except where we have already taken action in reliance on Your prior authorization.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of Your PHI as necessary for payment purposes. For example, we may use information regarding Your medical procedures and treatment to process and pay claims. We may also disclose Your PHI for the payment purposes of a Health Care Provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose Your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of Your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to Your Group Health Plan.

Family and Friends Involved in Your Care – If You are available and do not object, we may disclose Your PHI to Your family, friends, and others who are involved in Your care or payment of a claim. If You are unavailable or incapacitated and we determine that a limited disclosure is in Your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to Your Spouse or Domestic Partner concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide You with the benefits of Your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process and manage Your healthcare claims such as third party administrators, Pharmacy Benefit Managers, health plan auditors and health maintenance organizations. At times it may be necessary for us to provide certain components of Your PHI to one or more of these outside persons or organizations, additionally, one of these outside organizations may disclose Your PHI to PEBP.

Other Products and Services – We may use Your PHI to communicate with You about other health-related products and services that may be of interest to You. For example, we may use and disclose Your PHI for the purpose of communicating to You about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to Your Group Health Plan or provide other health care component benefits such as voluntary flexible spending accounts or life insurance.

Other Uses and Disclosures – We may make certain other uses and disclosures of Your PHI without Your authorization.

- We may use or disclose Your PHI for any purpose required by law. For example, we may be required by law to use or disclose Your PHI to respond to a court order.

- We may disclose Your PHI for public health activities, such as reporting of disease, Injury, birth and death, and for public health investigations
- We may disclose Your PHI to the proper authorities if we suspect Child abuse or neglect; we may also disclose Your PHI if we believe You to be a victim of abuse, neglect, or domestic violence.
- We may disclose Your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose Your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose Your PHI to the proper authorities for law enforcement purposes.
- We may disclose Your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose Your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose Your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose Your PHI if you are a member of the military as required by armed forces services, and we may also disclose Your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose Your PHI to workers' compensation agencies for Your workers' compensation benefit determination.
- We will, if required by law, release Your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.
- We may disclose Your PHI to report adverse reactions to medications.
- We may disclose Your PHI to assist with certain product recalls.

Plan Sponsors- PEBP may use or disclose protected health information to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of Your Protected Health Information in accordance with the more stringent standard.

PEBP will notify You promptly as required by law, if a breach occurs that may have compromised the privacy or security of Your information.

Rights That You Have

Access to Your PHI – You have the right of access to copy and/or inspect Your PHI that we maintain in designated record sets. Certain requests for access to Your PHI must be in writing, must state that You want access to Your PHI and must be signed by You or Your representative (e.g., requests for medical records provided to us directly from Your Health Care Provider).

Access request forms are available from PEBP at the address provided below. We may charge You a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about You be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, Your amendment request must be in writing, must be signed by You or Your representative, and must state the reasons for the amendment/correction request.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures, we or our business associates, have made by of Your PHI in the six years prior to the date of Your request. We are not required to account for disclosures we made before April 14, 2003, or disclosures to You, Your personal representative or in accordance with Your authorization or permission; for treatment, payment and other health care operations activities; as part of a limited data set; incidental to an allowable disclosure; or for national security or intelligence purposes; or to law enforcement or correctional institutions regarding persons in lawful custody. To be considered, Your account request must be in writing and signed by You or Your representative. You are entitled to one free accounting every 12 months. We reserve the right to charge You a reasonable fee for each additional accounting You request during the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of Your PHI for insurance payment or health care operations, disclosures made to persons involved in Your care, and disclosures for disaster relief purposes. For example, You may request that we not disclose Your PHI to Your Spouse or Domestic Partner. Your request must describe in detail the restriction you are requesting. We are not required to agree to Your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify You of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Restrictions on Use of Genetic Information - We will not use Your genetic information that is PHI for underwriting purposes.

Request for Confidential Communications – You have the right to request that communications regarding Your PHI be made by alternative means or at alternative locations. For example, You may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if You inform us that disclosure of all or part of Your information could place You in danger. Requests for confidential communications must be in writing, signed by You or Your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe Your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of Your rights. There will be no retaliation for filing a complaint.

For Further Information

If You have questions or need further assistance regarding this Notice, You may contact PEBP's Privacy Officer at the address or telephone number provided below.

PEBP Privacy Officer
901 S. Stewart St., Ste. 1001
Carson City NV 89701
(775) 684-7000 Phone
(800) 326-5496
(775) 684-7028 Fax

Effective Date

This Notice of Privacy Practices for PEBP is effective July 1, 2017, and replaces all other privacy notices that have been in effect since April 14, 2003.

You will find a copy of this notice on the PEBP website and in the Plan documents. Please call PEBP with any further questions regarding the privacy notice. (775) 684-7000 or (800) 326-5496.

The Plan Sponsor certifies that this Master Plan Document incorporates the provisions set forth in 45 CFR 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR 164.504(f)(2)(ii)

If You feel Your privacy rights have been violated, You may file a complaint with PEBP or with the federal government through the Office of Civil Rights. You will not be penalized for filing a complaint.

Office of Civil Rights
Dept. of Health & Human Services
907 7th St., Ste. 4-100
San Francisco CA 94103
(800) 368-1019 Phone
(415) 437-8329 Fax
TDD (800) 537-7697
<http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>

By law, PEBP is required to follow the terms in this privacy notice. PEBP has the right to change the way Your personal medical information is used and given out. If PEBP makes any changes to the way Your personal medical information is used and given out, PEBP will post the notice of changes on its website within 60 days of the change. You can request a copy of the PEBP Privacy Notice anytime by contacting PEBP.

PEBP Security Practices

By law, PEBP is required to:

- put in place administrative, physical, and technical safety measures to reasonably protect Your personal medical information that is stored electronically;
- make sure there are security measures in place to protect and separate Your personal medical information that is stored electronically from other agencies, employees, or employers who do not need access to it;
- make sure that any agents or vendors who help PEBP with its operations also have in place security measures to protect PEBP personal medical information; and
- report to the PEBP security officer any security problems or incidences resulting from unauthorized access, use or interference of systems operations in a system containing PEBP personal medical information, known by PEBP or any agent or vendor.

Other Notices Provided by PEBP

National Defense Authorization Act (NDAA)

On January 28, 2008, President Bush signed into law H.R. 4986, the National Defense Authorization Act (NDAA). Section 585 of the NDAA amends the Family and Medical Leave Act of 1993 (FMLA) to permit a "Spouse/ Domestic Partner, son, daughter, parent, or next of kin" to take up to 26 work weeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness."

The NDAA also permits an employee to take FMLA leave for "any qualifying exigency (as the Secretary [of Labor] shall, by regulation, determine) arising out of the fact that the Spouse/ Domestic Partner, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. You can read more about the National Defense Authorization Act by going to the US Department of Labor website at: www.dol.gov.

Heroes Earning Assistance and Relief Tax Act (HEART Act)

The Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act) requires employers to provide certain retirement and welfare benefits for returning military personnel and their beneficiaries. For more information on the HEART Act (Heroes Earning Assistance and Relief Tax), PEBP directs you to the IRS website at: www.irs.gov.

Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA, 38 U.S.C. § 4301 – 4335) is a federal law intended to ensure that persons who serve or have served in the Armed Forces, Reserves, National Guard or other "uniformed services:" (1) are not disadvantaged in their civilian careers because of their service; (2) are promptly reemployed in their civilian jobs upon their return from duty; and (3) are not discriminated against in employment based on past, present, or future military service. For more information about USERRA, please refer to the following website: <http://www.dol.gov/elaws/userra.htm>.

The Americans with Disability Amendments Act

Effective January 1, 2009, changes the language regarding any condition that substantially limits a major life activity will be considered a disability, even if the individual can offset or compensate for the disability with the mitigating measures such as hearing aids or artificial limbs. These provisions of the bill were designed to essentially overturn several Supreme Court decisions that found that individuals who could compensate for their disabilities were not afforded under the protection of the ADA. You can read more about the ADA and the Amendments Act by visiting the US Equal Employment Opportunity Commission at: www.eeoc.gov/ada.

Wellstone & Domenici Mental Health Parity & Addiction Equity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 is effective for PEBP on July 1, 2010. This legislation requires that full parity be established between mental health/ Substance Abuse benefits and other surgical and medical Benefits offered under the Plan. You can find more information at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html and searching for The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Genetic Information Non-discrimination Act of 2008

The Genetic Information Non-discrimination Act of 2008 (GINA) was enacted May 21, 2008. Title I (regarding genetic nondiscrimination in group health plans) is effective for Plan Years beginning after May 21, 2009. Title II (regarding genetic nondiscrimination in employment) becomes effective November 21, 2009. GINA amends ERISA, the Code and Public Health Service Act to prevent group health plans and health insurance companies from basing enrollment decisions, premium costs, or Participant contributions on genetic information. Group health plans and group insurers will be prohibited from requiring that individuals undergo Genetic Testing. Employers are preventing conditioning of hiring or firing decisions on the basis of genetic information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information in regards to either employment or the determination of Benefits. Genetic Testing is a Plan exclusion. You can read more about GINA at www.genome.gov/10002328.

Michelle's Law

Under the Public Employees' Benefits Program ("PEBP"), most dependent children are eligible for health coverage until age 26. However, dependent children under a legal guardianship who are unmarried are generally eligible for health coverage until age 19. Eligibility for dependent children under a legal guardianship may be extended beyond age 19 to age 26 if the child satisfies all of the following conditions:

- 1) Remains unmarried;
- 2) Is either enrolled as a full-time student at an accredited institution or resides with the Participant;
- 3) Is eligible to be claimed as a dependent on the Participant's or his/her Spouse's or Domestic Partner's federal income tax return for the preceding calendar year; and
- 4) Is a grandchild, brother, sister, step-brother, step-sister, or descendent of such relative.

Because eligibility may be conditioned on maintaining full-time student status, Michelle's Law applies only to the extended eligibility for dependent children under a legal guardianship from ages 19 -26 who meet the conditions above.

Should a dependent child under a legal guardianship (as described above) take a medically necessary leave of absence for a serious illness or injury that causes loss of full-time student status, his or her coverage cannot be terminated before the date that is the earlier of - (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the PEBP. A written certification stating that the dependent child is suffering from a serious illness or injury and that the leave of absence is medically necessary must be provided by a treating physician of the dependent child to PEBP in order for eligibility and coverage to continue.

For more details or to notify PEBP of a medically necessary leave of absence, please contact PEBP at (775) 684-7000 or (800) 326-5496.

NAC and NRS Regarding the PEBP Plan and Your Coverage

The information provided below is a summary of the applicable NRS and NAC. For detailed information, please refer to the Nevada Legislature website at <http://leg.state.nv.us/Law1.cfm>.

NAC 287.095 – Participant defined.

NAC 287.135 - Retired officer or employee defined.

NAC 287.317 - Participating public agency to notify the Program of appointment of persons eligible to participate in the Program or of termination of appointment; enrollment.

NAC 287.320 - Withdrawal from Program: Procedure; termination of coverage; limitation on reentry; eligibility of certain officers and employees after exclusion of group; liability of Program.

NAC 287.357 - Application to leave Program

NAC 287.440 - Payment of premiums or contributions by retired officers and employees.

NAC 287.450 - Employees on leave without pay: Payment of premiums or contributions; eligibility for coverage as a Dependent of a Participant; coverage upon return to work.

NAC 287.530 - Coverage of retired person, spouse, domestic partner or surviving dependent.

NAC 287.540 - Coverage of participating employee of State who reenrolls upon retirement or total disability; coverage of nonparticipating employee of State.

NAC 287.542 - Coverage of participating employee of local governmental agency who retires on or before September 1, 2008, and reenrolls upon retirement or total disability.

NAC 287.546 - Coverage of participating employee of local governmental agency who retires after September 1, 2008, and reenrolls upon retirement or total disability.

NAC 287.548 - Coverage of nonparticipating employee of local governmental agency who retires after September 1, 2008.

NAC 287.680 - Appeal of decision of appeals manager: Requirements; duties of Executive Officer or designee.

NRS 287.023 - Option of retired officer or employee or Dependent to cancel or continue group insurance, plan of benefits, medical and Hospital service, or coverage under Public Employees' Benefits Program; notice of selection of option; payment of costs for coverage.

NRS 287.0406 – Program is defined as the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043

NRS 287.043 - Defines the PEBP Board's powers and duties related to the Benefit structure, rate setting and administration of certain parts of the Public Employees' Benefits Program.

NRS 287.0435 - Creation; investment; disbursements; administration by State Treasurer; checking account for payment of claims.

NRS 287.0436 - Creation and purpose of the State Retirees' Health and Welfare Benefits Fund:

NRS 287.046 - Department of Administration will to establish assessment to pay portion of premiums or contributions for participating retirees with state service; amounts assessed to be deposited in Retirees' Fund; adjustments to portion paid to Program by Retirees' Fund.

NRS 287.047 - Retention by certain retired State officers and employees and Dependents' of membership in coverage under Program.

NRS 287.0475 - Reinstatement of insurance by retired public officer or employee or surviving spouse.

NRS 689B.020 - Group health insurance defined; eligible groups and benefits.

NRS 689B.033 - Required provision concerning coverage for newly born and adopted children and children placed for adoption.

NRS 689B.287 - Insurer prohibited from denying coverage solely because insured was intoxicated or under influence of controlled substance; exceptions.

NRS 695G.164 - Required provision concerning coverage for continued medical treatment.

NRS 695G.1665 - Required provision concerning coverage for prescription drugs irregularly dispensed for purpose of the synchronization of chronic medications.

NRS 695G.170 - Required provision concerning coverage for medically necessary emergency services.

NRS 695G.172 - Required provision concerning coverage for early refills of topical ophthalmic products.

Plan Definitions

The following are definitions of specific terms and words used in this document, or that would be helpful in understanding covered or excluded health care services. 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 has the ability to 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.

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) A determination by PEBP, the third-party administrator or utilization management company based upon the information provided or failure to provide, 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 benefit or service or is determined to be experimental 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;
- (b) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by PEBP, the third party administrator or utilization management company of a covered Participant's or Dependent's eligibility to participate in the Plan;
- (c) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.
- (d) 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: "Allowable Expenses" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under the Plan. When some other non-Medicare Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the other non-Medicare Plan's Allowable Expenses.

When some other non-Medicare Plan provides benefits in the form of services rather than cash payments, the Plan Administrator shall assess the value of each service rendered, by determining the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other non-Medicare Plan include the benefits that would have been payable had claim been duly made therefore, whether or not it is actually made.

Ambulance: A vehicle, helicopter, airplane or boat that is licensed or certified for Emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of 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 of 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 anesthesiologist who is administering the anesthetic, and that the anesthesiologist or anesthesiologist 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.
- 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: Services provided by a Hospital or other health care 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.

Autism Behavioral Interventionist:

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:

- A licensed psychologist;
- A licensed behavior analyst; or
- A licensed assistant behavior analyst.

Autism Spectrum Disorder: A group of disorders characterized by impairment of development in multiple areas, including the acquisition of reciprocal social interaction, verbal and nonverbal communication skills, and imaginative activity, and by stereotyped interests and behaviors. It includes but is not limited to autistic disorder, Rett syndrome, childhood disintegrative disorder, and Asperger syndrome.

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 communication materials produced by PEBP.

Behavioral Health Disorder: Behavioral Health Disorder is any Illness that is defined within the Mental Disorders section of the current edition of the International Classification of Diseases

(ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause.

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 Medical Plan Exclusions section of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Behavioral Health Practitioners: 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: Behavioral Health Treatment includes 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 the purpose of 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 of 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 of the following requirements:
- It is operated and equipped in accordance with any applicable state law for the purpose of 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 considered to 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.

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 in order 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.

Case Management: A process administered by the Utilization Management Company in which its medical professionals work with the patient, family, care-givers, Health Care Providers, Claims Administrator and PEBP to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

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 of the following criteria are met:

- a. The Participant has a neuro-musculoskeletal disorder; and
- b. 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: Means 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 in order 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 (UM) company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or health care facility.

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 particular 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 actually 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 amount of Deductibles is discussed in the Medical Expense Coverage section of this document. The Dental Deductibles are discussed in the separate Dental Master Plan Document.

Dental: As used in this document, Dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including Dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the Temporomandibular Joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, Injury, decay, malformation, disease or infection. Dental services and supplies are covered under the Dental expense coverage Plan, and are not covered under the medical expense coverage of the Plan unless the medical Plan specifically indicates otherwise in the Schedule of Medical Benefits.

Dependent: Any of the following individuals: Dependent Child(ren), Spouse or Domestic Partner as those terms are defined in this document.

Dependent Child(ren): For the purposes of this Plan, a Dependent Child is any of your Children under the age of 26 years, including:

- natural Child,
- Child(ren) of a Domestic Partner,
- stepchild,
- legally adopted Child or Child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the Employee of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child and the Child must be available for adoption and the legal adoption process must have commenced),
- Child who qualifies for benefits under a QMCSO/NMSN (see the Eligibility section for details on QMCSO/NMSN),
- Child under age 19 years for whom you have legal guardianship under a court order.

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.

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. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device)

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 (as defined in this Definitions section); and the charges for them are Usual and Customary (as defined in this Definitions section); and coverage for the services or supplies is not excluded (as provided in the Exclusions section); and the Plan Year Maximum Benefits for those services or supplies has not been reached.

Emergency: See Medical Emergency.

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 Exclusions section for which the Plan does not provide Plan benefits.

Experimental and/or Investigational: 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 Pre-certification 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 in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is:
 - approved by the FDA as an "Investigational new drug for treatment use"; or
 - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease," as that term is defined in FDA regulations; or
 - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
- The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided or considered for Pre-certification under the Plan's Utilization Management program:

- Medical records of the covered person;
- The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
- Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
- Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including (but not limited to) "United States Pharmacopoeia Dispensing Information"; and "American Hospital Formulary Service";
- The published opinions of: the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of

Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to Dental services or supplies;

- Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply;
- The latest edition of “The Medicare Coverage Issues Manual.”
- Nevada Statutes mandate the following criteria be met in cases of Cancer and Chronic Fatigue Syndrome:
 1. A policy of health insurance must provide coverage for medical treatment in a clinical study or trial if:
 - a. treatment is for either Phase I, II, III, IV cancer or Phase II, III, IV Chronic Fatigue Syndrome;
 - b. study is approved by:
 - i. Agency of National Institute of Health;
 - ii. A cooperative group (see bill for exact definition);
 - iii. FDA for new investigational drug
 - iv. US Dept. of Veteran Affairs;
 - v. US Dept. of Defense;
 - c. Health Care Provider and facility have authority to provide the care for Phase I cancer;
 - d. Health Care Provider and facility have experience to provide the care for Phase II, III, IV cancer or Chronic Fatigue Syndrome;
 - e. no other treatment considered a more appropriate alternative;
 - f. reasonable expectation based on clinical data that treatment will be at least as effective as other treatments;
 - g. study is conducted in Nevada;
 - h. Participant signs a statement of consent that he has been informed of:
 - i. the procedure to be undertaken;
 - ii. alternative methods of treatment;
 - iii. associated risks of treatment.
 2. Coverage for medical treatment is limited to:
 - a. a drug or device approved for sale by the FDA;
 - b. 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 Pre-certification of any procedure that might be deemed to be Experimental and/or Investigational, see the Pre-certification Review section of the Utilization Management section.

Explanation of Benefits (EOB): When a claim is processed by the Claims Administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to Your Deductible, if Your out of pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the Provider, etc.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Expedited Appeal: If a Participant appeals a decision regarding a denied request for Pre-certification (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.

Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Formulary: A list of Generic and Brand name Drug products available for use by Participants.

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 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 of the following requirements:
 - It has the primary purpose of providing a Home Health Care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
 - It has a full-time administrator.
 - It is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs).
 - It maintains written clinical records of services provided to all patients.
 - Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
 - Its employees are bonded.
 - It maintains malpractice insurance coverage.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." (See also the 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 of the following requirements:
 - It provides 24 hour-a-day, 7 day-a-week service.
 - It is under the direct supervision of a duly qualified Physician.
 - It has a full-time administrator.
 - It has a Nurse coordinator who is a Registered Nurse (RN) with four 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 approved by Medicare as a Hospital; and
- provides care and treatment by Physicians and Nurses on a 24-hour basis for Illness or Injury through the medical, surgical and diagnostic facilities on its premises.

A Hospital may include facilities for Behavioral Health Treatment that are licensed and operated according to law. Any portion of a Hospital used as an Ambulatory Surgical Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Sub-Acute Care Facility, or other place for rest, Custodial Care, or the aged shall not be regarded as a Hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn Child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy of a covered Employee or covered Spouse will be considered to be an Illness only for the purpose of coverage under this Plan. However, infertility is not an Illness for the purpose of coverage under this Plan.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an Inherited Metabolic Disorder under this Plan. See also Medical Foods.

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 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: See Special Care Unit.

Investigational: See the definition of Experimental and/or Investigational.

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 more costly than others that can achieve the same result.

Maximum Amount; Maximum Allowable Charge

“Maximum Amount and/or Maximum Allowable Charge” shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed:

1. The Reasonable and Appropriate amount;
2. The terms of the Plan;
3. Plan negotiated and contractual rates with provider(s);
4. The actual billed charges for the covered services; and,
5. Unusual circumstances or complications requiring additional time, skill and experience in connection with a particular 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: 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.

Medical Foods: See the definition of Special Food Product.

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 of 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 considered to 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 considered to be Cost-Efficient if it is no more costly 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 considered to be Medically Necessary for the medical or Dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be considered to 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 considered to be Medically Necessary if it is furnished in a Hospital or health care facility or other more costly 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 and treatment/services or substances are not a payable Benefit under this Plan.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Non-Participating Provider: A Health Care Provider who does not participate in the Plan's 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 in order 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 considered to be 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. The Plan's Open Enrollment Period is described in the Eligibility section of this document.

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 such time as the patient is able to achieve Active Rehabilitation. Continued hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to 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.

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.

Pre-certification: Pre-certification is a review procedure performed by the Utilization Management 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.

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/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.
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.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: Means the Public Employees' Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

Prophylactic Surgery: A surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an Illness, disease, physical or Mental Disorder or condition based on genetic information or Genetic Testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or Mental Disorder, even at its earliest stages. An example of Prophylactic Surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the Surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth 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: See the definition of Health Care Provider.

Reasonable and/or Reasonableness: 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:

- a. The facts and circumstances giving rise to the need for the service or supply;
- b. Industry standards and practices as they are related to similar scenarios; and
- c. The cause of the Injury or Illness necessitating the service or charge.

The Plan Administrator's determination will consider, but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and Organizations; (b) The Centers for Medicare and Medicaid Services (CMS); (c) Centers for Disease Control and Prevention; and (d) The Food and Drug Administration.

To be Reasonable, charges must be in compliance with 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 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.

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 Health Care Providers who have agreements with the Plan's PPO. See the section on Medical Networks for additional information.

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 (SNF): 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 of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
- It provides services under the supervision of Physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
- It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
- It is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; and
- It is not a hotel or motel.

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 and is intended to be consumed under the direction of a Physician for the dietary treatment of an inherited metabolic disease (as that term is defined in this section). The term does 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.

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.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability section of this document for an explanation of how the Plan may use the right of Subrogation to be substituted in place of a Covered Individual in that person's claim against a third party who wrongfully caused that person's Injury or Illness, so that the Plan may recover medical Benefits paid if the Covered Individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

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: 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 the purpose of determining Benefits under this Plan. Multiple Surgical Procedure Allowances are specified below:

Multiple Surgical Procedure Allowances:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: Usual and Customary Charge or negotiated fee;
- Secondary procedure in same operative area: limited to 50% of Usual and Customary Charge or negotiated fee;
- Bilateral secondary procedure in same operative area: limited to 50% of Usual and Customary Charge or negotiated fee;
- Add-on to secondary procedure in same operative area: limited to 100% of Usual and Customary Charge or negotiated fee;
- Separate (incidental) procedure in same operative area as any of the above: not covered;
- Separate operative area: limited to 50% of Usual and Customary Charge or negotiated fee.

Temporomandibular Joint (TMJ), Temporomandibular Joint (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 definition of Occupational, Physical and Speech Therapy.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the Transplanted organ or tissue in the recipient. (See the Schedule of Medical Benefits and the Exclusions section for additional information regarding Transplants. See also the Utilization Management section of this document for information about Pre-certification 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 Pre-certification 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 at all times when the facility is open.

Usual and Customary: "Usual and Customary" (U&C) shall mean covered expenses which are identified by the Plan Administrator, 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 be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located 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): Pre-certification 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: 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 as a result of Illness, Injury or congenital defect. The Plan's coverage of Well Baby Care is described under Wellness/Preventive Care in the Schedule of Medical Benefits.

You, Your: When used in this document, these words refer to the Employee or Retiree who is covered by the Plan. They do not refer to any Dependent of the Employee or Retiree.