Department of Health and Human Services
Aging and Disability Services Division
Office for Consumer Health Assistance
Payment for Medically Necessary Emergency Services Provided Out-of-Network
2021 Annual Report

Table of Contents

Introduction ... 3
Arbitrations of Claims Less Than $5,000 ... 3
Arbitration Timeline ... 3
Intake Process ... 4
Screening Process ... 6
Arbitration Process ... 9
Arbitration Case Data ... 12
Arbitrations for Claims of $5,000 or More ... 14
Conclusion ... 15
List of Exhibits ... 16

Introduction

In the 2019 Legislative Session, Assembly Bill No. 469 sponsored by the Committee on Health and Human Services was passed and went into effect January 1, 2020. Nevada Revised Statutes 439B.700 – NRS 439B.760 limits the amount a provider of health care may charge a person who has health insurance for certain medically necessary emergency services provided when the provider is out-of-network. This act removes the consumer from being balance billed under certain circumstances. The Nevada Department of Health and Human Services, Office for Consumer Health Assistance (OCHA) was designated to conduct arbitrations by qualified employees for claims of less than $5,000.

The following report provides data and analysis regarding arbitrations for calendar year 2021. The report includes applications which were under review as of 12/31/20. The report also includes cases which were pending an arbitration determination as of 12/31/20. Additional reference material is provided at the end of the report: List of Exhibits

Arbitrations of Claims Less Than $5,000

Arbitration Timeline

The timeline below shows the number of business days, as outlined in Revised Proposed Regulation LCB File No. R101-19, to complete the Arbitration Determination process from receipt of application, through the screening process and to the final determination.

Timeline	Number of business days
1. OCHA receives an application from an Out-of-Network Provider or Out-of-Network Emergency Facility	1
2. OCHA acknowledges receipt of Out-of-Network Provider or Out-of-Network Emergency Facility application	10
3. OCHA completes review of application. OCHA sends a Notification of Arbitration to the Out-of-Network Provider or Out-of-Network Emergency Facility and Third Party	20
4. The Out-of-Network Provider or Out-of-Network Emergency Facility and the Third Party submits Arbitrator selections to OCHA	10
5. OCHA sends a notification of assigned Arbitrator and request for relevant information from the Out-of-Network Provider or Out-of-Network Emergency Facility and the Third Party	10

Timeline	Number of business days
6. Relevant Information is due from the Out-of-Network Provider or Out-of-Network Emergency Facility and the Third Party	10
7. OCHA's assigned Arbitrator reviews all relevant information provided. OCHA's assigned Arbitrator renders a determination. OCHA sends a Notice of Arbitration Determination to Out-of-Network Provider or Out-of-Network Emergency Facility and the Third Party	45
Total business days	106

Analysis of the time for OCHA arbitrators to complete the Arbitration Determination process in this reporting period was 95 business days. If additional information is required for an application to be determined complete and clear, the timeframe will increase by an additional 30 business days.

Intake Process

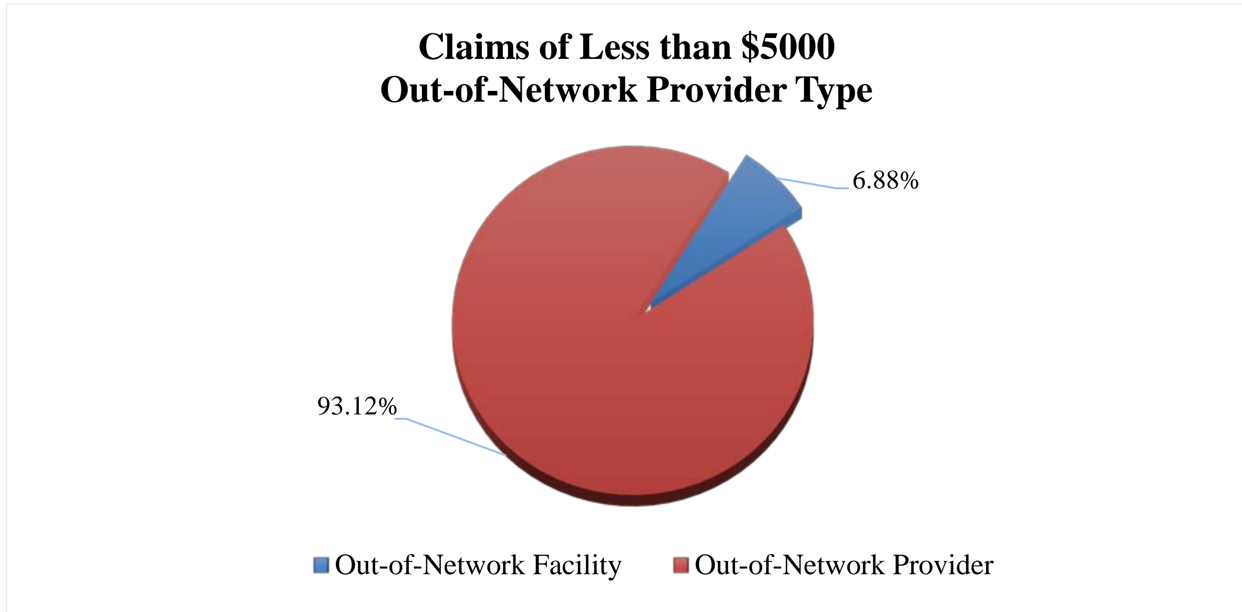
Request for Arbitration applications can be downloaded by the Out-of-Network Provider or Out-of-Network Emergency Facility from the OCHA website at http://dhhs.nv.gov/Programs/CHA/. Request for Arbitration applications are submitted to OCHA via email, fax, or regular mail.

In calendar year 2021, OCHA received 1,569 Request for Arbitration applications. This is a 101% increase in the number of applications received in calendar year 2020.

STATE OF NEVADA
Office for Consumer Health Assistance Applications Received from Out-Of-Network Facilities and Out-Of-Network Providers by County

For applications received between 1/1/2021 and 12/31/2021

County	January - December 2021		Total
	Out-of-Network Facility	Out-of-Network Provider	
Carson City	0	113	113
Clark	32	890	922
Douglas	0	18	18
Washoe	76	440	516
Statewide Total	108	1461	1569



The charts above reference total applications received from Out-of-Network Providers and Out-of-Network Emergency Facilities.

Analysis of the data above shows Out-of-Network Providers submitted the majority of applications throughout the year. Of applications received in the respective counties, the highest number of applications were received from providers in Clark County while the lowest number received was from providers in Douglas County.

STATE OF NEVADA
Office for Consumer Health Assistance Additional Amount Requested by Out-of-Network Providers and Out-of-Network Emergency Facilities for Applications Received by County

For applications received between 01/01/2021 and 12/31/2021

County	Under $500					$501 to $2000			$2001 to $4999			Total	Additional Amount Requested
	$0 to $100	$101 to $200	$201 to $300	$301 to $400	$401 to $500	$501 to $1000	$1001 to $1500	$1501 to $2000	$2001 to $3000	$3001 to $4000	$4001 to $4999		
Carson City	7	10	32	47	16	1	0	0	0	0	0	113	$34,756.31
Clark	11	54	186	172	50	431	6	3	9	0	0	922	$437,607.64
Douglas	5	11	2	0	0	0	0	0	0	0	0	18	$2,148.78
Washoe	14	60	103	78	59	141	23	18	20	0	0	516	$279,810.91
Statewide Total	37	135	323	297	125	573	29	21	29	0	0	1569	$754,323.64

Analysis of the data shows the majority of additional amount requested (58.4%) were less than or equal to $500.

Screening Process

The screening process includes OCHA reviewing each application to ensure the application is accurate, complete, and meets statutory requirements.

If the application has missing or inaccurate data, this is considered an incomplete application. The provider is notified of the missing or inaccurate data and may re-submit the application within 10 business days.

The screening decision statuses as of December 31, 2021, are seen in the chart below.

STATE OF NEVADA
Office for Consumer Health Assistance Applications Received by
Screening Decision Status

For applications screened between 01/01/2021 and 12/31/2021

Screening Decision Status	January - December 2021		Total	Percentage
	Out-of-Network Facility	Out-of-Network Provider		
Criteria met	92	1077	*1169	73.57%
Criteria not met	10	278	*288	18.12%
Under review	9	123	132	8.31%
Statewide Total	111	1478	1589	100.00%

*Included in the table above are 20 applications which were under review as of 12/31/20.

In calendar year 2020, the number of applications which met criteria was 262. In calendar year 2021, the number of applications which met criteria is 1169. This is a 346% increase in the number of applications which met criteria over the previous calendar year.

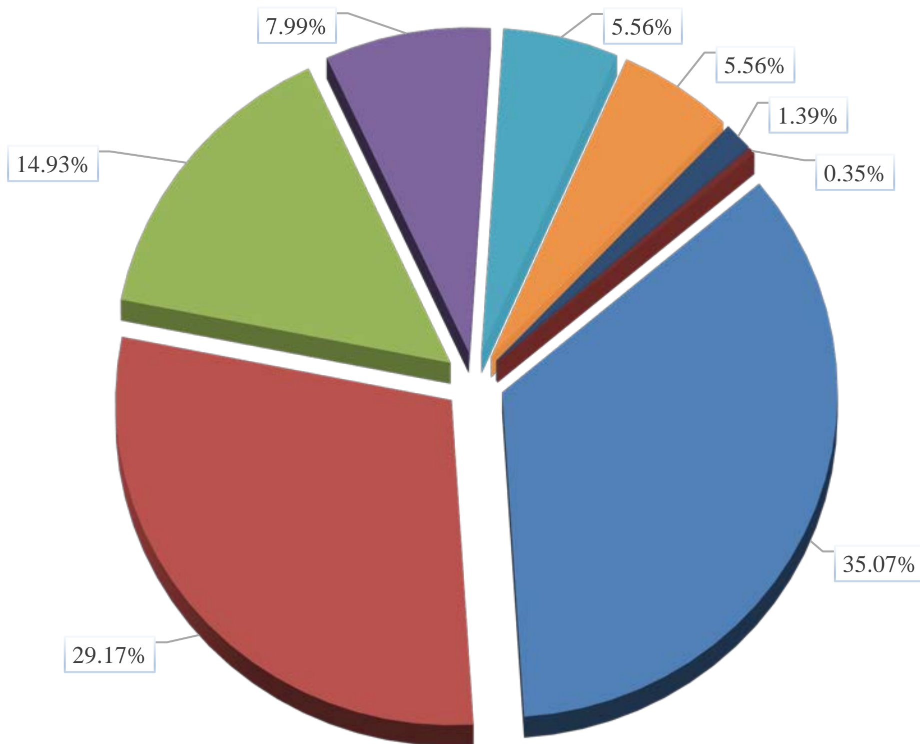
The chart below references the reasons applications did not meet criteria (ineligible) for arbitration.

STATE OF NEVADA
Office for Consumer Health Assistance Applications Which Did Not Meet Criteria for Arbitration

For applications screened between 01/01/2021 and 12/31/2021

Reasons applications did not meet criteria for arbitration	January - December 2021		Total	Percentage
	Out-of-Network Facility	Out-of-Network Provider		
The additional amount was requested past 30 days from Provider's receipt of payment by the Third Party NRS 439B.754 (1)	0	101	101	35.07%
Incomplete applications	1	83	84	29.17%
The Request for Arbitration application was submitted by Provider prior to 30 days for the Third Party to fail to pay the additional amount requested NRS 439B.754 (3)	1	42	43	14.93%
Application Withdrawn – Dispute Settled Prior to Arbitration Determination	1	22	23	7.99%
Duplicate application submitted	4	12	16	5.56%
The Request for Arbitration application was submitted by Provider after 30 business days from the Third Party's refusal or failure to pay the additional amount requested DHHS Proposed Regulation LCB File No. R101-19 Sec. 2.	3	13	16	5.56%
In-network Provider NRS 439B.749 and NRS 439B.751	0	4	4	1.39%
Claims of $5000 or more DHHS Proposed Regulation LCB File No. R101-19 Sec. 4.	0	1	1	0.35%
Entity or Organization has not elected to apply NRS 439B.736 (1) (c)	0	0	0	0.00%
Third Party does not meet definition of a Third Party under NRS 439B.736 (1) (a)	0	0	0	0.00%
Third Party not opted-in at time of service	0	0	0	0.00%
Statewide Total	10	278	288	64.93%

Reasons applications did not meet criteria for arbitration



- The additional amount was requested past 30 days from Provider's receipt of payment by the Third Party NRS 439B.754 (1)
- Incomplete applications
- The Request for Arbitration Application was submitted by Provider prior to 30 days for the Third Party to fail to pay the additional amount requested NRS 439B.754 (3)
- Application Withdrawn – Dispute Settled Prior to Arbitration Determination
- Duplicate application submitted
- The Request for Arbitration Application was submitted by Provider after 30 business days from the Third Party's refusal or failure to pay the additional amount requested DHHS Proposed Regulation LCB File No. R101-19 Sec. 2.
- In-network Provider NRS 439B.749 and NRS 439B.751
- Claims of $5000 or more DHHS Proposed Regulation LCB File No. R101-19 Sec. 4.

The data above shows reasons an application did not meet criteria for arbitration. The analysis results below show:

1. 35.07%, The additional amount was requested past 30 days from Provider's receipt of payment by the Third Party NRS 439B.754 (1):
   OCHA continues to collaborate with Out-of-Network Providers to review application requirements and refine the application submission process.
2. 29.17%, Application Incomplete:
   The percentage of incomplete applications in calendar year 2020 was 31.1%. The percent of incomplete applications for calendar year 2021 decreased to 28.42%. This is an improvement in requests for arbitration applications meeting initial criteria for arbitration.
3. 7.99%, Application Withdrawn:
   During calendar year 2021, OCHA received 23 withdrawals of requests for arbitration. This was due to the Provider and Third Party settling the dispute prior to arbitration.

Arbitration Process

The arbitration process includes applications which initially met criteria to open an arbitration case.

STATE OF NEVADA
Office for Consumer Health Assistance Cases in Arbitration between 01/01/2021 and 12/31/2021

Screening Decision Status	January - December 2021		Total
	Out-of-Network Emergency Facility	Out-of-Network Provider	
Criteria Met	100	1115	1169

In 2021, 1,169 arbitration cases were opened based on the screening process.

At the end of the reporting period, there were 338 cases which were deemed inapplicable for arbitration, 515 cases pending an arbitration determination, and 310 cases which were closed with a determination for a prevailing party.

STATE OF NEVADA
Office For Consumer Health Assistance Arbitration Cases by Status

For cases in arbitration between 01/01/2021 and 12/31/2021

Arbitration Cases by Status	January - December 2021		Total	Percentage
	Out-of-Network Emergency Facility	Out-of-Network Provider		
Cases closed due to inapplicability	1	337	*338	27.82%
Dispute settled prior to arbitration determination	6	45	51	4.20%
Request for arbitration withdrawn	0	1	1	0.08%
Cases closed with a Prevailing Party	58	252	*310	25.51%
Cases pending an arbitration determination	35	480	515	42.39%
Statewide Total	100	1115	1215	100.00%

*Included in the table above are 46 cases which were pending an arbitration determination as of 12/31/20.

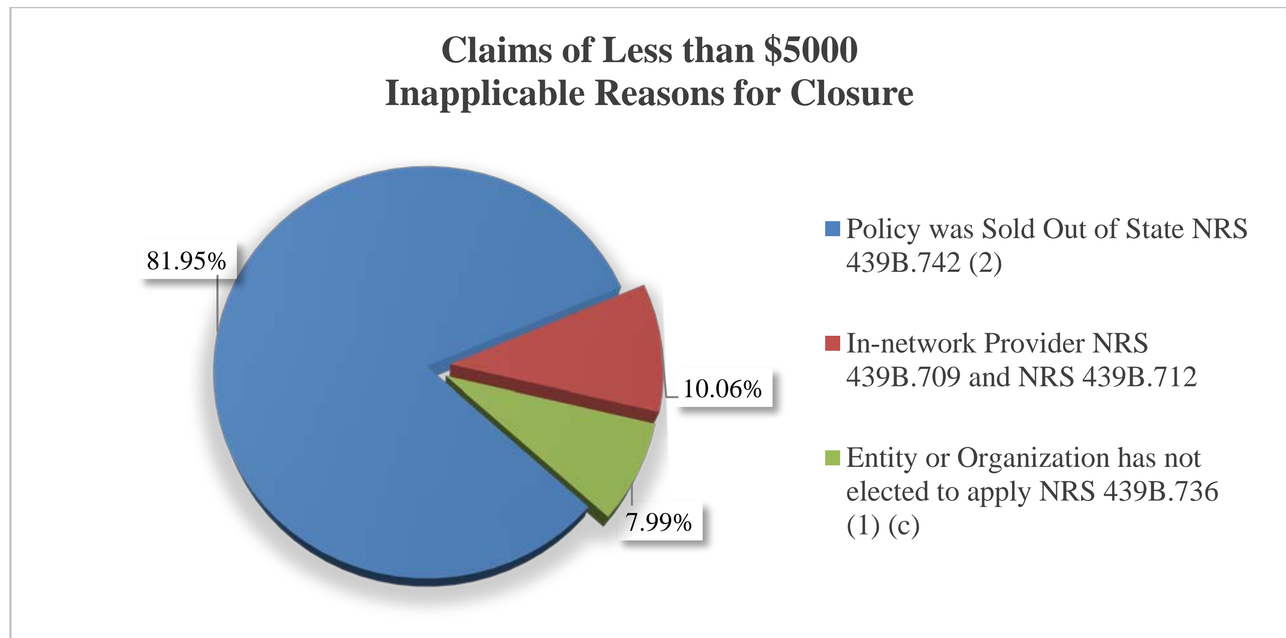
The number of arbitrations closed with a prevailing party in calendar year 2020 was 97. The number of arbitrations closed with a prevailing party in calendar year 2021 was 310. This represents a 220% increase in number of arbitrations closed with a prevailing party from the previous calendar year.

The chart below references the arbitration cases closed due to Inapplicable Reasons.

STATE OF NEVADA
Office For Consumer Health Assistance Arbitration Cases Closed Due to Inapplicable Reasons

For arbitration cases closed between 01/01/2021 and 12/31/2021

Inapplicable Reasons for Closure	January - December 2021		Total	Percentage
	Out-of-Network Emergency Facility	Out-of-Network Provider		
Policy was Sold Out of State NRS 439B.742 (2)	0	277	277	81.95%
In-network Provider NRS 439B.709 and NRS 439B.712	1	33	34	10.06%
Entity or Organization has not elected to apply NRS 439B.736 (1) (c)	0	27	27	7.99%
Third Party does not meet Criteria: Policy is covered through Medicare NRS 439B.736 (1) (a)	0	0	0	0.00%
Third Party does not meet Criteria: Policy is covered through Medicaid NRS 439B.736 (2)	0	0	0	0.00%
Statewide Total	1	337	338	100.00%



Analysis of the data on the previous page shows there are two main reasons an arbitration case did not meet criteria for arbitration:

1. 81.95%, Policy was Sold Out of State, NRS 439B.742 (2):
   Upon review of relevant information OCHA verified the policies for these arbitration cases were sold out of state.

2. 10.06% In-network Provider, NRS 439B.709 and NRS 439B.712:
   Upon review of relevant information OCHA verified providers for these arbitration cases were in-network providers.

Arbitration Case Data

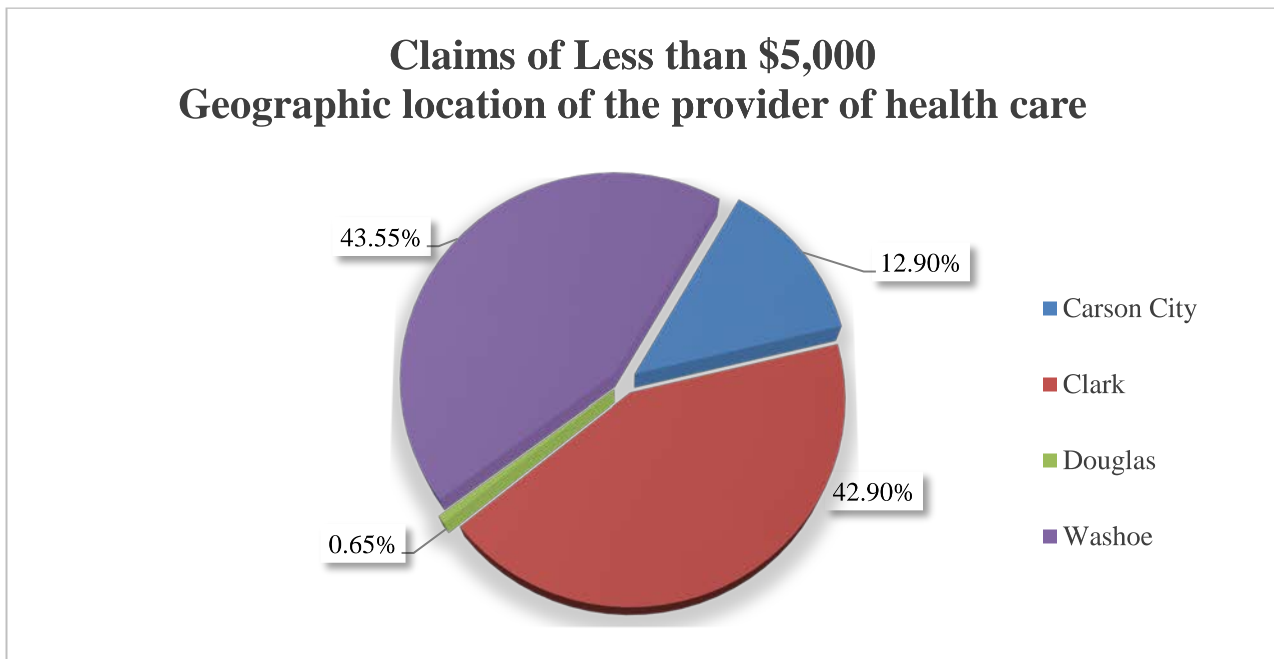
As of December 31, 2021, there were 310 arbitration cases closed with a determination and a prevailing party.

The charts below display information about the geographic location of the provider of health care for medically necessary emergency services in arbitration cases.

STATE OF NEVADA
Office for Consumer Health Assistance Arbitration Cases with a Prevailing Party by Geographic Location of the Provider of Health Care for Medically Necessary Emergency Services

For arbitration cases closed between 1/1/2021 and 12/31/2021

County	January - December 2021		Total	Percent
	Out-of-Network Emergency Facility	Out-of-Network Provider		
Carson City	0	40	40	12.90%
Clark	9	124	133	42.90%
Douglas	0	2	2	0.65%
Washoe	49	86	135	43.55%
Statewide Total	58	252	310	100.00%



STATE OF NEVADA
Office for Consumer Health Assistance Arbitration Cases by County and Prevailing Party

For arbitration cases closed between 1/1/2021 and 12/31/2021

County	Prevailing Party - Provider		Prevailing Party - Third Party			Total
	Out-of-Network Emergency Facility	Out-of-Network Provider	Elect-in Entity or Organization	Issuer of a Health Benefit plan as defined by NRS 695G.019	Public Employees' Benefits Program (PEBP)	
Carson City	0	15	0	25	0	40
Clark	3	110	0	20	0	133
Douglas	0	1	0	1	0	2
Washoe	49	65	0	21	0	135
Statewide Total	52	191	0	67	0	310
Prevailing Party Total	243		67			310

STATE OF NEVADA
Office for Consumer Health Assistance Arbitration Cases by Additional Amount Requested, County, and Prevailing Party

For arbitration cases closed between 1/1/2021 and 12/31/2021

County	Prevailing Party - Provider		Prevailing Party - Third Party			Total
	Out-of-Network Emergency Facility	Out-of-Network Provider	Elect-in Entity or Organization	Issuer of a Health Benefit plan as defined by NRS 695G.019	Public Employees' Benefits Program (PEBP)	
Carson City	$0.00	$5,368.01	$0.00	$7,699.07	$0.00	$13,067.08
Clark	$3,452.46	$52,966.26	$0.00	$16,868.07	$0.00	$73,286.79
Douglas	$0.00	$202.34	$0.00	$106.60	$0.00	$308.94
Washoe	$74,456.67	$26,256.18	$0.00	$8,681.66	$0.00	$109,394.51
Statewide Total	$77,909.13	$84,792.79	$0.00	$33,355.40	$0.00	$196,057.32

Arbitrations for Claims of $5,000 or More

For arbitrations of claims of $5,000 or more, Out-of-Network Providers and Out-of-Network Emergency Facilities must request a list of five randomly selected arbitrators from the American Arbitration Association (AAA) or Judicial Arbitration and Mediation Services (JAMS).

Organizations conducting arbitrations for claims of $5,000 or more are required to report on or before December 31 of each year to the Department of Health and Human Services on the form prescribed by OCHA.

County	Cases Arbitrated Provider		Cases Arbitrated Third Party			Provider Prevail	Third Party Prevail
	Out-of-Network Emergency Facility	Out-of-Network Provider	Elect-in Entity or Organization	Issuer of a Health Benefit plan as defined by NRS 695G.019	Public Employees' Benefits Program (PEBP)		
Carson City							
Clark	2					Pending	Pending
Douglas							
Washoe	1					1	
Statewide Total	3					1	

As of December 31, 2021, JAMS and AAA reported three requests for arbitration were received. Two requests are pending determination of a prevailing party.

Provider of Health Care or Third Party Relevant Information

Report information is confidential pursuant to NRS 439B.760 (3.) (a) (1) and 439B.760 (4.). The provider of health care and\or Third Party relevant information is included **Exhibit C: Provider of Health Care or Third Party Relevant Information**

As of December 31, 2021, OCHA received relevant information from a third party indicating 135 disputed payments by out-of-network providers and out-of-network emergency facilities were settled prior to arbitration.

Provider and Third Party Contract Data, 439B.760 (3)

Revised Proposed Regulation LCB File No. R101-19 includes Providers of medically necessary emergency service and Third Parties to report to OCHA the percentage of increase of contracts entered into and percentage of decrease of contracts.

As of December 31, 2021, providers of medically necessary emergency service and Third Parties report zero increase of contracts entered into and zero decrease in contracts.

Election by Entities and Organizations Not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760

Entities or organizations not otherwise subject to the provisions of NRS 439B.700 to 439B.760 may elect to participate under these provisions, NRS 439B.757.

During calendar year 2021, thirteen (13) additional entities or organizations elected to participate under the provisions of NRS 439B.700 to 439B.760. As of December 14, 2021, the total number of entities electing to participate under the provisions of NRS 439B.700 to 439B.760 is thirty-seven (37). **(Exhibit D: List of Election of Entities and Organization Not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760)**

As of December 31, 2021, no entities or organizations have elected to withdraw their participation.

Conclusion

OCHA continues collaborating with stakeholders to assist with the request for arbitration applications. OCHA received the Revised Proposed Regulation LCB File No. R101-19 on September 9, 2021. A public workshop was held December 14, 2021, and a hearing to adopt regulation will be scheduled in 2022. While authorized regulations by the Director of the Department of Health and Human Services are pending adoption, out-of-network providers and third parties continue to honor Revised Proposed Regulation LCB File No. R101-19.

List of Exhibits

Exhibit A: Payment for Medically Necessary Emergency Services Provided Out-of-Network, NRS 439B.700-NRS 439B.760

Exhibit B: Revised Proposed Regulation LCB File No. R101-19 (Rev. 9/09/21)

Exhibit C: Provider of Health Care or Third Party Relevant Information

Exhibit D: List of Election of Entities and Organization Not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760

Exhibit A: AB469 Codified NRS Chapter 439B

AB469, 2019 Legislature
Effective January 1, 2020
Codified NRS Chapter 439B

PAYMENT FOR MEDICALLY NECESSARY EMERGENCY SERVICES PROVIDED OUT-OF-NETWORK

NRS 439B.700 Definitions. [Effective January 1, 2020.] As used in NRS 439B.700 to 439B.760, inclusive, unless the context otherwise requires, the words and terms defined in NRS 439B.703 to 439B.739, inclusive, have the meanings ascribed to them in those sections.
(Added to NRS by 2019, 320, effective January 1, 2020)

NRS 439B.703 "Covered person" defined. [Effective January 1, 2020.] "Covered person" means a policyholder, subscriber, enrollee or other person covered by a third party.
(Added to NRS by 2019, 320, effective January 1, 2020)

NRS 439B.706 "Independent center for emergency medical care" defined. [Effective January 1, 2020.] "Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.
(Added to NRS by 2019, 320, effective January 1, 2020)

NRS 439B.709 "In-network emergency facility" defined. [Effective January 1, 2020.] "In-network emergency facility" means a hospital or independent center for emergency medical care that is an in-network provider.
(Added to NRS by 2019, 320, effective January 1, 2020)

NRS 439B.712 "In-network provider" defined. [Effective January 1, 2020.] "In-network provider" means, for a particular covered person, a provider of health care that has entered into a provider contract with a third party for the provision of health care to the covered person.
(Added to NRS by 2019, 320, effective January 1, 2020)

NRS 439B.715 "Medically necessary emergency services" defined. [Effective January 1, 2020.] "Medically necessary emergency services" means health care services that are provided by a provider of health care to screen and to stabilize a covered person after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

1. Serious jeopardy to the health of the covered person;
2. Serious jeopardy to the health of an unborn child of the covered person;
3. Serious impairment of a bodily function of the covered person; or
4. Serious dysfunction of any bodily organ or part of the covered person.

(Added to NRS by 2019, 320, effective January 1, 2020)

NRS 439B.718 "Out-of-network emergency facility" defined. [Effective January 1, 2020.] "Out-of-network emergency facility" means a hospital or independent center for emergency medical care that is an out-of-network provider.
(Added to NRS by 2019, 320, effective January 1, 2020)

NRS 439B.721 "Out-of-network provider" defined. [Effective January 1, 2020.] "Out-of-network provider" means, for a particular covered person, a provider of health care that has not entered into a provider contract with a third party for the provision of health care to the covered person.
(Added to NRS by 2019, 320, effective January 1, 2020)

NRS 439B.724 "Provider contract" defined. [Effective January 1, 2020.] "Provider contract" means a contract between a third party and an in-network provider to provide health care services to a covered person.
(Added to NRS by 2019, 320, effective January 1, 2020)

NRS 439B.727 "Provider of health care" defined. [Effective January 1, 2020.] "Provider of health care" has the meaning ascribed to it in NRS 695G.070.
(Added to NRS by 2019, 320, effective January 1, 2020)

NRS 439B.730 "Prudent person" defined. [Effective January 1, 2020.] "Prudent person" means a person who:
1. Is not a provider of health care;
2. Possesses an average knowledge of health and medicine; and
3. Is acting reasonably under the circumstances.
(Added to NRS by 2019, 321, effective January 1, 2020)

NRS 439B.733 "Screen" defined. [Effective January 1, 2020.] "Screen" means to conduct the medical screening examination required to be provided to a patient in the emergency department of a hospital pursuant to 42 U.S.C. § 1395dd.
(Added to NRS by 2019, 321, effective January 1, 2020)

NRS 439B.736 "Third party" defined. [Effective January 1, 2020.]
1. "Third party" includes, without limitation:
(a) The issuer of a health benefit plan, as defined in NRS 695G.019, which provides coverage for medically necessary emergency services;
(b) The Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043; and
(c) Any other entity or organization that elects pursuant to NRS 439B.757 for the provisions of NRS 439B.700 to 439B.760, inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.
2. The term does not include the State Plan for Medicaid, the Children's Health Insurance Program or a health maintenance organization, as defined in NRS 695C.030, or managed care organization, as defined in NRS 695G.050, when providing health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department.
(Added to NRS by 2019, 321, effective January 1, 2020)

NRS 439B.739 "To stabilize" and "stabilized" defined. [Effective January 1, 2020.] "To stabilize" and "stabilized" have the meanings ascribed to them in 42 U.S.C. § 1395dd(e)(3).
(Added to NRS by 2019, 321, effective January 1, 2020)

NRS 439B.742 Inapplicability of provisions to certain hospitals, persons and health care services. [Effective January 1, 2020.] The provisions of NRS 439B.745 and 439B.748 do not apply to:
1. A hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e) or any medically necessary emergency services provided at such a hospital;
2. A person who is covered by a policy of health insurance that was sold outside this State; or
3. Any health care services provided more than 24 hours after notification is provided pursuant to NRS 439B.745 that a person has been stabilized.
(Added to NRS by 2019, 321, effective January 1, 2020)

NRS 439B.745 Limitation on amount out-of-network provider may collect from covered person; duties of out-of-network emergency facility upon providing services. [Effective January 1, 2020.]

1. An out-of-network provider shall not collect from a covered person for medically necessary emergency services, and a covered person is not responsible for paying, an amount that exceeds the copayment, coinsurance or deductible required for such services provided by an in-network provider by the coverage for that person.

2. An out-of-network emergency facility that provides medically necessary emergency services to a covered person shall:

(a) When possible, notify the third party that provides coverage for the covered person not later than 8 hours after the covered person presents at the out-of-network emergency facility to receive medically necessary emergency services; and

(b) Notify the third party that the condition of the covered person has stabilized to such a degree that the person may be transferred to an in-network emergency facility not later than 24 hours after the person's emergency medical condition is stabilized. Not later than 24 hours after the third party receives such notice, the third party shall arrange for the transfer of the person to such a facility.

(Added to NRS by 2019, 321, effective January 1, 2020)

NRS 439B.748 Payment to out-of-network emergency facility by third party. [Effective January 1, 2020.]

1. If an out-of-network emergency facility had a provider contract as an in-network emergency facility within the 24 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage for the covered person shall pay to the out-of-network emergency facility for those services, and the out-of-network emergency facility shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network emergency facility:

(a) If the out-of-network emergency facility was an in-network emergency facility within the 12 months immediately preceding the provision of medically necessary emergency services, 108 percent of the amount that would have been paid for those services pursuant to the most recent applicable provider contract between the third party and the out-of-network emergency facility, less the amount of the copayment, coinsurance or deductible, if applicable.

(b) If the out-of-network emergency facility was an in-network emergency facility within the 24 months immediately preceding the provision of medically necessary emergency services, but not within the 12 months immediately preceding the provision of those services, 115 percent of the amount that would have been paid for those services pursuant to the most recent applicable provider contract between the third party and the out-of-network emergency facility, less the amount of the copayment, coinsurance or deductible, if applicable.

2. If an out-of-network emergency facility did not have a provider contract as an in-network emergency facility within the 24 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage to the covered person shall pay to the out-of-network emergency facility an amount that the third party has determined to be fair and reasonable as payment for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network emergency facility.

(Added to NRS by 2019, 322, effective January 1, 2020)

NRS 439B.751 Payment to out-of-network provider, other than emergency facility, by third party. [Effective January 1, 2020.]

1. If an out-of-network provider, other than an out-of-network emergency facility, had a provider contract as an in-network provider within the 12 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person and:

(a) The out-of-network provider terminated the most recent applicable provider contract between the third party that provides coverage for the covered person and the out-of-network provider without cause before it was scheduled to expire, the third party shall pay to the out-of-network provider for those services, and the out-of-network provider shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the amount that would have been paid for those services pursuant to that provider contract, less the amount of the copayment, coinsurance or deductible, if applicable.

(b) The out-of-network provider terminated the most recent applicable provider contract between the third party that provides coverage for the covered person and the out-of-network provider for cause before it was scheduled to expire or the third party terminated the contract without cause, the third party shall pay to the out-of-network provider for those services, and the out-of-network provider shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, 108 percent of the amount that would have been paid for those services pursuant to the provider contract, less the amount of the copayment, coinsurance or deductible, if applicable.

(c) The third party that provides coverage for the covered person terminated the most recent applicable provider contract between the third party and the out-of-network provider for cause before it was scheduled to expire, the third party shall pay to the out-of-network provider an amount that the third party has determined to be fair and reasonable as payment for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider.

(d) The contract was not terminated by either party, the third party that provides coverage for the covered person shall pay to the out-of-network provider for those services, and the out-of-network provider shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the amount that would have been paid for those services pursuant to the most recent applicable provider contract between the third party and the out-of-network provider plus an amount equal to the percentage of increase in the Consumer Price Index, Medical Care Component, during the immediately preceding calendar year, less the amount of the copayment, coinsurance or deductible, if applicable.

2. If an out-of-network provider, other than an out-of-network emergency facility, did not have a provider contract as an in-network provider within the 12 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage to the covered person shall submit to the out-of-network provider an offer of payment in full for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider.

(Added to NRS by 2019, 322, effective January 1, 2020)

NRS 439B.754 Determination of amount owed when no recent contract exists between out-of-network provider and third party; arbitration to resolve dispute; no interest pending resolution of dispute; confidentiality of arbitration. [Effective January 1, 2020.]

1. An out-of-network provider shall accept or reject an amount paid pursuant to subsection 2 of NRS 439B.748 or paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751 as payment in full for

the medically necessary emergency services for which the payment was offered within 30 days after receiving the payment. If an out-of-network provider fails to comply with the requirements of this section, the amount paid shall be deemed accepted as payment in full for the medically necessary emergency services for which the payment was offered 30 days after the out-of-network provider received the payment.

2. If an out-of-network provider rejects the amount paid as payment in full, the out-of-network provider must request from the third party an additional amount which, when combined with the amount previously paid, the out-of-network provider is willing to accept as payment in full for the medically necessary emergency services.

3. If the third party refuses to pay the additional amount requested by the out-of-network provider pursuant to subsection 2 or fails to pay that amount within 30 days after receiving the request for the additional amount, the out-of-network provider must request a list of five randomly selected arbitrators from an entity authorized by regulations of the Director of the Department to provide such arbitrators. Such regulations must require:

(a) For claims of less than $5,000, the use of arbitrators who will conduct the arbitration in an economically efficient manner. Such arbitrators may include, without limitation, qualified employees of the State and arbitrators from the voluntary program for the use of binding arbitration established in the judicial district pursuant to NRS 38.255 or, if no such program has been established in the judicial district, from the program established in the nearest judicial district that has established such a program.

(b) For claims of $5,000 or more, the use of arbitrators from nationally recognized providers of arbitration services, which may include, without limitation, the American Arbitration Association, JAMS or their successor organizations.

4. Upon receiving the list of randomly selected arbitrators pursuant to subsection 3, the out-of-network provider and the third party shall each strike two arbitrators from the list. If one arbitrator remains, that arbitrator must arbitrate the dispute concerning the amount to be paid for the medically necessary emergency services. If more than one arbitrator remains, an arbitrator randomly selected from the remaining arbitrators by the entity that provided the list of arbitrators pursuant to subsection 3 must arbitrate that dispute.

5. The out-of-network provider and the third party shall participate in binding arbitration of the dispute concerning the amount to be paid for the medically necessary emergency services conducted by the arbitrator selected pursuant to subsection 4. The out-of-network provider or third party may provide the arbitrator with any relevant information to assist the arbitrator in making a determination.

6. The arbitrator shall require:

(a) The out-of-network provider to accept as payment in full for the provision of the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the amount paid by the third party pursuant to subsection 2 of NRS 439B.748 or paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable; or

(b) The third party to pay the additional amount requested by the out-of-network provider pursuant to subsection 2.

7. If the arbitrator requires:

(a) The out-of-network provider to accept the amount paid by the third party pursuant to subsection 2 of NRS 439B.748 or paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable, as payment in full for the provision of the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the out-of-network provider must pay the costs of the arbitrator.

(b) The third party to pay the additional amount requested by the out-of-network provider pursuant to subsection 2, the third party must pay the costs of the arbitrator.

8. An out-of-network provider or a third party must pay its own attorney's fees incurred during the process prescribed by this section.

9. Interest does not accrue on any claim for which an offer of payment is rejected pursuant to subsection 1 for the period beginning on the date of the rejection and ending 30 days after the arbitrator renders a decision.

10. Except as otherwise provided in this subsection and NRS 439B.760, any decision of an arbitrator pursuant to this section and any documents associated with such a decision are confidential and are not admissible as evidence during a legal proceeding, including, without limitation, a legal proceeding between the third party and the out-of-network provider. The decision of an arbitrator and any documents associated with such a decision may be disclosed and are admissible as evidence during a legal proceeding to enforce the decision.

(Added to NRS by 2019, 323, effective January 1, 2020)

NRS 439B.757 Election by certain entities and organizations not otherwise covered to submit to provisions; regulations. [Effective January 1, 2020.] Any entity or organization, not otherwise subject to the provisions of NRS 439B.700 to 439B.760, inclusive, that provides coverage for emergency medical services, including, without limitation, a participating public agency, as defined in NRS 287.04052, and any other local governmental agency which provides a system of health insurance for the benefit of its officers and employees, and the dependents of such officers and employees, pursuant to chapter 287 of NRS, may elect for the provisions of NRS 439B.700 to 439B.760, inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons. The Director of the Department of Health and Human Services shall:

1. Publish on an Internet website maintained by the Department a list of third parties that have made such an election; and

2. Adopt regulations governing such an election, which may include, without limitation, regulations that establish the procedure by which a third party may make such an election.

(Added to NRS by 2019, 325, effective January 1, 2020)

NRS 439B.760 Reports; confidentiality of information. [Effective January 1, 2020.]

1. On or before December 31 of each year, an arbitrator who arbitrated a matter pursuant to NRS 439B.754 during the immediately preceding 12 months shall report to the Department of Health and Human Services in the form prescribed by the Department:

(a) The number of cases arbitrated by the arbitrator;

(b) The types of providers of health care and third parties involved in those cases;

(c) The prevailing party in each such arbitration;

(d) Information concerning the geographic location of the provider of health care that provided medically necessary emergency services; and

(e) Any other information requested by the Department.

2. A provider of health care or third party:

(a) Shall provide to the Department any information requested by the Department to complete the report required by subsection 3; and

(b) May provide to the Department any other information relevant to that report.

3. On or before January 31 of each year, the Department shall:

(a) Compile a report which consists of:

(1) Aggregated information provided to the Department pursuant to subsections 1 and 2, presented in a manner that does not reveal the identity of any provider of health care, third party or patient;

(2) An analysis of any identifiable trends in the information described in subparagraph (1); and
(3) An analysis of the impact of actions taken pursuant to NRS 439B.700 to 439B.760, inclusive, on provider contracts and the provision of health care in this State;
(b) Post the report on an Internet website maintained by the Department; and
(c) Submit the report to the Director of the Legislative Counsel Bureau for transmittal to:
(1) In even-numbered years, the Legislative Committee on Health Care; and
(2) In odd-numbered years, the next regular session of the Legislature.
4. Any information disclosed to the Department pursuant to this section is confidential.
(Added to NRS by 2019, 325, effective January 1, 2020)

List of Exhibits

Exhibit B: Revised Proposed Regulation LCB File No. R101-19 (Rev. 9/9/21)

REVISED PROPOSED REGULATION OF THE

DIRECTOR OF THE DEPARTMENT

OF HEALTH AND HUMAN SERVICES

LCB File No. R101-19

September 9, 2021

EXPLANATION – Matter in *italics* is new; matter in brackets [~~omitted material~~] is material to be omitted.

AUTHORITY: §§ 1-4, NRS 439B.754; § 5, NRS 439B.757; § 6, NRS 439B.760.

A REGULATION relating to health care; prescribing requirements concerning the arbitration of certain disputes over payment for medically necessary emergency services; prescribing the manner by which certain entities may become subject to provisions of law regarding the resolution of such disputes; requiring the reporting of certain information concerning payment for medically necessary emergency services; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires a third-party insurer and an out-of-network provider of health care that have a dispute regarding the payment for medically necessary emergency services rendered to a covered person to participate in arbitration to resolve the dispute. If such a dispute arises, existing law requires the out-of-network provider to request a list of five randomly selected arbitrators from an entity authorized by regulations of the Director of the Department of Health and Human Services to provide such arbitrators. (NRS 439B.754) For a dispute over a claim of less than $5,000, **section 2** of this regulation requires the request to be submitted to the Department. **Section 2** also: (1) prescribes the required contents of the request; (2) provides for the review and approval of the request by the Department; and (3) requires the Department to provide the out-of-network provider and third party with a written list of five randomly selected employees of the State who are qualified to arbitrate the dispute and who are determined not to have a conflict of interest. **Section 3** of this regulation provides for the selection of an arbitrator and prescribes the procedure for the arbitration. For a dispute about a claim in the amount of $5,000 or more, **section 4** of this regulation requires the out-of-network provider to request a list of five randomly selected arbitrators from the American Arbitration Association or JAMS.

Existing law authorizes an entity or organization not otherwise subject to provisions of law governing the resolution of disputes between a third-party insurer and an out-of-network provider of health care over payment for medically necessary emergency services to elect to have those provisions to apply to the entity or organization. Existing law requires the Director to adopt

regulations governing such an election. (NRS 439B.757) **Section 5** of this regulation prescribes the procedure for making and withdrawing such an election.

Existing law requires the Department to compile a report which consists of certain information concerning the resolution of disputes regarding the payment of medically necessary emergency services. Existing law requires a provider of health care or third party to provide to the Department any information requested by the Department to complete that report. (NRS 439B.760) **Section 6** of this regulation requires a third party that provides coverage to residents of this State and a provider of health care who provides medically necessary emergency medical services in this State to annually submit to the Department certain information for the purpose of compiling that report.

Section 1. Chapter 439B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 6, inclusive, of this regulation.

Sec. 2. ***1. To request a list of randomly selected arbitrators pursuant to subsection 3 of NRS 439B.754 to arbitrate a dispute over a claim of less than $5,000, an out-of-network provider must submit a request to the Department. If the out-of-network provider submits the request because the third party has refused or failed to pay the additional amount requested by the out-of-network-provider pursuant to subsection 2 of NRS 439B.754, the out-of-network provider must submit the request by:***

(a) If the third party refused to pay the additional amount, not later than 30 business days after the date on which the third party notifies the out-of-network provider of the refusal.

(b) If the third party failed to pay the additional amount for 30 business days after receiving a request for the additional amount, not later than 30 business days after that date.

2. A request submitted pursuant to subsection 1 must be in the form prescribed by the Department and include, without limitation:

(a) The date on which the medically necessary emergency services to which the complaint pertains were provided and the type of medically necessary emergency services provided;

--2--
LCB Draft of Revised Proposed Regulation R101-19

(b) The contact information for and location of the out-of-network provider that provided the medically necessary emergency services;

(c) The type and specialty of each health care practitioner who provided the medically necessary emergency services;

(d) The type of third party that provides coverage for the covered person to whom the medically necessary emergency services were rendered and contact information for that third party; and

(e) Documentation of:

(1) The date on which the out-of-network provider received payment from the third party pursuant to subsection 2 of NRS 439B.748 or paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable, and the amount of payment received;

(2) The date on which the out-of-network provider requested additional payment from the third party pursuant to subsection 2 of NRS 439B.754, and the additional amount requested; and

(3) The date on which the third party refused to pay the additional amount, if applicable.

3. If the Department does not receive a request pursuant to subsection 1 within the prescribed time, the out-of-network provider shall be deemed to have accepted the payment received from the third party pursuant to subsection 2 of NRS 439B.748 or paragraph (c) of subsection 1 or subsection 2 of NRS 439B.751, as applicable, as payment in full for the medically necessary emergency services.

4. Not later than 10 business days after receiving a request pursuant to subsection 1, the Department shall notify the out-of-network provider in writing of the receipt of the request. Not later than 20 business days after providing such notification, the Department shall:

(a) Review the request and verify the information contained therein; and

(b) Notify the out-of-network provider in writing of any additional information necessary to complete or clarify the request.

5. The Department will approve a request not later than 5 business days after determining that the request includes the documentation required by subsection 2 and is otherwise complete and clear. Not later than 5 business days after approving a request, the Department shall:

(a) Notify the out-of-network provider and the third party in writing of the approval.

(b) Randomly select five employees of the Office for Consumer Health Assistance of the Department who are qualified to arbitrate the dispute and ensure that those arbitrators do not have a conflict of interest that would prevent the arbitrator from impartially rendering a decision. For the purposes of this paragraph, a conflict of interest shall be deemed to exist if the arbitrator, or any person affiliated with the arbitrator:

(1) Has direct involvement in the licensing, certification or accreditation of a health care facility, insurer or provider of health care;

(2) Has a direct ownership interest or investment interest in a health care facility, insurer or provider of health care;

(3) Is employed by, or participating in, the management of a health care facility, insurer or provider of health care; or

(4) Receives or has the right to receive, directly or indirectly, remuneration pursuant to any arrangement for compensation with a health care facility, insurer or provider of health care.

(c) Provide to the out-of-network provider and the third party a written list of five arbitrators selected pursuant to paragraph (b) who have been determined not to have a conflict of interest.

Sec. 3. *1. Not later than 10 business days after the Department provides a written list of arbitrators to an out-of-network provider and a third party pursuant to subsection 5 of section 2 of this regulation, the out-of-network provider and third party shall strike arbitrators from the list in the manner required by subsection 4 of NRS 439B.754 and provide the name or names of any remaining arbitrators on the list in writing to the Department.*

2. Not later than 10 business days after receiving the name of any remaining arbitrator on the list pursuant to subsection 1, the Department shall:

(a) If one arbitrator who does not have a conflict of interest remains, notify the out-of-network provider and the third party in writing of the name of that arbitrator.

(b) If more than one arbitrator who does not have a conflict of interest remains, randomly select an arbitrator from the remaining arbitrators as required by subsection 4 of NRS 439B.754 and notify the out-of-network provider and the third party in writing of the name of that arbitrator.

3. The out-of-network provider or third party may provide the arbitrator with any relevant information to assist the arbitrator in making a determination not later than 10 business days after the date on which the Department notifies the out-of-network provider and the third party in writing of the name of that arbitrator pursuant to subsection 2.

4. An arbitrator selected pursuant to subsection 2 may request from the third party and the out-of-network provider any information the arbitrator deems necessary to assist in making a determination. The out-of-network provider and third party shall provide such information to the arbitrator not later than 10 business days after the date of the request. If either party fails to provide information requested by the arbitrator within that time, the arbitrator may proceed and make a determination based on the evidence available to the arbitrator.

5. Not later than 45 business days after the expiration of the period for submission of the information pursuant to subsection 3 or 4, whichever is later, the arbitrator shall make a determination as provided in subsection 6 of NRS 439B.754 and notify the parties of that determination.

Sec. 4. *An out-of-network provider that wishes to request a list of randomly selected arbitrators pursuant to subsection 3 of NRS 439B.754 to arbitrate a dispute over a claim of $5,000 or more must request a list of five randomly selected arbitrators from:*

1. The American Arbitration Association or its successor organization; or

2. JAMS or its successor organization.

Sec. 5. *1. To elect to have the provisions of NRS 439B.700 to 439B.760, inclusive, apply to an entity or organization that is not otherwise subject to those provisions as authorized pursuant to NRS 439B.757, the entity or organization must apply to the Department in the form prescribed by the Department. The application must include, without limitation:*

(a) The name of and contact information of the entity or organization; and

(b) A description of the type of entity or organization, as applicable, that it is.

2. If an application is received pursuant to subsection 1:

(a) On or after the first day of any month and on or before the fourteenth day of that month, the election to have the provisions of NRS 439B.700 to 439B.760, inclusive, apply to the applicant becomes effective on the first day of the immediately following month.

(b) On or after the fifteenth day of any month and on or before the last day of that month, the election to have the provisions of NRS 439B.700 to 439B.760, inclusive, apply to the applicant becomes effective on the fifteenth day of the immediately following month.

3. Any entity or organization may withdraw its election to have the provisions of NRS 439B.700 to 439B.760, inclusive, apply to the entity or organization by submitting an application to the Department in the form prescribed by the Department not less than 120 business days before the date on which the withdrawal is requested to become effective. The application must include, without limitation:

(a) The name of and contact information for the entity or organization;

(b) A description of the type of entity or organization, as applicable, that it is;

(c) The date on which the entity or organization requests the withdrawal to become effective; and

(d) The reason for requesting to withdraw the election.

4. Any medically necessary emergency services to which an election pursuant to this section apply that are provided while the election is effective are subject to the provisions of NRS 439B.700 to 439B.760, inclusive.

Sec. 6. *1. On or before December 31 of each year, each provider of health care who provides medically necessary emergency services in this State shall submit to the Department in the form prescribed by the Department:*

(a) The name of and contact information for the provider of health care;

(b) A description of the type of provider of health care that it is;

(c) Whether there was an increase or decrease in the number of contracts with third parties entered into by the provider of health care during the immediately preceding 12 months and the amount of the increase or decrease, stated as a percentage; and

(d) For each new contract with a third party entered into by the provider of health care during the immediately preceding 12 months, the type of the third party.

2. On or before December 31 of each year, each third party that provides coverage to residents of this State shall submit to the Department in the form prescribed by the Department:

(a) The name of and contact information for the third party;

(b) A description of the type of third party that it is;

(c) Whether there was an increase or decrease in the number of contracts with providers of health care who provide medically necessary emergency services entered into by the third party during the immediately preceding 12 months and the amount of the increase or decrease, stated as a percentage; and

(d) For each new contract with a provider of health care who provides medically necessary emergency services entered into by the third party during the immediately preceding 12 months, the type of the provider of health care.

--8--
LCB Draft of Revised Proposed Regulation R101-19

List of Exhibits

Exhibit C: Provider of Health Care or Third Party Relevant Information

December 28, 2021

TRANSMITTED VIA ELECTRONIC MAIL

Carrie Embree
Governor's Consumer Health Advocate
Nevada Department of Health and Human Services
Aging and Disability Services Division
3320 West Sahara Ave, Suite 100
Las Vegas Nevada 89102

Dear Ms. Embree:

The [redacted] on behalf of our [redacted] is providing claims information from Nevada's short term [redacted] pursuant to NRS 439B.760(2)(b) related to out of network emergency services covered under NRS 439B.700 through NRS 439B.760 inclusively. The information is being provided to the Office of Consumer Health Advocate (OCHA's) for inclusion in its annual reporting requirement to the Nevada Legislature.

Below is a summary of the limited information collected to date:

Calendar Year 2021

Claims that fell under AB 469:	1,546
Claims submitted for arbitration:	120 (8% of total AB 469 claims - submitted as of 12/18/21)
Under $5,000 to OCHA	90
Rejected for technical reasons	1 (1% of claims submitted)
Pending arbitration	44 (49% of claims submitted)
Arbitration complete	45 (50% of claims submitted)
(43 in favor of hospitals with 2 in favor of payers)	
Over $5,000 to AAA or JAM	30
Pending arbitration	15
Arbitration complete	15 (50% of claims submitted)
(12 in favor of [redacted] with 3 in favor of payer)	

[redacted] acknowledges during the creation of the legislation, known as AB 469, stakeholders were aware physicians would have larger numbers of out of network emergency claims than hospitals. In an emergency - patients, family members and the ambulance service are focused on getting the patient to a contracted or in-network hospital (except in the most extreme circumstances when the patient is taken to the closet hospital for lifesaving care).

[redacted] notes the higher percentage of claims submitted for arbitration from the initial year of 2020. While the regulations have not been finalized, hospitals have become more familiar with the process and are using it. Further, we are please to note the majority of claims are settled in favor of the [redacted] irrespective of the arbitration process.

[redacted] looks forward to 2022 and greater clarity in the process to ensure a higher rate of claim resolution. We ask OCHA and/or the Department of Health and Human Services (DHHS) work to finalize regulations. Please feel free to contact me if there are questions pertaining to the information provided.

Sincerely,

List of Exhibits

Exhibit D: List of Election of Entities and Organization Not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760

Election by Entities and Organizations not Otherwise Covered to Submit to Provisions of NRS 439B.700 to 439B.760
As of December 15, 2021

	Third Party Name	d/b/a (If applicable)	Third Party Type	Customer Service Phone Number - Eligibility/Claims	Notifications/Transfer & Stabilization Primary Contact	Secondary Contact	Contact Information for Arbitration Disputes	Mailing Address	Participation Effective Date	Opt-Out Date
1	Culinary Health Fund		Self-Insured Taft-Hartley Health Plan	702-733-9938	Nancy Nikolski 702-892-7338 Cell: 702-281-8014 Fax: 702-735-1649 nnikolski@culinaryhealthfund.org		Cindy Pearson 702-691-5602 cpearson@culinaryhealthfund.org	1901 Las Vegas Blvd S. Suite 101 Las Vegas, NV 89104	**1/1/2020**	
2	Clark County Firefighters Local Union 1908 Security Fund			800-777-3575	Nicole Powell 800-777-3575, Ext 1492 npowell@ebms.com		Nicole Powell 800-777-3575, Ext 1492 npowell@ebms.com	EBMS PO Box 21367 Billings, MT 59104-1367	**1/1/2020**	
3	North Las Vegas Firefighters Union Health & Welfare Fund				Cindy Matthews 330-834-2302 cmatthews@healthplan.org			4040 Losee Road North Las Vegas, NV 89030	**1/1/2020**	
4	Banner Health		Self-Insured Employer ERISA Plan	855-788-5803	David J. Schuitema, CEBS 602-747-7984 david.schuitema@bannerhealth.com	Ashely Allen 602-747-8135 ashely.allen@bannerhealth.com	Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		**4/15/2020**	
5	Atlantis Casino Resort & Spa		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists-HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	**4/15/2020**	
6	City of Reno		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists-HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	**4/15/2020**	
7	Peppermill Casino, Inc		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists-HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	**4/15/2020**	
8	Douglas County School District		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists-HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	**4/15/2020**	
9	Washoe County Self-Funded Group Health Plan		Local Government	775-328-2088	Ashley Berrington 775-328-2088 aberrington@washoecounty.us	Kristie Harmon 775-328-2079 kharmon@washoecounty.us	Ashley Berrington 775-328-2088 aberrington@washoecounty.us	1001 E. 9th Street Reno, NV 89512	**5/1/2020**	
10	Renown Health		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists-HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	**5/1/2020**	
11	Teamsters Local 631 Security Fund for Southern Nevada		Self-Funded Health Plan	702-415-2185	Nancy Nikolski 702-283-2421 nnikolski@culinaryhealthfund.org		Kayla Harmer, Plan Manager 702-415-2180 x7316 kayla.harmer@benesys.com	BeneSys Administrators Attn: Kayler Harmer 8311 W. Sunset Rd., Suite 250 Las Vegas, NV 89113	**5/1/2020**	

	Third Party Name	d/b/a (If applicable)	Third Party Type	Customer Service Phone Number - Eligibility/Claims	Notifications/Transfer & Stabilization Primary Contact	Secondary Contact	Contact Information for Arbitration Disputes	Mailing Address	Participation Effective Date	Opt-Out Date
12	Plumbers & Pipefitters Local 525 Health & Welfare Fund		Self-Funded Health Plan	702-415-2199	Chanelle Bergren 614-933-6606 BergrenC1@ahhinc.com		Denise Best, Plan Manager 702-415-2180, Ext. 7319 denise.best@benesys.com	BeneSys Administrators Attn: Kayler Harmer 8311 W. Sunset Rd., Suite 250 Las Vegas, NV 89113	**5/1/2020**	
13	Cement Masons and Plasterers Health and Welfare Trust		Multi-Employer ERISA Health and Welfare Plan	702-415-2190	Innovative Care Management, Inc (Pre-Authorization Dept.) 503-654-9447 onlineprecert@innovativecare.com	Kayla Harmer, Plan Manager 702-415-2180 x7316 kayla.harmer@benesys.com	Kayla Harmer, Plan Manager 702-415-2180 x7316 kayla.harmer@benesys.com	BeneSys Administrators Attn: Kayler Harmer 8311 W. Sunset Rd., Suite 250 Las Vegas, NV 89113	**5/1/2020**	
14	Las Vegas Firefighters		Self-Funded	844-711-3473	Chanelle Bergren 614-933-6606 BergrenC1@ahhinc.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	**5/1/2020**	
15	Teamsters Security Fund Southern Nevada Hotel & Casino Workers	Teamsters Local 986	Health & Welfare Trust Fund	702-734-8601	Danielle Galuppi 702-853-9605 dgaluppi@zenith-american.com	Cecilia Bacero 702-682-9044 cbacero@teamstershwfund.com	Danielle Galuppi, Client Services Executive 702-853-9605 dgaluppi@zenith-american.com	2200 S. Rancho Blvd. Ste 295 Las Vegas, NV 89102	**5/1/2020**	
16	Electrical Workers Local 357 Health and Welfare Trust		Self-Funded Health Plan	702-415-2188	Innovative Care Management, Inc (Pre-Authorization Dept.) 503-654-9447 onlineprecert@innovativecare.com	Denise Best 702-415-2180, Ext. 7319 denise.best@benesys.com	Denise Best, Plan Manager 702-415-2180, Ext. 7319 denise.best@benesys.com	IBEW Local 357 H&W Fund Attn: Denise Best 8311 W. Sunset Rd., Ste. 205 Las Vegas, NV 89113	**6/1/2020**	
17	Lander County School District		Self-Funded Health Plan	775-352-6900	Russell Klein 775-635-5347 rklein@landernv.nt		Russell Klein, Superintendent 775-635-5347 rklein@landernv.nt	P.O. Box 1300 Battle Mountain, NV 89820	**6/15/2020**	
18	Meruelo, LLC	Grand Sierra Resort	Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists-HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	**7/1/2020**	
19	El Dorado Resorts, Inc.		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists-HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	**8/1/2020**	
20	City of Sparks		Self-Funded Plan	775-982-3232	Referral Specialist 775-982-2725 ReferralSpecialists-HometownHealth@HometownHealth.com		Melissa Mills 775-982-5604 Melissa.mills@hometownhealth.com	10315 Professional Circle Reno, NV 89521	**8/1/2020**	
21	Edwards Lifesciences		Self-Funded Plan	800-955-1237	Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		**10/1/2020**	
22	Lululemon USA		Self-Funded Plan	888-325-2439	Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		**10/15/2020**	
23	Xylem, Inc.		Self-Funded Plan	866-991-0369	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		**12/1/2020**	
24	SWIFT		Self-Funded Plan	540-829-1326	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		**12/15/2020**	

	Third Party Name	d/b/a (If applicable)	Third Party Type	Customer Service Phone Number - Eligibility/Claims	Notifications/Transfer & Stabilization Primary Contact	Secondary Contact	Contact Information for Arbitration Disputes	Mailing Address	Participation Effective Date	Opt-Out Date
25	The Nature Conservancy		Self-Funded Plan	800-962-6842	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		1/1/2021	
26	Clarke Environmentsl Mosquito Management, Inc.		Self-Funded Plan	888-632-3862	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		1/1/2021	
27	Planned Systems International Employee Benefit Plan		Self-Funded Plan	888-632-3862	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		1/15/2021	
28	Collabera Inc.		Self-Funded Plan	973-889-5261	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		2/1/2021	
29	IBA USA Inc.		Self-Funded Plan	877-204-9186	Rasa Kudirka 571-407-4509 rasa.kudirka@iba-group.com	Marley Huckabee 703-885-0315 marley.huckabee@iba-group.com	Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		2/15/2021	
30	Allergy Partners, PLLC		Self-Funded Plan	888-266-5519	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		4/1/2021	
31	Merlin Entertainments		Self-Funded Plan		Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		5/1/2021	
32	Jordache Enterprises Inc		Self-Funded Plan	888-792-3862	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		9/1/2021	
33	Personal Injury of Nevada	Naqvi Injury Law	Self-Funded Plan	702-897-4400	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		10/1/2021	
34	Bendix Commercial Vehicle Systems, LLC		Self-Funded Plan	833-637-0022	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		12/1/2021	
35	University of St. Augustine for Health Servic		Self-Funded Plan	737-202-3224	Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		1/1/2022	
36	Korte Construction Company	The Korte Company	Self-Funded Plan		Susan D. Bowman 314-242-0259 susan.bowman@koreco.com		Kathy Reimer-Pollard Senior Account Manager 314-506-1792 kmreimer@aetna.com	1285 Fern Ridge Parkway Suite 200 St. Louis, MO 63141	1/1/2022	
37	NICE Systems Inc.	NICE	Self-Funded Plan		Aetna Provider Service Center 888-632-3862		Brady O'Brien Business Project Program Manager nvarbitration@aetna.com		1/1/2022	

List of Exhibits