PROPOSED REGULATION OF THE BOARD OF THE PUBLIC EMPLOYEES' BENEFITS PROGRAM

LCB File No. R002-12

MANDATORY CHANGES FOR STATE AND FEDERAL STATUTORY CHANGES

NAC 287.085 "Open enrollment" defined. (NRS 287.043) "Open enrollment" means the event in which~~[:~~

~~1. P]~~ ***p***articipants in the Program may change elections offered by the Program concerning coverage and dependents ~~[or, if eligible, join an opt-out plan]~~.

~~[2. Participants in an opt-out plan may join the Program or another opt-out plan for which they are eligible.]~~

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; A by R097-03, 9-24-2003; R023-09, 11-25-2009)

NAC 287.090 "Opt-out plan" defined. (NRS 287.043) "Opt-out plan" means an alternative plan to provide life, accident or health insurance, or any combination thereof, for a group which is approved by the Board and is secured ~~[from:]~~ ***pursuant to NRS 287.0479.***

~~[1. An insurer that is authorized by the Commissioner of Insurance to provide such insurance; or~~

~~2. An employee benefit plan, as defined in 29 U.S.C. § 1002(3), that has been approved by the Board.]~~

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

NAC 287.312 Dependents: Eligibility of ~~[unmarried]~~ child of participant, spouse or domestic partner. (NRS 122A.100, 287.043)

1. Except as otherwise provided in subsection 4, the following children of a participant or his or her spouse or domestic partner are eligible for coverage as a dependent if approved pursuant to NAC 287.313:

(a) Any child who is under the age ***set by the Board at which the child would not otherwise be eligible to receive coverage under Program*** ~~[of 19 years]~~.

(b) Any child who is ***over the age described in paragraph (a)*** ~~[19 years of age or older]~~ if:

(1) At ~~[the]~~ ***that*** age ~~[of 19 years]~~, the child is incapable of self-support because of a physical or mental disability;

(2) ~~[On the 19th birthday of the child, t]~~***T***he child is covered by the Program or has received continuous coverage since the child was ***the age described in paragraph (a)*** ~~[18 years of age]~~ as a dependent under another group health plan or credible coverage; and

(3) Within 30 days after the ~~[19th]~~ birthday of the child ***at which he or she achieves the age described in paragraph (a)***, if the child is covered by the Program on th***at***~~[e 19th]~~ birthday of the child or, if the child is initially enrolled in the Program on his or her ~~[19th]~~ birthday ***at which he or she achieves the age described in paragraph (a)***, within 30 days after the effective date of the child's coverage under the Program, the participant or his or her spouse or domestic partner provides to the Program:

(I) A written statement by a physician who provides care to the child that is prepared within 90 days before provision of the statement to the Program indicating that the child has a

mental or physical impairment which causes the child to be incapable of self-sustaining employment and to depend on the participant or his or her spouse or domestic partner primarily for support; and

(II) Any other documentation required by the Program that demonstrates financial support of the child by the participant or his or her spouse or domestic partner.

~~[(c) Any child who is 19 years of age or older but less than 24 years of age, if the child is enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school and accredited trade or business school, on a full-time basis.~~

~~(d) Any child who is 24 years of age or older, if:~~

~~(1) The child was enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school and accredited trade or business school, on a full-time basis between the child's 19th birthday and his or her 24th birthday;~~

~~(2) At the age of 24 years, the child is incapable of self-support because of a physical or mental disability if the disability occurred while the child was a full-time student; and~~

~~(3) The participant or his or her spouse or domestic partner provides supporting evidence to the Program within 30 days after the 24th birthday of the child which demonstrates that the child qualifies for coverage and insurance pursuant to this paragraph.]~~

2. To determine whether the child of a participant or his or her spouse or domestic partner continues to be eligible for coverage pursuant to paragraph (b) of subsection 1, the Executive Officer or his or her designee may require:

(a) Submission of periodic updates to the documentation provided by the participant or his or her spouse or domestic partner pursuant to subparagraph (3) of paragraph (b) of subsection 1; and

(b) Submission of the child to a mental or physical examination conducted by a physician selected by and at the expense of the Program.

3. Children eligible for coverage as a dependent pursuant to this section may include biological children, adopted children, children placed in the residence of the participant for adoption, stepchildren and any other child who is related to the participant or his or her spouse or domestic partner if the participant or his or her spouse or domestic partner is legally responsible for the child and the child is financially dependent on the participant or his or her spouse or domestic partner for care and support.

4. ***A foster child*** ~~[The following children]~~ of a participant or his or her spouse or domestic partner ***is*** ~~[are]~~ not eligible for coverage as a dependent.~~[:~~

~~(a) A foster child.~~

~~(b) A child who is married.~~

~~(c) A child who is in a domestic partnership.]~~

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; A by R154-03, 3-22-2004; R089-05, 6-28-2006; R126-07, 1-30-2008; R016-08, 8-26-2008, eff. 7-1-2009; R107-09, 4-20-2010; R107-09, 4-20-2010, eff. 7-1-2010)

NAC 287.350 "Group" defined. (NRS 287.043, 287.0479) As used in NAC 287.350 to 287.389, inclusive, unless the context otherwise requires, "group" means a group of not less than 300 active state officers or employees or retired state officers or employees ***who are organized***

for reasons other than acquiring insurance, ~~[or any combination thereof,]~~ who participate in the Program and who apply to leave the Program pursuant to NRS 287.0479.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

NAC 287.357 Application to leave Program: Contents. (NRS 287.043, 287.0479) An application to leave the Program must include, without limitation:

1. A copy of the plan of benefits to be offered under the proposed opt-out plan, including, without limitation, a description of:

(a) The benefits to be provided under the proposed opt-out plan;

(b) The manner for determining eligibility for benefits under the proposed opt-out plan; and

(c) The circumstances under which any participant in the proposed opt-out plan, including, without limitation, active and retired officers and employees, may lose coverage under the proposed opt-out plan.

2. A description of the manner in which initial eligibility for benefits under the proposed opt-out plan will be determined, including, without limitation, whether members of the group will experience any gap in coverage during the period between when the group leaves the Program and coverage is available for the group under the proposed opt-out plan.

3. ***The proposed effective date of the opt-out plan which must coincide with the start of a Program plan year.***

4. The organizational entity to which all the proposed participants belong and a ~~[A]~~ list of the proposed participants in the proposed opt-out plan, including, without limitation, the name, social security number and date of birth of each proposed participant.

~~[4]~~ ***5***. The federal tax identification number of the proposed opt-out plan.

~~[5. Audited financial statements of the proposed opt-out plan, if any, for the 2 years immediately preceding the date of application, which must reflect unqualified opinions by the persons who performed the audit of the financial statements concerning the financial soundness of the proposed opt-out plan.]~~

6. A copy of the contract pursuant to which the members of the group will receive coverage from the proposed opt-out plan. The contract must include, without limitation, the amount of premiums or contributions that will be required to maintain coverage for the members of the group under the proposed opt-out plan.

7. Evidence establishing that the proposed opt-out plan is or will be operated pursuant to such sound accounting and financial management practices as to ensure that the group will continue to receive adequate benefits. Such evidence ***shall*** ~~[may]~~ include***:***

(a) ~~[f]~~***F***inancial statements***;*** ~~,~~

(b) ***Audits of financial statements of the proposed opt-out plan, if any, for the 2 years immediately preceding the date of application, which must reflect unqualified opinions by the persons who performed the audit of the financial statements;*** ~~[annual audits]~~ and

(c) ~~[a]~~***A***ny other information requested by the Board or determined by the group to be relevant to the financial management practices of the proposed opt-out plan.

➥ ***in order to evaluate the financial soundness of the proposed opt-out plan.***

8. A completed Business Associate Agreement that is consistent with the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, ***as amended,*** and is in a form acceptable to the Board, or a certification that the opt-out plan is a covered entity under and complies with ~~[the]~~ ***all federal*** privacy regulations ~~[of that federal Act]~~.

9. If the proposed opt-out plan is secured from an insurer, a copy of the current certificate of authority issued by the Commissioner of Insurance to the insurer which indicates that the insurer is authorized to provide the coverage proposed to be offered under the proposed opt-out plan in this State.

10. The name and contact information of a representative of the group who will be available to answer questions from the Board concerning the application.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003; A by R089-05, 6-28-2006)

NAC 287.359 Application to leave Program: Dates for submission; duties of Board. (NRS 287.043, 287.0479)

1. To apply to leave the Program in the next plan year, a group must submit an application to the Board on or ~~[after the first day of the first month of the current plan year but]~~ before ~~[:~~

~~(a) T]~~*t*he first day of the ~~[fourth]~~ ***tenth*** month ***prior to the proposed effective date*** ~~[of the current plan year; or~~

~~(b) If the current plan year is less than a calendar year, the date set forth by the Board as the last day to submit an application to leave the Program in the next plan year.~~

~~➥ If an application is received at any other time during the current plan year, the Board will return the application to the applicant.]~~

2. If additional information is required to process any application, the Board will notify the representative of the group who is designated pursuant to NAC 287.357.

3. The Board will provide an opportunity for:

(a) A representative of the Program to present arguments for or against the approval of an application.

(b) The representative of the group who is designated pursuant to NAC 287.357 to present arguments that support the approval of an application.

4. The Board will grant or deny each application received pursuant to subsection 1 not later than ~~[:~~

~~(a) T]~~*t*he 15th day of the sixth month ***prior to the proposed effective date*** ~~[of the current plan year; or~~

~~(b) If the current plan year is less than a calendar year, 75 days after the date set forth by the Board as the last day to submit an application to leave the Program in the next plan year.]~~

5. The Board will notify each applicant of the date and time of the meeting during which the Board will render a decision on the application of the applicant.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003; A by R089-05, 6-28-2006; R023-09, 11-25-2009)

NAC 287.361 Application to leave Program: Considerations for ~~[grant]~~ *approval* or denial; basis for findings by Board. (NRS 287.043, 287.0479)

1. In determining whether to ~~[grant]~~ ***approve*** or deny an application to leave the Program, the Board:

(a) Shall consider whether:

(1) The departure of the group from the Program would cause an increase of more than 5 percent in the costs of premiums or contributions for the remaining participants in the Program;

(2) The proposed opt-out plan is financially sound and operated pursuant to sound accounting and financial management practices; and

(3) The proposed opt-out plan provides adequate benefits at the time of application that includes offering the same coverage to active officers and employees and retired officers and employees using rates based on the commingled experience of all active and retired participants.

(4) The applicant meets the requirements of subsection 3 of NRS 287.0479.

(b) May consider:

(1) Whether the cumulative impact of a group leaving the Program on the costs of premiums or contributions for the remaining participants in the Program is so detrimental as to cause a significant negative impact on the Program;

(2) ~~[Whether the composition of the group indicates adverse selection that would constitute a significant negative impact on the Program;~~

~~(3)~~ ~~]~~Whether the current financial condition of the Program is such that the departure of the group would constitute a significant negative impact on the Program;

(~~[4]~~ ***3***) Whether the departure of the group is administratively feasible;

(~~[5]~~ ***4***) Whether independent, actuarial or other reviews obtained by the Board indicate that the departure of the group will cause a significant negative impact on the Program; and

(~~[6]~~ ***5***) Any other information that the Board deems relevant.

2. Findings by the Board concerning the considerations described in subsection 1 must be based exclusively on substantial evidence.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003; A by R089-05, 6-28-2006)

NAC 287.363 Approval of application by Board: Format and contents of decision; responsibilities of and noncompliance by group. (NRS 287.043, 287.0479)

1. A decision of the Board to ~~[grant]~~ ***approve*** an application to leave the Program will be in writing and will include, without limitation, the effective date of departure of the group from the Program and the dates for completion of any administrative tasks necessary to effect the departure of the group.

2. ***Such approval of an*** ~~[If the Board grants the]~~ application of a group to leave the Program ***shall be conditioned upon***:

(a) The group ~~[must]~~ submit***ting*** to the Board a completed release and waiver of rights agreement, in a form acceptable to the Board, obtained from and signed by each member of the group. ~~[Such an agreement must include, without limitation, a description of the circumstances, if any, under which a member of the group, including, without limitation, active and retired members, may return to the Program.]~~

(b) A contract, in a form acceptable to the Board, ~~[must]~~ be***ing*** executed between the Program and the proposed opt-out plan of the group. The contract must~~[:~~

~~(1) S]~~***s***et forth the terms of coverage for the group, provisions for the payment of premiums or contributions of participants to the opt-out plan and such other details necessary to effect departure of the group from the Program.

~~[(2) Include, without limitation, provisions regarding the return to the Program of individual members of the group.]~~

➥ ***Prior to the date set forth by the Board pursuant to subsection 1.***

3. The completed release and waiver of rights agreement ~~[must be submitted to the Board]~~, and the contract between the Program and the proposed opt-out plan of the group that are required pursuant to subsection 2 must be ***submitted to and*** executed between the Program and the proposed opt-out plan of the group, on or before~~[:~~

~~(a) T~~]*t*he 25th day of the ***fourth*** ~~[eighth]~~ month ***prior to the approved effective date*** ~~[of the plan year in which the application is approved; or~~

~~(b) If the current plan year is less than a calendar year, the date set forth by the Board~~]**.**

4. If a group whose application to leave the Program has been approved by the Board fails to comply with the requirements of this section or any provision of the decision of the Board to grant the application of the group, the Board may declare the contract between the Program and the opt-out plan of the group void.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003; A by R023-09, 11-25-2009)

NAC 287.369 Effective date of departure from Program; coverage by Program until departure; request to rescind approval of Board. (NRS 287.043, 287.0479)

1. The effective date of departure from the Program of a group whose application has been approved by the Board is the first day of the plan year that is at least 120 days after the date on which the Board approves the application.

2. The Program shall provide coverage to participants in a group that has been approved by the Board to leave the Program until the effective date of departure of the group from the Program set forth in the decision of the Board granting the application of the group to leave the Program.

3. ~~[At any time before the effective date of departure of a group from the Program, the group may request the Board to rescind its decision to grant the application of the group]~~ ***A group whose application to leave the Program has been approved by the Board may only rejoin the Program as a group using the procedures delineated in NAC 287.310 for local government agencies***.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

NAC 287.371 Eligibility of officer or employee to join opt-out plan*; change in coverage*. (NRS 287.043, 287.0479)

1. If an officer or employee is eligible to join an opt-out plan at the time of his or her employment, the officer or employee ~~[may elect to]~~ ***shall*** join the opt-out plan or ***decline coverage*** ~~[the Program]~~ upon commencing employment.

2. If an officer or employee ~~[:~~

~~(a) Was eligible to join an opt-out plan at the commencement of his or her employment but joined the Program; or~~

~~(b) B~~]***b***ecomes eligible to join an opt-out plan after the commencement of his or her employment,

~~[➥~~] the officer or employee ***shall*** ~~[may]~~ ***terminate coverage in*** ~~[join the opt-out plan in lieu of]~~ the Program ~~[at an open enrollment]~~ ***on the last day of the month concurrent with or subsequent to the date the officer or employee becomes eligible to join the opt-out-plan and shall join the opt-out plan or decline coverage on that date.***

3. If an officer or employee in an opt-out plan transfers to a different participating state agency and lose eligibility to remain in the opt-out plan, the officer or employee shall terminate coverage in the opt-out plan on the last day of the month concurrent with or subsequent to the date the officer or employee transfers to the new agency. The officer or employee shall:

(a) ***Join the Program if his or her new position is not part of an opt-out group;***

(b) ***Join a different opt-out plan if his or her new position is part of an opt-out group; or***

(c) ***Decline coverage,***

➥ ***subject to the enrollment requirements of the Program or opt-out plan, as applicable***.

~~[3]~~ ***4***. It is the responsibility of an officer or employee that is eligible to join an opt-out plan ***or who loses eligibility to remain in the opt-out plan*** or the administrator of the opt-out plan to notify the Program of the eligibility ***or loss of eligibility*** of the officer or employee to join ***or remain in*** the opt-out plan. ~~[Failure to provide such notification to the Program may result in the ineligibility of the employee to select the opt-out plan upon commencement of his or her employment or at open enrollment.]~~ ***Notice shall be provided to the Program and to the opt-out plan within 60 days of the officer or employee becoming eligible for or losing eligibility of participating in the opt-out plan.***

5. The Program is not liable for any expenses or claims of an officer or employee, or any dependents thereof, after the last day of the month in which the officer or employee becomes eligible for participating in an opt-out plan.

6. An opt-out plan is not liable for any expenses or claims of an officer or employee, or any dependents thereof, after the last day of the month in which the officer or employee loses eligibility of participating in the opt-out plan.

7. No lapse in coverage may occur to a participant when he or she changes coverage pursuant to this subsection.

8. A retired officer or employee or the survivor of a deceased officer or employee who was eligible for coverage under an opt-out plan at the time of his or her retirement shall remain in the opt-out plan and is not eligible for coverage under the Program unless the opt-out group rejoins the Program.

9. When a member in an opt-out plan dies, the survivor shall remain in the opt-out plan if he or she is eligible for coverage under the opt-out plan. The survivor is not eligible for coverage under the Program.

10. When an officer or employee joins an opt-out plan, the Program shall not consider that decision to be a declination of coverage.

11. If a participant in an opt-out plan becomes ineligible for participation in the opt-out plan, he or she may elect to continue coverage under the opt-out plan pursuant to the Public Health Services Act, 42 U.S.C. § 300bb-1(a), or the Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, as applicable.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

NAC 287.373 Notification of Program regarding certain changes in status and court orders. (NRS 287.043, 287.0479)

1. Within 15 calendar days after a change in the status of a participant in an opt-out plan that affects the rate of his or her premium or contribution, the opt-out plan shall notify the Program of that change in an electronic format acceptable to the Program.

2. If an officer or employee has declined participation in ~~[the Program and any]~~ ***an*** opt-out plan, the officer or employee shall notify the Program within ~~[31]~~ ***60*** days after the officer or employee has:

(a) Been ordered to obtain health insurance for his or her child pursuant to NRS 31A.350; or

(b) A change in life status or the addition of a dependent that initiates eligibility for both the declined employee and any affected dependent.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

~~[NAC 287.377 Requirements for change in coverage. (NRS 287.043, 287.0479)~~

~~1. A participant in an opt-out plan may only join a different opt-out plan or the Program during open enrollment. No lapse in coverage may occur to a participant when he or she changes coverage pursuant to this subsection.~~

~~2. When a participant in an opt-out plan retires or becomes a survivor of a deceased officer or employee, the participant may not select another opt-out plan for which he or she is eligible or the Program until the next open enrollment.~~

~~3. When an officer or employee joins an opt-out plan, the Program shall not consider that decision to be a declination of coverage.~~

~~4. If a participant in the Program elects to join an opt-out plan, the participant shall submit to the Program a signed release and waiver of rights agreement, which is in a form acceptable to the Board.~~

~~5. If a participant in an opt-out plan becomes ineligible for participation in the opt-out plan, he or she may elect to continue coverage under the opt-out plan pursuant to the Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, until the next period of open enrollment.~~

~~(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)]~~

NAC 287.383 Premiums or contributions for participants in opt-out plans: Requirements for billing. (NRS 287.043, 287.0479) The Program shall bill on a monthly basis:

1. Each payroll center that deducts and pays the premium or contribution for a participant in an opt-out plan from the salary or monthly retirement allowance, as applicable, of the participant for the amount of the premiums or contributions for such participants based on the schedule of rates for premiums or contributions for that opt-out plan. ~~[A payroll center shall maintain the schedule of rates for each opt-out plan in which persons for whom the payroll center deducts and pays such premiums or contributions participate.]~~

2. Each participant in an opt-out plan that is responsible for the paying of his or her premium or contribution directly.

3. The Retired Employees' Group Insurance Budget Account ***in the State Retirees' Health and Welfare Benefits Fund*** for the portion of the amount of the premiums or contributions for participants in an opt-out plan who retired from the service of the State that is paid by the State pursuant to subsection 2 of NRS 287.046. The Program shall identify separately the portion of the amount billed to the State pursuant to this subsection that is attributable to participants in each opt-out plan.

4. The Active Employee Group Insurance Subsidy Budget Account in the Agency Fund for the Payroll of the State for the portion of the amount of the premiums or contributions for officers and employees in an opt-out plan that is paid by the State pursuant to subsection 1 of NRS 287.044. The Program shall identify separately the portion of the amount billed to the State pursuant to this subsection that is attributable to participants in each opt-out plan.

(Added to NAC by Bd. of Pub. Employees' Benefits Prog. by R097-03, eff. 9-24-2003)

NAC 287.440 Payment of premiums or contributions by retired officers and employees. (NRS 287.043, 287.046)

1. Except as otherwise provided in subsection***s*** 2 ***and 3***, retired officers and employees shall pay their premiums or contributions directly to the Program.

2. ***Except as provided in subsection 3,*** ~~[R]~~***r***etired officers and employees who receive a retirement benefit from the Public Employees' Retirement System shall pay their premiums or contributions to the Program through an automatic deduction from that benefit unless the retirement benefit is less than the premium or contribution.

3. Retired officers and employees whose healthcare coverage is provided through the Program by an individual medical plan offered through an exchange to supplement Medicare coverage shall pay the insurer directly.

(Added to NAC by Com. on Benefits, eff. 5-4-92; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; R154-03, 3-22-2004; R089-05, 6-28-2006; R107-09, 4-20-2010)

NAC 287.520 Coverage as both employee and dependent prohibited; change of status from employee to dependent. (NRS 287.043)

1. ***Except as otherwise provided in subsection 1 of NAC 287.530,*** ~~[A]~~ ***a*** person ***who is eligible to be covered as a participant*** may not ***elect to*** be covered by the Program as ~~[both an employee and a dependent.]~~ ***a spouse or domestic partner.*** If the person qualifies as both ***an employee and a dependent spouse or domestic partner***, he or she ***must be*** ~~[is]~~ covered ~~[only]~~ as an employee and not as a dependent.

2. If a participating officer or employee changes his or her status to that of a dependent because he or she no longer qualifies as an employee, he or she must enroll as a dependent within 60 days after losing status as an employee to be eligible for coverage and insurance as a dependent. If a participant complies with the requirements of this subsection, his or her coverage or insurance is not limited by any waiting period that would otherwise apply.

(Added to NAC by Com. on Group Ins., eff. 5-27-86; A by Com. on Benefits, 5-4-92; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001)

NAC 287.660 ~~[Review: Grounds; waiver; terms and conditions]~~ ***Notice of denial of claim; right to appeal.*** (NRS 287.043)

1. ***The Claims Administrator of the Program responsible for the processing and payment of claims shall notify a participant if a claim is denied in whole or in part. The denial shall:***

(a) Be in writing;

(b) Explain the reason for the denial;

(c) Include a reference to the plan provisions on which the denial was based;

(d) Request additional information if it is necessary to process the claim; and

(e) Include the steps required to appeal the denial.

2. A participant may request a***n appeal*** ~~[review]~~ of a claim submitted for himself or herself or a dependent if the participant feels the claim was not adjudicated pursuant to the current terms and conditions of the Program.

~~[2. The failure to request a review in a timely manner will be deemed to be a waiver of any further right of review or appeal under the Program unless the Program determines that the failure was acceptable.~~

~~3. Upon request, the Program may review claims that are the responsibility of an insurer, health maintenance organization or any other risk-bearing vendor which has responsibility for all~~

~~the processing and payment of claims. A review of claims will be governed by the terms and conditions of the contract between the participant and vendor.]~~

(Added to NAC by Com. on Group Ins., eff. 3-9-88; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; R016-08, 8-26-2008, eff. 7-1-2009)

NAC 287.670 Request for ~~[review]~~ *appeal*: Requirements; action by Claims Administrator. (NRS 287.043)

1. To initiate a***n appeal*** ~~[review]~~ of a claim, a participant must submit a written request to the Claims Administrator of the Program within ~~[60]~~ ***180*** days after the date on which ***the participant received the notice of denial*** ~~[the claim was adjudicated or to the insurer in accordance with the terms and conditions of the contract between the participant and the vendor.]~~ A request for a***n appeal*** ~~[review]~~ of a claim must include:

(a) The name of the participant;

(b) The social security number or member identification number of the participant;

(c) ***A copy of the Explanation of Benefits with the initial claim determination provided to the participant by the Claims Administrator;*** ~~[The identifying number of the claim for benefits]~~;

(d) A ***copy of the claim submitted to the Claims Administrator*** ~~[statement indicating whether the claim is for a participant or a dependent or surviving dependent of the participant]~~; and

(e) A statement setting forth the reasons the claim is being contested.

2. ***An Appeals Manager of*** ~~[T]~~***t***he Claims Administrator shall:

(a) Review a request for the ~~[review]~~ ***appeal*** of a claim ~~[with the vendors and consultants of the Board]~~ to determine if the claim was adjudicated pursuant to the current terms and conditions of the Program ***and*** under the contract between the Program and applicable vendor; and

(b) Within ~~[30]~~ ***20*** days after receiving the request for a***n appeal*** ~~[review]~~, advise the participant in writing of:

(1) The decision of the Claims Administrator; ~~[and]~~

(2) The specific provision of the applicable plan of the Program used by the Claims Administrator as the basis for the decision***; and***

(3) The steps required to appeal the decision.

3. As used in this section, "member identification number" means the number assigned to a participant by the Program.

(Added to NAC by Com. on Group Ins., eff. 3-9-88; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; R154-03, 3-22-2004; R126-07, 1-30-2008; R016-08, 8-26-2008, eff. 7-1-2009)

NAC 287.680 ~~[Initial]~~ *Second level of* appeal ~~[of review]~~: Requirements; action by Executive Officer or designee. (NRS 287.043)

1. If a participant in the Program is unsatisfied with the results of an initial ***appeal*** ~~[review]~~ of a claim, the participant may file a~~[n]~~ ***Level 2*** appeal with the Executive Officer or a designee thereof. The ***Level 2*** appeal must be***:***

(a) ***Submitted*** in writing***;*** ~~[, include all supporting documentation and~~

~~(b) be f~~]***F***iled within 35 days ***of receipt of the written decision on the initial appeal of the claim from*** ~~[after]~~ the Claims Administrator of the Program ~~[issues the written decision on the review of the claim]~~ ***; and***

(c) ~~[. The]~~ ***Contain*** supporting documentation***,*** ~~[must]~~ includ***ing***~~[e]~~, without limitation***:***

(1) ~~[, a]~~ ***A*** copy of the request for ***appeal*** ~~[review]~~ of the claim submitted to the Claims Administrator ***pursuant*** to NAC 287.670,***; and***

(2) ~~[a]~~***A*** copy of the decision of the Claim Administrator concerning the claim***;*** and

(3) ~~[a]~~***A***ny other information provided to the Claims Administrator by the participant.

2. The Executive Officer or the designee shall***:***

(a) ~~[r]~~***R***eview the material submitted by the participant to determine if the claim was adjudicated ***pursuant to the current terms and conditions of the Program and under the contract between the Program and applicable vendor*** ~~[correctly]~~***; and*** ~~[.]~~

(b) Within 30 days after receipt of the participant's appeal,

~~[3. The Executive Officer or the designee shall]~~ notify the participant in writing of***:***

(1) ~~[t]~~***T***he ***final internal benefit determination*** ~~[decision]~~ ***of whether or not to uphold or overturn the initial appeal;***

(2) The reason for the decision;

(3) The specific provision of the applicable plan of the Program used as the basis for the decision; and

(4) The participant's right to request an External Appeal and the steps to file such an appeal ~~[within 30 days after receipt of the participant's appeal]~~.

(Added to NAC by Com. on Group Ins., eff. 3-9-88; A by Com. on Benefits, 5-4-92; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; R154-03, 3-22-2004; R126-07, 1-30-2008)

NAC 287.690 ***External Review of adverse determination*** ~~[Appeal to and decision of Board]~~**.** (NRS 287.043)

1. If a participant in the Program is not satisfied with the decision of the Executive Officer or the designee on the appeal made by the participant, the participant may file an ***External Review of Adverse Determination*** ~~[appeal]~~ with the ***Office for Consumer Health Assistance pursuant to NRS 695G.241 to 695G.310, inclusive.*** ~~[Board for a review by the Board of the claim]~~.

2. The appeal must be filed within ***four months of the receipt of the final internal benefit determination from*** ~~[35 days after the date on which]~~ the Executive Officer or the designee ~~[issues the written decision concerning the review.~~

~~2. Except as otherwise provided in this subsection, after the receipt of an appeal pursuant to this section, the Executive Officer or the designee shall prepare a written report concerning the appeal and present the report to the Board at its next meeting. If an appeal is received after the deadline for placing items on the agenda for the next meeting of the Board, the Executive Officer or the designee shall present the report to the Board at its next following meeting. The report presented to the Board must include the grounds for the appeal, supporting documentation, information concerning the claim and recommendations for action by the Board.~~

~~3. Not later than 10 days before the date of the meeting in which an appeal that was made by a participant pursuant to this section will be heard by the Board, the Executive Officer or the designee shall notify the participant in writing of the date, time and place of the meeting and provide to the participant the written report concerning the appeal that was prepared by the Executive Officer or the designee pursuant to subsection 2.~~

~~4. The participant may appear with an attorney or other representative of his or her choosing before the Board in a closed portion of an open meeting held pursuant to NRS 241.030~~

~~to review orally the claim and the reasons why the participant is not satisfied with the adjudication of the claim.~~

~~5. Except as otherwise provided in NRS 241.033, the Chair may at any time before or during the closed portion of the open meeting determine which additional persons, if any, are allowed to attend the closed portion of the open meeting. The Board may allow the Claims Administrator of the Program to present an explanation of the decision that the Claims Administrator made pursuant to NAC 287.670 at the closed portion of the open meeting.~~

~~6. The Board may render a decision on the claim at that time during its open meeting or defer action to a future meeting if additional information is required for review.~~

~~7. The Executive Officer or the designee shall mail to the participant by first-class mail notice of the decision of the Board within 15 days after the decision is rendered.~~

~~8. A decision of the Board is final.~~**]**

(Added to NAC by Com. on Group Ins., eff. 3-9-88; A by Com. on Benefits, 5-4-92; A by Bd. of Pub. Employees' Benefits Prog. by R126-00, 12-22-2000, eff. 1-1-2001; R154-03, 3-22-2004; R089-05, 6-28-2006; R126-07, 1-30-2008)

New Section: Expedited Appeal

1. Except as provided in subsection 4, a participant may request an expedited appeal for a medical condition that would seriously jeopardize his or her or his or her dependent's life or health or the ability to regain maximum function if treatment is delayed. A request for an expedited appeal may be submitted to the Program or the Claims Administrator, as applicable, orally or in writing;

2. All necessary information may be transmitted between the participant and the Program or the Claims Administrator, as applicable, by telephone, facsimile or other similarly expeditious method.

3. If the participant provides all necessary information, a decision on an expedited appeal will be provided within 72 hours of receipt of the request.

4. A participant may submit an expedited appeal under the External Review of Adverse Determination provisions with the Office of Consumer Health Assistance pursuant to NRS 695G.241 to 695G.310, inclusive.