Nevada Division of Insurance
Network Adequacy Declaration Document

1. Carrier affirms that it will comply with Nevada's Network Adequacy laws and regulations.

   *If response is **No,** a justification must be provided. Justifications will be reviewed by the Nevada Division of Insurance on a case-by-case basis in review of this form.*

   ☐Yes ☐ No

2. a. Carrier affirms that it will maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. This includes providers that specialize in mental health and substance abuse services for all plans except dental plans.

   *If response is **No,** a justification must be provided. Justifications will be reviewed by the Nevada Division of Insurance on a case-by-case basis in review of this form.*

   ☐Yes ☐ No

3. For Qualified Health Plan (QHP) issuer's, the carrier affirms that it will comply with Federal Regulation 156.230 (a) (1).

   ☐Yes ☐ No ☐ Not Applicable

4. Carrier affirms that network data provided is representative of contracts expected to be in place January 1st, 2024 and that all data submitted is accurate and current as of the date of filing.
   *If response is **No**, a justification must be provided. Justifications will be reviewed by the Nevada Division of Insurance on a case-by-case basis in review of this form.*

   ☐Yes ☐ No

5. Carrier affirms that it will maintain current directory links (i.e. provider and drug formulary) and inform the Division of any changes in the URL within 72 hours.

   *If response is **No**, a justification must be provided. Justifications will be reviewed by the Nevada Division of Insurance on a case-by-case basis in review of this form.*

   ☐Yes ☐ No

5. Please provide a detailed description of the company's process for updating your provider directory to comply with NAC 687B.778. The response should include a detailed description of the process by which the company responds to a consumer complaint related company's provider directory which incorrectly indicates a provider is accepting new patients. Include in the response the average time required from the date of complaint to the date the provider directory is updated.

6. Please provide a list of Telehealth services.

    a. For any providers acting as a Distant site as defined by NRS 629.515 4. (a) please indicate by adding (T) after the provider's last name on the CMS ECP/Network Adequacy template. *List below the total number of Distant sites flagged in the CMS ECP/Network Adequacy template.*

    b. Please attach a separate exhibit displaying the telehealth utilization by specialty and county for your membership for plan year 2022. Utilization must provide a monthly breakdown for the entire year and reflect claim data received as of March 31, 2023. The exhibit must include utilization based on percentage of membership and the total number of visits.

7. Please provide a list of all providers designated as providing autism services or autism applied behavioral analysis such as licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst, registered behavior technician, state certified behavior interventionist, or any other autism provider designation for each Network ID defined within the CMS Network ID Template. Use the Autism Provider Template provided on the Division's website.

8. Carrier affirms that it will comply with Nevada's Network Adequacy requirements pertaining to benefits relating to reproductive health care, hormone replacement therapy and preventative health care; specifically the provider requirements outlined in NRS 689A.0405, NRS 689A.0418, NRS 689A.0419, and NRS 689A.044. The provider requirements are specified in subsection 2 of these statutes.

    *If response is **No,** a justification must be provided. Justifications will be reviewed by the Nevada Division of Insurance on a case-by-case basis in review of this form.*

    ☐Yes ☐ No

9. Please indicate whether the network is leased or rented.
   If any part of the network is rented or leased, provide a breakdown of the percentage of the facilities and providers included in your network that are leased or rented. Indicate in the response the name of the entity or entities renting or leasing the network.

10. Please indicate whether the network is a tiered network.
    *If the network is tiered provide a description of the network which **must** include a breakdown of the cost share differences for each tier and a geographical breakdown by county showing the percentage of providers/facilities in each tier.*

11. Please provide a narrative related to the following illnesses: cancer, diabetes mellitus, epilepsy, heart disease, HIV, multiple sclerosis, rheumatoid arthritis, and severe mental illness. The narrative should include established patterns of care for treatment, highlighting the accessibility of the providers included in the treatment of these illnesses based on the health plan network used for each plan being offered.

Signature	Date
Print Name	Title/Position