

Introduction to Employee Benefits

Plan Year 2011

STATE OF NEVADA

Public *Employees'* *Benefits* *Program*

901 S. Stewart St., Suite 1001
Carson City, NV 89701
(775) 684-7000 or (800) 326-5496
Fax: (775) 684-7028

www.pebp.state.nv.us

N e v a d a PUBLIC EMPLOYEES' BENEFITS PROGRAM



What's Inside:

- Medical Plan Options
- Medical and Pharmacy Plan Comparison
- Dental Plan Benefits
- State Active Employee/Domestic Partner Rates
- Non-State Active Employee/Domestic Partner Rates
- Voluntary Products
- Qualifying Events Quick Reference
- Employee Leave(s) of Absence
- Initial COBRA Notification
- Vendor Contact Information

Plan Year 2011

July 1, 2010 - June 30, 2011

State of Nevada
Public Employees’ Benefits Program

Table of Contents

Introduction.....	1
Employee Benefit Package	3
Resource for Additional Plan Benefit Information	4
Medical Plan Comparison.....	5
Pharmacy Plan Comparison.....	6
Elements of the Self-funded PPO Plan Medical and Vision Benefits	7
Elements of the Self-funded PPO Pharmacy Benefit	10
Self-funded PPO Plan Wellness Benefit.....	11
Hometown Health Plan	13
Health Plan of Nevada	16
Dental Plan.....	19
Elements of the Dental Plan.....	22
Group Basic Life, AD & D and Long-Term Disability (LTD) Insurance	23
Portability and Conversion Options.....	24
Plan Administrators for Dental, Basic Life, AD & D, and LTD	25
State Active Employee Rates.....	26
State Active Employee/Domestic Partner Rates.....	27
Non-State Active Employee/Domestic Rates	28
Completing the Employee Benefit Enrollment and Change Form	29
Life and AD & D Beneficiary Designation	30
Voluntary Flexible Spending (FSA) Accounts.....	31
Voluntary Group Life, AD & D, and Short-term Disability Insurance	32
Voluntary Auto, Home, RV, Renters and Long-Term Care Insurance	33
Qualifying Events Quick Reference Table	34
Coordination of Benefits (COB).....	37
Important Information About Your Coverage	38
Employee Leave(s) of Absence	40
Initial COBRA Notification.....	42
Self-funded PPO Contacts	47
Fully Insured Product Contacts.....	48
Voluntary Product Contacts.....	48

This document is for informational purposes only. Any discrepancies between the information contained herein and the *Self-funded PPO Master Plan Document/HMO Evidence of Coverage Certificates* shall be superseded by the plans’ official documents.

Introduction

PEBP offers a comprehensive benefit package to eligible employees. These benefits include medical, prescription drug, dental, vision, \$20,000 basic life, long-term disability, and accidental death and dismemberment insurance.

State employees enrolled in a PEBP medical plan are eligible to participate in the Flexible Spending Health Care and/or Dependent Care Accounts. In addition, all active employees enrolled in a medical plan may purchase voluntary life insurance, short-term disability, auto, home, and long-term care insurance.

As a new employee, you must enroll or decline coverage by completing the enclosed Employee Benefit Enrollment and Change Form. Your enrollment paperwork must be returned to your Agency Representative (your agency's designated human resources liaison) within 7 days of receiving this package.

Enrollment paperwork that is not received by PEBP on the date coverage is scheduled to become effective will result in the employee only being placed in the Self-funded PPO Plan (default coverage). Except as otherwise provided in NAC 287.510, an employee enrolled in the default plan may not change plans or add dependents (without a qualifying status change) until the next open enrollment period. Employees enrolled in the default plan will be charged a monthly premium for that coverage.

The enclosed material is intended to provide you with a summary of the main features of your benefit package. Additional information regarding your benefit options may be obtained by visiting the PEBP website at www.pebp.state.nv.us. Please note that we have made every effort to ensure the accuracy of the enclosed information; however, in the event of a discrepancy, the provisions of the plan document will govern. Should you have any questions regarding your benefits, please contact the PEBP office at 775-684-7000 or 800-326-5496.

The Basics to Help You Get Started

Initial Enrollment

You may enroll yourself and your eligible dependent(s) in benefit coverage. To enroll dependent(s) on your health plan, you will be required to furnish supporting documentation for each dependent you wish to cover. A listing of required documentation can be found on page 2. Please complete the enclosed Employee Benefit Enrollment and Change Form (BECF), attach copies of any applicable supporting documents and return the paperwork to your Agency Representative.

Start of Coverage Following Initial Enrollment

New Hire

Full-time (or seasonal) employees are eligible for benefits on the first day of the month following *three consecutive* months of full-time employment. Full-time employment is defined as working *80 hours or more per month*. Note: For benefit purposes only, include furlough time as hours worked when determining full-time employment.

Reinstated Employee

Reinstated employees are individuals who previously met the eligibility requirements to enroll in PEBP coverage and who subsequently lost PEBP coverage due to termination of employment, and who returns to work for the same employer within 12 months of the previous termination date. Coverage for reinstated employees becomes effective on the first day of the month *concurrent with or following* the reinstatement (hire) date. For example, an employee who terminates employment on January 13, 2010, then reinstates employment with the same employer on May 15, 2010, would be eligible for coverage effective June 1, 2010.

Rehire Employee

A rehire employee is an individual who returns to work more than 12 months after the previous termination date. Coverage for a rehire begins on the first day of the month following *three consecutive* months of full-time employment. Full-time employment is defined as working *80 hours or more per month*.

Eligible dependent(s) coverage begins on the later of:

- The day an employee becomes eligible for medical coverage,
- The day an employee acquires an eligible dependent by birth, adoption, placement for adoption, marriage or certificate of a domestic partnership, or
- The first day of the month concurrent with or following the date of the Qualifying Event. Refer to page 34 for information regarding Qualifying Events.

Dependent	Required Supporting Documents
1. Child	Social Security number and a copy of certified birth certificate; if a stepchild or a domestic partner dependent, a copy of the parent's marriage certificate or Certified Registration of Domestic Partnership issued by the Nevada Secretary of State which links the child(ren) to the employee.
2. Child age 19 through age 23	Documents as required for Child in #1 above and a statement of full-time student status from the Registrar's office of an accredited program: University, community/junior college, graduate school, accredited trade or business school, etc.
3. Adoption	Documents as required for Child in #1 above and a copy of the adoption or placement for adoption signed by the agency making the placement, followed by the final adoption decree (signed by a judge) within 6 months following the adoption date.
4. Legal guardianship	Documents as required for Child in #1 above and a copy of the court order for guardianship (signed by a judge).
5. Disabled child age 19 or older	Documents as required for Child in #1 above and a copy of birth certificate, Certification of Disabled Child form (available from PEBP) and proof of continuous healthcare coverage.
6. Newborn	Copy of hospital birth confirmation and Social Security number (within 120 days).
7. Spouse/Domestic Partner	Copy of certified Marriage certificate or Certified Registration of Domestic Partnership issued by the Nevada Secretary of State.
If the required document(s) cannot be furnished on the date your enrollment document is due, do not wait to submit your enrollment form. Proceed with adding your dependent(s) and PEBP will notify you regarding the required documents to activate coverage for your dependent(s).	

Employee Benefit Package



Plan Options

- Self-funded PPO Plan
- Health Plan of Nevada (HPN) HMO Plan (available in Southern Nevada)
- Hometown Health Plan (HMO) (available in Northern Nevada)

All plans include:

- Medical
- Prescription Drug
- Vision Care

Plan benefits differ depending upon the medical plan option.

- Dental

Dental plan benefits are the same regardless of the medical plan option.

Basic benefits included in your medical package:

- \$20,000 employee basic life insurance
- \$2,000 dependent life insurance
- Long-term disability insurance

Additional Voluntary Products

- Flexible Spending Plan (Health and Dependent Care)
- Long-term Care Insurance
- Supplemental Life Insurance
- Short-term Disability Insurance
- Auto/Homeowners' Insurance

-
- Non-state employees are not eligible to participate in the Flexible Spending Plan.
 - The domestic partner and/or domestic partner's dependents of an eligible employee are not eligible to participate in the Flexible Spending Plan.

Resource for Additional Plan Benefit Information

Start here to access PPO and HMO plan information:

www.pebp.state.nv.us

Welcome to PEBP - Windows Internet Explorer

http://www.pebp.state.nv.us/

Welcome to PEBP

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP
Health Matters
... We're in it together

Need Help? About PEBP PEBP Health Plans Staying Informed Forms

Calendar of Events

Select A Month

Enroll Now

Update Your Information

Quick Links

Employee
Retiree
Agency Reps
Provider Search
Wellness
Vendor Contact Information

Welcome to the
Public Employees' Benefits Program

[Active Employees](#)

[State Retirees](#)

[Non-State Retirees](#)

[Frequently Asked Questions](#)

**Self-funded PPO
Plan Master Plan Document**

[Master Plan Document Plan Year 2011
Self-funded PPO Medical and Dental Plan](#)

- HMO Plan Documents
- PPO and HMO Provider Listings
- Dental Provider Listing
- PPO and HMO Drug Formularies
- Voluntary Product Vendors
- Much more...

Medical Plan Comparison

Benefit Category	Self-funded PPO Plan	Health Plan of Nevada	Hometown Health Plan
	Amount You Pay In-Network	Amount You Pay In-Network	Amount You Pay In-Network
Medical deductible	\$800 individual \$1,600 family (per plan year)	No deductible	\$250 individual \$750 family (per plan year)
Out-of-pocket maximum	\$3,700 person \$7,400 family (per plan year)	\$6,800 person (per calendar year)	\$6,200 person \$12,400 family (per plan year)
Hospital inpatient	\$105 admission copayment, plus 20% after deductible	\$200 copayment per admission	\$1,500 per admission, after deductible
Outpatient Same Day Surgery	20% coinsurance after deductible	\$50 copayment per admission	\$1,000 copayment per admission, after deductible
Primary care visit	\$20 copayment	\$15 copayment	\$25 copayment
Specialist visit	\$30 copayment	\$15 copayment	\$45 copayment
Urgent Care visit	\$45 copayment	\$15 copayment	\$50 copayment, after deductible
Emergency room visit	\$70 copayment, 20% coinsurance after deductible	\$50 copayment, plus \$25 physician copayment	\$300 copayment per visit, after deductible
General laboratory services	20% coinsurance after deductible	No charge	No charge for independent lab/office visit. \$75 copayment for outpatient setting, after deductible
Chiropractic services	\$30 copayment per visit	\$15 copayment per visit	\$45 copayment per visit \$1,000 plan year max, after deductible
Wellness/Prevention	No charge up to \$2,500 plan year maximum	\$15 copayment for primary care physician	\$25 copayment for primary care visit \$45 copayment for specialist visit
Vision exam	One exam every 12 months, paid at 80% U&C	\$10 copayment every 12 calendar months	\$15 copayment every 12 months
Hardware (frames, lenses, contacts)	\$125 allowance every 24 months	\$10 copayment/ lenses frames - \$100 allowance, contacts \$115 in lieu glasses	15 to 20% discount

The PPO family deductible applies when two or more individuals are covered on the plan. The family deductible cannot be met by one person, but by a combination of eligible claims for all covered family members. PPO (in-network) and non-PPO (out-of-network) out-of-pocket maximums are maintained separately. Refer to the *Self-funded PPO Master Plan Document*, or the *HMOs' Evidence of Coverage (EOC)* for more information.

Pharmacy Plan Comparison

Benefit Category	Self-funded PPO Plan	Health Plan of Nevada	Hometown Health Plan
	Amount You Pay In-Network	Amount You Pay In-Network	Amount You Pay In-Network
Pharmacy Deductible	\$50 per person (applies to Preferred Brand only)	No deductible	No deductible
Retail Pharmacy - 30 day supply			
Preferred Generic (Tier 1)	\$5 copayment (no deductible)	\$7 copayment	\$7 copayment
Preferred Brand (Tier 2)	\$40 copayment, after deductible	\$35 copayment	\$40 copayment
Non-Preferred (Tier 3)	100% of contracted price	\$55 copayment	Greater of \$75 copayment per script or 40%
Specialty Drugs	Greater of \$50 copayment or 25% of drug cost max \$100 per prescription, after deductible	Applicable retail pharmacy copayment will apply	30% coinsurance
Mail Order - 90 day supply			
Preferred Generic (Tier 1)	\$15 copayment (no deductible)	\$14 copayment	\$14 copayment
Preferred Brand (Tier 2)	\$120 copayment, after deductible	\$70 copayment	\$80 copayment
Non-formulary (Tier 3)	100% of contracted price	Not available through mail order	Greater of \$150 copayment per script or 40%
Specialty Drugs	Not available through mail order	Applicable retail pharmacy copayment applies	Not available through mail order

The health plans above offer three distinct drug formularies. When determining which plan is right for you, you will want to review the applicable plan's drug formulary at www.pebp.state.nv.us.

Elements of the Self-funded PPO Plan Medical and Vision Benefits



The Self-funded PPO Plan consists of a PPO network of doctors and healthcare facilities who agree to provide medical services at discounted rates. Claims are submitted for the services you receive, and you share 20% (in-network) or 50% (out-of-network) for the cost of those services. Although you may access services with any provider, your out-of-pocket costs will be lower if you use PPO network providers. Certain services require you to pay a copayment, and other services require that you satisfy a plan year deductible before the plan begins paying its portion of the claim. The PPO plan features open access which allows an individual to see a specialist without obtaining a referral from a primary care physician. The plan includes two PPO networks, the Statewide PPO Network and Beech Street. Participants who live in Nevada will use the Statewide PPO Network. The national PPO network, Beech Street, is available for individuals seeking services outside of Nevada, or for participants residing or traveling outside of Nevada.

The Self-funded PPO Plan has a \$800 individual (employee only) deductible and a \$1,600 family (employee plus one or more family members) deductible. The plan is structured with fixed copays for certain services, e.g., primary care visit - \$20 copay; specialist visit - \$30 copay; and urgent care visit - \$45 copay. The PPO plan includes a \$2,500 Wellness/Preventative benefit (using in-network providers) per plan year for each covered person. The plan year in-network out-of-pocket maximum is \$3,700 for one individual and \$7,400 for the family. The PPO plan is specified as the “base” plan to which an employee would be auto-enrolled if a plan selection is not made during the initial enrollment period.

Statewide PPO Network

The Statewide PPO Network consists of a partnership between Hometown Health Providers (northern Nevada) and Sierra Health Care Options, Inc. (southern Nevada). Health care providers who are members of the Statewide PPO Network accept the PPO negotiated amounts in place of their standard charges for covered services. Your out-of-pocket costs are lower when medical services or supplies are received from in-network PPO providers. To locate providers in Nevada, contact the Statewide PPO Network at 800-336-0123 or search for providers online at www.pebp.state.nv.us.

Beech Street PPO Network

The Beech Street PPO Network is the PPO plan’s national network of providers. Beech Street may be utilized when traveling or seeking medical care outside of Nevada. To locate providers, contact Beech Street at 800-432-1776 or search for providers online at www.pebp.state.nv.us.

PPO Vision Care

The PPO Vision Care benefit provides for one vision exam per covered person, per plan year. Benefits are paid at 80% of usual and customary. The hardware allowance (frames, lenses and contact lenses) is \$125 every 24 months, or rolling 2 year period. Participants are free to choose any vision care provider. Claim forms for vision care reimbursement are available at website at www.pebp.state.nv.us.

Elements of the Self-funded PPO Medical Plan



Plan Year Deductible: Each plan year, you are responsible for paying all of your eligible medical expenses until satisfying the plan year deductible before the plan begins to pay benefits.

\$800 Individual and \$1,600 Family Deductible: Medical deductibles for individual or family coverage, accumulate separately for in-network and out-of-network provider expenses. If both in-network and out-of-network providers are used, the deductible will have to be met twice--once for in-network and once for out-of-network.

For coverage of two or more persons, the family deductible applies. The family deductible could be met by any combination of eligible medical expenses from two or more members of the family coverage tier. No one single family member would be required to contribute more than the equivalent of the individual deductible toward the family deductible.

Coinsurance: Once you have met your plan year deductible, the plan generally pays a percentage of the eligible medical expenses, and you are responsible for paying the rest. The part you pay is called the coinsurance. If you use the services of a health care provider who is a member of the plan's PPO, you will be responsible for paying less money out of pocket. In-Network the Plan generally pays 80% of the PPO fee and you pay the remaining 20%. Out-of-Network the Plan generally pays 50% of Usual and Customary charges and you pay the remaining 50%. Note: If you fail to follow certain requirements of the plan's utilization management program, the plan may pay a smaller percentage of cost. For more information, refer to the Master Plan Document located at www.pebp.state.nv.us.

Copayments: Copayments are a set dollar amount that an individual must pay for certain services, while the plan pays the rest of the cost for that service (or its coinsurance amount). For example, a visit to your primary care physician would require you to pay a \$20 copay for that visit (copayments and deductible amounts do not apply to wellness/preventive care). For In-Network services you pay a copay for office visits, urgent care, outpatient behavioral visits, emergency room visits, and outpatient prescription drugs; the plan then pays either the remainder of the eligible expenses or the plan coinsurance amount. If using Out-of-Network providers, coinsurance usually applies.

Plan Year Out-of-Pocket Maximums - Medical: Each plan year, after an individual or family has incurred a maximum out-of-pocket cost for coinsurance, no other coinsurance will apply to covered eligible medical expenses. As a result, the plan will pay 100% of all covered eligible expenses. Note: the plan year deductible and copayment amounts do not apply to Out-of-Pocket Maximums.

Out-of-Pocket Maximum (in-network): \$3,700 individual and \$7,400 family. The family Out-of-Pocket Maximum cannot be met by one person, but by a combination of eligible claims for all covered family members. Note: Some expenses that you pay out-of-pocket will not apply to this maximum.

Out-of-Pocket Maximum (out-of-network): \$10,600 Individual and \$21,200 Family. The in-and out-of-network Out-of-Pocket Maximums are not interchangeable.

Elements of the Self-funded PPO Medical Plan



General Overall Lifetime Maximum: \$2 million per person (PPO [in-network] and non-PPO [out-of-network] combined.)

Limited Overall Lifetime Maximum: Certain eligible medical expenses are subject to Limited Overall Maximums for each covered individual. Once the plan has paid the Limited Overall Maximum Plan Benefits for any of those services or supplies on behalf of a covered individual, it will not pay any further plan benefits for those services or supplies for that covered individual, even though the General Overall Lifetime Maximum Plan Benefit has not been reached.

Restoration of Lifetime Maximum Benefit: If the plan pays benefits during the year, the remaining lifetime maximum benefit will be increased by \$1,000 on the first day of the next plan year. In no event will the lifetime maximum under this plan be increased to more than \$2 million.

Plan Year Maximum Benefits: Benefits for certain eligible medical expenses are subject to plan year maximums per covered individual or family. Once the plan has paid the Plan Year Maximum Benefits for any of those services or supplies on behalf of any covered individual or family, it will not pay any further plan benefits for those services or supplies of that individual or family for the balance of the plan year.

Pre-certification Review: Pre-certification reviews are completed before services are provided to assure they meet or exceed acceptable standards of care and that the admission and length of stay in a hospital or skilled nursing/sub acute facility, surgery, and other health care services are medically necessary. For more information regarding the pre-certification provisions, refer to the *Self-funded PPO Plan Master Plan Document* at www.pebp.state.nv.us.

Concurrent Review: Concurrent review is an ongoing assessment of the health care as it is being provided, including (but not limited to) inpatient confinement in a hospital or skilled nursing /sub acute facility.

Case Management: Case management is a voluntary process administered by PEBP's utilization management (UM) company. UM medical professionals work with the patient, family, caregivers, health care providers, Claims Administrator and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential health care providers. The Case Manager of the UM company will work directly with your physician, hospital, and/or other health care facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from health care providers, and may contact you or your family to assist in making plans for continued health care services, or to assist you in obtaining information to facilitate those services.

Diabetes Care Management Program: The Diabetes Care Management Program is available to all primary PPO participants, spouses and domestic partners with diabetes. Participants who are diagnosed with diabetes and who are actively engaged in the Diabetes Care Management Program will receive the following benefits: copayments for physician office visits indicating a primary diagnosis of diabetes will be paid under the \$2,500 individual wellness benefit, routine laboratory blood services such as hemoglobin (A1c) test will be paid under the individual wellness benefit, and copayments for diabetes related medications such as insulin will be reduced by 50%.

Elements of the Self-funded PPO Pharmacy Benefits



PPO Pharmacy Plan: Benefits for prescription drugs are provided through the Prescription Drug Plan. This plan provides a mandatory generic program meaning that if a brand name drug is dispensed in place of a generic, regardless of whether you or your physician requests it, you will pay 100% of the discounted rate.

Prescription Drug Deductible: There is a \$50 annual preferred name-brand prescription drug deductible per person (no family deductible applies). The annual deductible does not apply to generic drugs.

3-Tier Pharmacy Benefit Structure: The prescription drug program is designed to include a 3-tier benefit/payment structure which includes: Tier 1) Preferred Generic, Tier 2) Preferred Brand, and Tier 3) Non-Preferred Brand. For copayment amounts applicable to each Tier, refer to the *Pharmacy Plan Comparison* on page 6.

Prior Authorization: Prior Authorization (pre-certification) may be required for certain drugs. Prescription drugs that require prior authorization should be reviewed prior to purchase to ensure that you do not incur additional expenses in addition to the required copayment or deductible. For information regarding prior authorizations, contact Catalyst Rx at 800-799-1012 .

Retail Drugs: To obtain a 30-day supply of medication, present your ID card to any network retail pharmacy. To view a listing of in-network retail pharmacies visit: <https://www.catalystrx.com> or www.pebp.state.nv.us.

Mail Order Prescription Drug Service: The mail order service provides for a 90-day supply of non-emergency, extended-use “maintenance” prescription drugs, such as for high blood pressure, diabetes or birth control. The mail order service is administered by Walgreens. To obtain a 90-day supply, simply request a new prescription from your doctor, complete the Walgreens registration (included with your PPO medical ID card) and mail to Walgreens.

Specialty Medications: Specialty medications are limited to a 30 day supply and are available through Walgreen’s pharmacy network only. It is essential that Specialty medications be purchased through Walgreens to ensure you do not incur out-of-pocket costs in addition to your copayment. To learn more about the Walgreen’s Specialty Pharmacy call 866-823-2712.

Diabetic Sense Program: This is a preferred mail order service for diabetic supplies for participants who enroll in this benefit. Enrolled participants receive up to a 90-day supply of the following items at no charge: blood glucose monitors, test strips, insulin syringes, alcohol pads, and lancets. To enroll in this program, contact Diabetic Sense-Catalyst Rx at 877-852-3512.

Self-funded PPO Plan Wellness Benefit



Self-funded PPO Wellness/Preventive Care Benefit

The PPO Wellness Benefit provides a \$2,500 (per person, per plan year) benefit to participants and their covered dependents. Preventive care benefits are not subject to the plan year deductible or copayment.

The Wellness Benefit is available only when using in-network PPO providers. (Note: Wellness benefits are healthcare services that are not provided as a result of illness, injury or congenital defect.)

The following preventive screenings are covered under the PPO Wellness Benefit:

- Physical Exam, Screening Lab and X-rays
- Well-child Examinations and Immunizations
- Prostate Screening (e.g., PSA blood test)
- Routine Sigmoidoscopy
- Routine Colonoscopy
- Adult Immunizations
- Screening Mammogram
- Pelvic Exam and Pap Smear
- Osteoporosis Screening
- Hypertension Screening
- Skin Cancer Screening
- Routine Hearing Exam
- Weight Loss Program (medically supervised)
- Tobacco Cessation Programs
- Stress Management Programs

For additional information regarding the Wellness Benefit, refer to the Master Plan Document at www.pebp.state.nv.us.

Self-funded PPO Plan Live Well, Be Well Prevention Plan



PEBP is pleased to offer the Live Well, Be Well Prevention Plan as an expanded benefit to the Self-funded PPO Plan beginning July 1, 2010. During this first year, the program will only be offered to active and retired **primary participants enrolled in the PPO plan**. To participate in the program, you must complete your registration on or before October 31, 2010.

The Live Well, Be Well Prevention Plan focuses on three key elements:

Baseline Assessment: determines an individual's current health profile derived from the results of a blood test and responses to a Health Risk Appraisal.

Intervention: integrates the current health profile (baseline) results with intervention strategies aimed at improving health, and preventing the onset of illness and disease.

Live Well, Be Well Prevention Plan: includes several components aimed at maintaining and improving health. Some of the benefits include a personalized prevention plan report and website, healthy action plans, schedule of community events and challenges, secure online data storage for lab tests and other medical records, scheduled reminders about preventive screenings and doctor appointments, a summary of Self-funded PPO Plan benefits, a medical library where you can learn about health, wellness, medical tests and a host of other resources available on your personalized Live Well, Be Well Prevention Plan website.

Registration and Incentives

Register between July 1, 2010 and October 31, 2010, complete a blood test, and a Health Risk Appraisal to receive a \$25 gift card and the opportunity to save up to \$360 off your health insurance premium annually. Plus, you will get the tools you need to live healthier. If you qualify to enroll, register today so you can start your program early and be on your way to better health!

For more information about the Live Well, Be Well Prevention Plan, visit our website at www.pebp.state.nv.us.

Note: Employees with an initial start of your coverage on or after November 1, 2010, will not be eligible for the Live Well, Be Well Prevention Plan until Plan Year 2012, beginning July 1, 2011.

Hometown Health Plan Northern Nevada HMO Plan



Hometown Health Plan is a health maintenance organization (HMO) available to participants in Carson City, Churchill, Douglas, Elko, Eureka, Lander, Lincoln, Lyon, Humboldt, Mineral, Pershing, Storey, Washoe, and White Pine Counties. This plan features medical, prescription drug, and vision coverage (Hometown Health participants receive dental coverage through the PPO dental plan). Medical services must be received from a network provider. In addition, a primary care provider must be selected at initial enrollment.

Important Plan Information

Hometown Health Plan offers members Open Access (self-referral) to select specialists contracted with Hometown Health Plan (HMO). In many cases, this feature gives members the ability to see contracted specialists without obtaining a primary care physician's (PCP) referral. However, the following services require PCP referral:

Services that require PCP referral and Hometown Health Plan authorization include:

- All out-of-area services
- Any non-contracted provider or service
- Plastic surgery services
- Gastric bypass or lap banding services
- Anesthesiology and Physiatry services including pain management.
- Genetic counseling and testing
- Second-opinion services

Prior Authorization required for the following:

- All inpatient services in any facility type, including acute and skilled care, mental health care, drug or alcohol detoxification, or rehabilitation.
- Surgical services performed while an inpatient, same day surgery or outpatient office
- Home Health Care
- Durable Medical Equipment (DME), prosthetic and orthopedic devices over \$100
- Transplant services, including the evaluation process
- Medications specified by Hometown Health Plan as Special Pharmaceuticals
- Botox injections

It is the member's obligation to comply and cooperate with the Managed Care/Utilization Program. Prior authorization by Hometown Health Plan does not guarantee that all charges are covered under the policy.

Primary Care Physician (PCP)

The Primary Care Physician plays an important role in coordinating health care and arranging for covered services available to Hometown Health members. These include x-rays, laboratory tests, therapies, hospital admissions, follow-up care and prior authorizations.

How to Receive Medical Care

For routine medical care, select a Primary Care Physician from Hometown Health's Provider Directory at www.hometownhealth.com or www.pebp.state.nv.us.

Selecting and changing your Primary Care Physician (PCP)

[To choose your Primary Care Physician \(PCP\) follow these steps:](#)

Choose a specific PCP from the Hometown Health Plan Provider list at www.hometownhealth.com. Be sure to select the HMO providers.

- Primary Care Physicians include: General Practice Physician, Internal Medicine, and Pediatrics. Women may select both a PCP and a obstetrician/gynecologist.
- When you have selected the PCP, you will find the identifying PCP number for the PCP. Please use the PCP number in the space provided on your Benefit Enrollment and Change Form to identify the PCP for each member enrolling in Hometown Health Plan.
- If you wish to change your PCP, contact Hometown Health Customer Service at 775-982-3232 or 800-336-0123, Monday through Friday 7:30 a.m. until 5:30 p.m. Your PCP change will be effective immediately.
- You will not need a referral to a specialist except for specific services. Please refer to the Hometown Health Evidence of Coverage Certificate (EOC) for more information on this topic. The EOC is available at www.pebp.state.nv.us.

My Hometown Benefits - personalized online access to information

"My Hometown Benefits" at www.hometownhealth.com provides personalized real-time information on the following items:

- Claims and authorizations
- Benefit status
- Prescription drug benefits
- Obtain directions to one of more than 1,300 providers
- Healthcare related topics, including self help tools for asthma and diabetes provided by My Health Zone, a leading health information website

Retail Prescription Drugs

The retail prescription drug program allows participants to fill prescriptions up to a 30 day supply. Hometown Health Plan's prescription drug formulary and listing of participating pharmacies can be found at www.hometownhealth.com.

Mail-Order Drug Program

The mail-order drug program is for maintenance medications that a person would need to take for more than a 90-day period. When using this benefit for new prescriptions, request your Physician to write two prescriptions. One for a 30-day supply to take to the retail pharmacy and one for a 90-day supply with refills for the mail-order program. If you are already taking a maintenance medication and getting your refills at a retail pharmacy, simply request a 90-day prescription with refills from your Physician.

VSP Vision Care for Life

Hometown Health utilizes VSP as the Vision Plan Administrator. For a summary of vision benefits available through Hometown Health Plan, refer to the Medical Plan Comparison on page 5. For a listing of VSP providers, visit: www.hometownhealth.com.

HMO Reciprocity

Participants enrolled in Hometown Health Plan are eligible for expanded statewide provider access. Hometown Health Plan and Health Plan of Nevada (Southern Nevada HMO Plan) have a special network reciprocity agreement that allows HMO members to utilize both networks under certain circumstances. Reciprocity applies when traveling to/from northern/southern Nevada, and for dependents who are away at school in either the northern or southern part of the state. Expanded access is based on Hometown Health Plan's plan provisions. Hometown Health Plan's pre-authorization requirements and referral guidelines still apply as described in the Hometown Health Plan Evidence of Coverage Certificate.

Health Plan of Nevada (HPN) Southern Nevada HMO Plan



The Health Plan of Nevada (HPN) service area includes Clark, Esmeralda and Nye Counties. Health Plan of Nevada allows participants to access dependable care at fixed copayments. HPN offers a wide selection of physicians, hospitals, pharmacies and other health care providers.

Important Plan Information

HPN requires that you select a primary care physician (PCP) at initial enrollment. The employee (primary member) and each covered dependent may select a different PCP. A female member may select two (2) PCP's: A general practice Physician and an Obstetrician or Gynecological Physician.

To select a primary care physician, or to review *HPN's Evidence of Coverage*, visit the PEBP website at www.pebp.state.nv.us, or contact HPN at (702) 242-7300 or (800) 777-1840.

Services Requiring Prior-Authorization

All covered services not provided by the PCP require Prior Authorization from the PCP and HPN's Managed Care Program. The following Covered Services require Prior Authorization and Review through HPN's Managed Care Program:

- Non-emergency Inpatient admissions and extensions of stay in a Hospital, Skilled Nursing Facility, or Hospice
- Outpatient surgery provided in any setting, including technical and professional services
- Diagnostic and Therapeutic Services
- Home Healthcare Services
- Mental Health, Severe Mental Illness, and Substance Abuse Services
- All Specialist visits or consultations
- Prosthetic Devices, Orthotic Devices, and Durable Medical Equipment
- Courses of treatment, including allergy testing or treatment (e.g., skin, RAST); angioplasty; Home Health Care Services; physiotherapy or Manual Manipulation; rehabilitation therapy (physical, speech, occupational)

Vision - Eye Med Vision Care

Benefits are only available through participating providers who have agreed to provide services to Health Plan of Nevada members. For a complete list of providers, hours, locations, contact EyeMed Vision Care at 877-226-1115. For a summary of vision benefits available through HPN, refer to the Medical Plan Comparison on page 5.

Health Plan of Nevada (HPN) Southern Nevada HMO Plan



HPN Pharmacy Benefits

Health Plan of Nevada provides you with access to a wide range of effective and affordable prescription medications. You can view the Preferred Drug Benefit Guide at <http://stateofnv.healthplanofnevada.com>. The list is periodically updated and includes covered generic and brand name medications which are available at plan pharmacies for your specific plan copayment. Health Plan of Nevada's generic substitution policy requires your pharmacist to dispense generic drugs when available, unless otherwise directed by your provider. Generic drugs are effective equivalents of their brand name counterparts. However, if a brand name drug is dispensed when a generic equivalent is available, you will pay the generic copayment plus the difference between the generic and brand name contracted cost. Please refer to the Health Plan of Nevada Prescription Drug Benefit Rider at <http://stateofnv.healthplanofnevada.com> for specific details.

Mail Order Pharmacy Program

Preferred maintenance medications may be obtained through HPN's contracted mail order pharmacy, Medco By Mail (maintenance medications are used to treat a chronic illness or life threatening long-term condition such as asthma, diabetes, high blood pressure, arthritis or cardiovascular disease). For the drug to be available through the mail order pharmacy it must be on the Health Plan of Nevada's (HPN) Preferred Drug List AND be considered maintenance by HPN. For mail order inquiries, call 877-417-0536.



Health Education and Wellness (HEW)

HPN's Health Education and Wellness (HEW) offers health education in a face-to-face setting and on the internet. **MyHEWOnline** programs include: Diabetes, Heart Health, Pregnancy, Preventive Healthcare, Stop Smoking, and Weight Management.

Another feature of **MyHEWOnline** is the Health Risk Assessment (HRA). The HRA is your first step to better health. It is designed to help you identify your health and lifestyle profile. After completing the questionnaire, you will receive a personalized profile with recommendations to help improve your overall health. To learn more about HPN's Education and Wellness (HEW) program visit: <http://stateofnv.healthplanofnevada.com>

Health Plan of Nevada (HPN) Southern Nevada HMO Plan



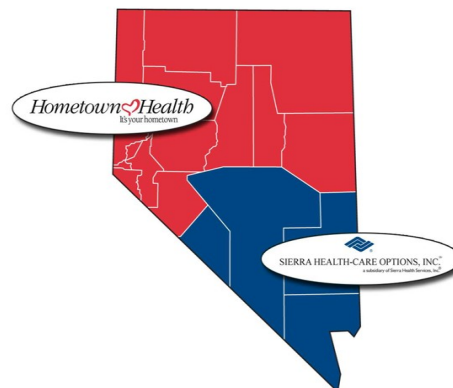
We're At Your Service

Health Plan of Nevada offers members 24-hour access to an online member center, We're At Your Service. This service is easy to use and allows you to obtain information about your benefits, claims and more, such as:

- Verify your prescription drug coverage
- Locate participating pharmacies
- Ask a pharmacist questions anytime, day or night
- Inquire on the status of a claim
- Verify the name of your Primary Care Physician
- Change your address (address must also be changed with PEBP)
- Request a new ID card

HMO Reciprocity

Participants enrolled in Health Plan of Nevada are eligible for expanded statewide provider access. HPN and Hometown Health Plan (Northern Nevada HMO Plan) have a special network reciprocity agreement that allows HMO members to utilize both networks under certain circumstances. Reciprocity applies when traveling to/from northern/southern Nevada, and for dependents who are away at school in either the northern or southern part of the state. Expanded access is based on the primary participant's designated HMO plan provisions. HPN's pre-authorization requirements and referral guidelines still apply as described in the HPN Evidence of Coverage Certificate.



Dental Plan For All Plan Options

Benefit Category	Explanation and Limitations	In-Network	Out-of-Network
<p>Plan Year Maximum</p>		<p>\$1,500 per person</p>	<p>\$1,000 per person</p>
<p>Preventive Services</p> <ul style="list-style-type: none"> • Oral examination • Prophylaxis (cleaning of teeth) • Bitewing x-rays • Topical application of sodium or stannous fluoride • Space maintainers • Application of sealants 	<ul style="list-style-type: none"> • Preventive services are subject to the plan year maximum dental benefits. • Oral examination is limited to four times per plan year. • Prophylaxis, scaling, cleaning and polishing limited to four times per plan year. • Bitewing x-rays limited to twice per plan year. • Fluoride treatment for individuals age 18 and under is payable twice per plan year. • Initial installation of space maintainer (to replace a primary tooth until a permanent tooth comes in) is payable for individuals under age 16. Plan allows fixed, unilateral (band or stainless steel crown type), fixed cast type (Distal shoe), or removable bilateral type. 	<p>No deductible 100% of the discounted PPO allowed fee schedule.</p>	<p>No deductible, Plan pays 80% of the in-network provider fee schedule. (Under no circumstances will the combination of PPO and Non-PPO benefit payments exceed the plan year maximum of \$1,500)</p>

The PPO Dental Plan is provided to all eligible **PPO and HMO** participants. Diversified Dental Services is the PPO dental network for Nevada residents. In the event that a participant lives more than 50 miles from an in-network PPO provider, resides, or travels outside of Nevada, benefits for an out-of-network provider will be considered at the in-network benefit level. Usual and Customary allowance will apply. The participant may be responsible for any amount billed by the provider that exceeds the Usual and Customary allowance.

Dental Plan For All Plan Options

Benefit Category	Explanation and Limitations	In-Network	Out-of-Network
<p>Basic Services</p> <ul style="list-style-type: none"> • Film fees, including examination and diagnosis, except for injuries • Periapical, entire dental film series (14 films) including bitewings every 36 months or panoramic survey covered once every 36 months • Oral surgery, limited to alveoplasty or alveolectomy, removal of cysts or tumors, torus and impacted wisdom teeth, including local anesthesia and postoperative care • Simple and multiple tooth extractions and removal of impacted teeth • Alveolar or gingival reconstructions and alveoplasty, incision/drainage abscess, removal of odontogenic cysts and neoplasm's and other surgical procedures, including maxillary sinusotomy for removal of tooth fragment, and frenectomy • General anesthesia in conjunction with a covered surgical procedure • Emergency periodontal treatment • Periodontal maintenance, sub gingival curettage, root planning and perio-scaling per quadrant (not cleaning) • Pulp capping • Amalgam restorations for primary and permanent teeth, synthetic, silicate, plastic and composite fillings • Appliance for thumb sucking (under age 16) or night guard for bruxism. 	<p>Explanation and Limitations</p> <ul style="list-style-type: none"> • Plan year deductible applies • Basic services are subject to plan year maximum • Full-mouth periodontal maintenance, payable four times per plan year. • Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition. • For multiple restorations, one tooth surface will be considered a single restoration. • No coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan began. • Initial installation of a removable, fixed or cemented inhibiting appliance to correct thumb sucking is payable for individuals under age 16. • Alternate procedures, such as CT scans used for dental procedures are not payable. 	<p>80%, after deductible</p>	<p>After the deductible is met, the in-network provider fee schedule. (Under no circumstances will the combination of PPO and Non-PPO benefit payments exceed the plan year maximum of \$1,500)</p>

The PPO Dental Plan is provided to all eligible **PPO and HMO** participants. Diversified Dental Services is the PPO dental network for Nevada residents. In the event that a participant lives more than 50 miles from an in-network PPO provider, resides, or travels outside of Nevada, benefits for an out-of-network provider will be considered at the in-network benefit level. Usual and Customary allowance will apply. The participant may be responsible for any amount billed by the provider that exceeds the Usual and Customary allowance.

Dental Plan For All Plan Options

Benefit Category	Explanation and Limitations	In-Network	Out-of-Network
<p>Major Services</p> <ul style="list-style-type: none"> • Gold restorations (inlays and onlays) only when teeth cannot be restored with a filling material • Repair or re-cementing of inlays, crowns, bridges and dentures • Initial installation of fixed or removable bridges, dentures and full or partial dentures (except for special characterization of dentures) including abutment crowns • Dental implants (endosseous, ridge extension, and ridge augmentation only) • Post and core on non-vital teeth only • Denture relining and/or adjustment more than six months after installation • Prosthodontics (artificial appliance of the mouth). No coverage of fees to install or modify an appliance for which an impression was made before coverage under this dental plan began. • Crown (acrylic, porcelain or gold with gold or non-precious metal), including crown build up only when teeth cannot be restored with a filling material. • Teeth added to a partial denture to replace extracted natural teeth, including clasps if needed. 	<p>Plan year deductible applies</p> <ul style="list-style-type: none"> • Major services subject to plan year maximum benefits. • No coverage for a crown, bridge or gold restoration when the tooth was prepared before coverage under this dental plan began. • Facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered. 	<p>After the deductible is met, plan pays 50% of the PPO allowed fee schedule</p>	<p>After the deductible is met, plan pays 50% of the in-network provider fee schedule.</p> <p>(Under no circumstances will the combination of PPO and Non-PPO benefit payments exceed the plan year maximum of \$1,500)</p>
<p>The PPO Dental Plan is provided to all eligible PPO and HMO participants. Diversified Dental Services is the PPO dental network for Nevada residents. In the event that a participant lives more than 50 miles from an in-network PPO provider, resides, or travels outside of Nevada, benefits for an out-of-network provider will be considered at the in-network benefit level. Usual and Customary allowance will apply. The participant may be responsible for any amount billed by the provider that exceeds the Usual and Customary allowance.</p>			

Elements of the Dental Plan For All Plan Options

Under the dental plan you must satisfy the plan year deductible before the plan will pay benefits for Basic and Major services. Eligible dental expenses provided in network for preventive services are not subject to the plan year deductible. There are two types of deductibles, individual and family:

Individual Deductible: The maximum amount one covered person has to pay each plan year before plan benefits are available for basic and major services. The plan's individual deductible is \$50.

Family Deductible: The family deductible is the maximum amount that a family of three or more has to pay each plan year. The plan's family deductible is \$150.

Payment of Dental Benefits: Dental services and supplies are considered to have been incurred on the date the services are performed or on the date the supplies are furnished. However, this rule does not apply to the following services because they must be performed over a period of time:

Fixed Partial Dentures, Bridgework, Crowns, In-lays, and On-lays. All services related to installation of fixed partial dentures, bridgework, crowns, in-lays and on-lays are considered to have been incurred on the date the tooth (or teeth) is (or are) prepared for the installation.

Removable Partial or Complete Dentures. All services related to the preparation of removable partial or complete dentures are considered to have been incurred on the date the impression for the dentures is taken.

Root Canal Treatment (Endodontic): All services related to root canal treatment (endodontic) are considered incurred on the date the tooth is opened for treatment.

Pretreatment Estimates: Whenever you expect that your dental expenses for a course of treatment will be more than \$300, you should use the pretreatment estimate procedure. This procedure informs you about how much you will have to pay before you begin treatment.

To obtain a pretreatment estimate, you and your dentist should complete the regular dental claim form indicating the type of work to be performed, along with supporting x-rays and the estimated cost (valid for a 60-day period). Once received, the claims administrator (UMR) will review the form and then send your dentist a statement within the next 60 days showing what the plan will pay. Your dentist may call UMR for a prompt determination of the benefits payable for a particular dental procedure.

Group Basic Life, AD & D and Long Term Disability Insurance For All Plan Options

Benefit Description	Benefit Features All Eligible Participants
Group Basic Life and Accidental Death and Dismemberment (AD & D) Coverage	<p>Employees enrolled in a PEBP-sponsored medical plan receive \$20,000 Basic Life and \$20,000 AD & D coverage. Dependent Life insurance of \$2,000 is also provided for your legal spouse or domestic partner and eligible children. Refer to the Life Insurance Certificate at http://www.standard.com/mybenefits/nevada/life_add.html for more information about this benefit.</p> <p>The Accelerated Benefit for Basic Life is available under certain circumstances. To exercise this option, or to learn more, contact The Standard at 888-288-1270.</p>
Beneficiary Financial Counseling	<p>The beneficiary of a deceased active employee may be eligible to receive comprehensive and objective financial counseling through an arrangement with PricewaterhouseCoopers. Services include a beneficiary guide about settling an estate and other important topics, personal financial counseling, financial analysis, 12 months of unlimited toll-free telephone access to financial counselors, a financial web site and newsletter "Your Money, Your Future." See the Beneficiary Counseling Brochure at http://www.standard.com/mybenefits/nevada/life_add.html#ben for more information.</p>
Medex Travel Assist	<p>Medex Travel Assist is designed to respond to most medical care situations and many other emergencies you and your family experience when you travel 100 miles or more from your home. Medex provides a wide-ranging program of information, referral, coordination and assistance services. These services include pre-trip assistance, medical assistance, emergency transportation, travel and technical assistance, legal services and medical supplies. Assistance is available 24 hours a day, 365 days a year whether you are 100 or 10,000 miles away from your home. Simply print out and carry the Medex Travel Assist Card available at http://www.standard.com/mybenefits/nevada/life_add.html#ben</p>
Long Term Disability (LTD) Insurance	<p>Long Term Disability Insurance is designed to help protect you against a loss of income in the event you become disabled and are unable to work for an extended period of time. If your LTD claim is approved, benefits become payable at the end of the 180-day Benefit Waiting Period (no benefits are paid during the Benefit Waiting Period). The monthly LTD benefit is based on your earnings from the State of Nevada or participating public agency. Your monthly LTD benefit is 60 percent of the first \$12,500 of your monthly earnings, as defined by the group insurance policy, reduced by deductible income. For more information about the LTD benefit, see the LTD Certificate of Insurance at http://www.standard.com/mybenefits/nevada/ltd.html.</p>

Life Insurance Portability and Conversion Options

Benefit Description	Benefit Features All Eligible Participants
<p>Portability of Life Insurance (Healthy Employees)</p>	<p>If your employment ends, or you are working less than the minimum number of hours to maintain health insurance eligibility, you may elect portable life coverage for yourself and your dependents. In the case of your death, your insured dependents may also elect portable life coverage for themselves. However, children cannot become insured for portable life coverage unless the surviving spouse or surviving domestic partner also becomes insured for portable life coverage. Portable life coverage is the current coverage and amounts that you and your dependents are insured for under the life insurance benefit. The amount of life insurance coverage that you port must be equal to or greater than the amount of the accidental death and dismemberment insurance. You must apply for portable coverage and pay any required premium within 31 days after the date your coverage ends or you begin working less than the required number of hours to maintain life insurance eligibility. Your dependents must apply for portable coverage within 31 days after the date the employee dies. You and your dependents may not apply for portable coverage if: you or they have an injury or sickness, the group life insurance is cancelled, required premium payments are not made, or in the case of a surviving child, surviving spouse or the surviving domestic partner are not eligible for (or does not elect) portable coverage.</p>
<p>Conversion of Life Insurance (Employees with a Disability)</p>	<p>A conversion right is the right given to an insured person under a group life insurance plan to convert coverage (without evidence of insurability) to an Individual Policy upon termination of the group coverage. The maximum amounts that can be converted are the amounts the employee and his dependents are insured for under the group policy. Lower amounts may also be converted. To convert coverage, the insured person must apply for conversion by obtaining, completing and returning a conversion application to The Standard. An insured person must apply for conversion within 31 days after the date employment terminates, or the date the insured person and/or his dependents are no longer eligible to participate in group life insurance coverage.</p>
<p>Important! Complete your Life Insurance Beneficiary Designation</p>	<p>Employees must complete the Beneficiary Designation form at the time of initial enrollment. The Beneficiary Designation and Change Form is included in this packet. Future changes to beneficiary designations may be made by downloading the Beneficiary Designation and Change Form at www.standard.com/mybenefits/nevada/ or by visiting www.pebp.state.nv.us, select Vendor Contact Information, and Standard Insurance.</p>

Plan Administrators: Dental Benefits, Basic Life, AD & D and LTD For All Plan Options

Dental Plan Administrator

For dental claim status and inquiries, Level I Claim Appeal, verification of eligibility and PPO plan benefit information, contact:

UMR

P.O. Box 2876
Clinton, IA 52733-2876
877-963-8232
Group Number 220701
www.umar.com



Preferred Provider Dental Network

To obtain a directory of preferred dental providers, provider inquiries, or to nominate new providers, contact:

Diversified Dental Services, Inc.

P.O. Box 36100
Las Vegas, NV 89133-6100
866-270-8326 (northern Nevada)
800-249-3538 (southern Nevada)
www.ddsppo.com



Diversified Dental Services, Inc.

Basic Life, AD & D and Long-term Disability Insurance Administrator

To obtain information regarding beneficiary designations, beneficiary financial counseling for an existing claim, Portability or Conversion applications, or claim status inquiries, contact:

The Standard

920 SW Sixth Ave.
Portland, OR 97204
888-288-1270
www.standard.com/mybenefits/nevada/index.html



State Active Employee Rates

Effective July 1, 2010 - June 30, 2011

Self-funded PPO Plan	Rate	Base Subsidy	Supplemental Subsidy	Employee Premium
Employee Only	\$624.66	\$580.93	0.00	\$43.73
Employee + Spouse	\$1,502.36	\$1,223.52	0.00	\$278.84
Employee + Child(ren)	\$765.77	\$684.24	0.00	\$81.53
Employee + Family	\$1,189.92	\$994.78	0.00	\$195.14
Hometown Health Plan Northern Nevada HMO	Rate	Base Subsidy	Supplemental Subsidy	Employee Premium
Employee Only	\$718.83	\$611.01	\$43.13	\$64.69
Employee + Spouse	\$1,615.83	\$1,212.00	\$10.26	\$393.57
Employee + Child(ren)	\$812.18	\$673.55	0.00	\$138.63
Employee + Family	\$1,307.02	\$1,005.09	0.00	\$301.93
Health Plan of Nevada Southern Nevada HMO	Rate	Base Subsidy	Supplemental Subsidy	Employee Premium
Employee Only	\$365.40	\$310.59	0.00	\$54.81
Employee + Spouse	\$722.09	\$549.57	0.00	\$172.52
Employee + Child(ren)	\$618.27	\$480.01	0.00	\$138.26
Employee + Family	\$972.25	\$717.18	0.00	\$255.07

- State employees: Pre-tax insurance premiums are generally deducted from the first paycheck each month.
- State Employees on Leave Without Pay (LWOP) pay 100% of Rate.

Notes

State Active Employee/Domestic Partner Rates
Effective July 1, 2010 - June 30, 2011

State Active Employee/Domestic Partner	Self-funded PPO Plan					
	\$800 Individual - \$1,600 Family Deductible					
	Rate	Base Subsidy	Supp Subsidy	Employee Premium	Pre Tax Deduction	Post Tax Deduction
Employee + DP	1,502.36	580.93	0.00	921.43	43.73	877.70
Employee + DP's Child(ren)	765.77	580.93	0.00	184.84	43.73	141.11
Employee + Children of both	765.77	684.24	0.00	81.53	81.53	0.00
Employee + DP + EE's Child(ren)	1,189.92	684.24	0.00	505.68	81.53	424.15
Employee + DP + DP's Child(ren)	1,189.92	580.93	0.00	608.99	43.73	565.26
Employee + DP + Children of both	1,189.92	684.24	0.00	505.68	81.53	424.15
State Active Employee/Domestic Partner	Hometown Health Plan					
	Northern HMO					
	Rate	Base Subsidy	Supp Subsidy	Employee Premium	Pre Tax Deduction	Post Tax Deduction
Employee + DP	1,615.83	611.01	10.26	994.56	64.69	929.87
Employee + DP's Child(ren)	812.18	611.01	0.00	201.17	64.69	136.48
Employee + Children of both	812.18	673.55	0.00	138.63	138.63	0.00
Employee + DP + EE's Child(ren)	1,307.02	673.55	0.00	633.47	138.63	494.84
Employee + DP + DP's Child(ren)	1,307.02	611.01	0.00	696.01	64.69	631.32
Employee + DP + Children of both	1,307.02	673.55	0.00	633.47	138.63	494.84
State Active Employee/Domestic Partner	Health Plan of Nevada					
	Southern HMO					
	Rate	Base Subsidy	Supp Subsidy	Employee Premium	Pre Tax Deduction	Post Tax Deduction
Employee + DP	722.09	310.59	0.00	411.50	54.81	356.69
Employee + DP's Child(ren)	618.27	310.59	0.00	307.68	54.81	252.87
Employee + Children of both	618.27	480.01	0.00	138.26	138.26	0.00
Employee + DP + EE's Child(ren)	972.25	480.01	0.00	492.24	138.26	353.98
Employee + DP + DP's Child(ren)	972.25	310.59	0.00	661.66	54.81	606.85
Employee + DP + Children of both	972.25	480.01	0.00	492.24	138.26	353.98

The **Employee Premium** column above is the amount you will pay for your health insurance.

For deduction purposes, there are two parts: Pre-Tax and Post-Tax. The employee's benefit cost is deducted Pre-Tax, while the Domestic Partner's benefit cost is deducted Post-Tax.

Non-State Active Employee/Domestic Partner Rates
Effective July 1, 2010 - June 30, 2011

Non-State Active Employee	Self-funded PPO Plan		
	\$800 Individual - \$1,600 Family Deductible		
	Rate	Supp Subsidy	Employee Premium
Employee Only	\$ 860.94	\$ 0.00	\$ 860.94
Employee + Spouse/Domestic Partner	\$ 1,541.39	\$ 0.00	\$ 1,541.39
Employee + Child(ren)	\$ 815.52	\$ 0.00	\$ 815.52
Employee + Family	\$ 1,458.64	\$ 55.55	\$ 1,403.09

Non-State Active Employee	Hometown Health Plan		
	Northern HMO		
	Rate	Supp Subsidy	Employee Premium
Employee Only	\$ 818.93	\$ 41.79	\$ 777.14
Employee + Spouse/Domestic Partner	\$ 1,846.41	\$ 124.75	\$ 1,721.66
Employee + Child(ren)	\$ 926.02	\$ 0.00	\$ 926.02
Employee + Family	\$ 1,490.08	\$ 0.00	\$ 1,490.08

Non-State Active Employee	Health Plan of Nevada		
	Southern HMO		
	Rate	Supp Subsidy	Employee Premium
Employee Only	\$ 364.26	\$ 0.00	\$ 364.26
Employee + Spouse/Domestic Partner	\$ 719.76	\$ 0.00	\$ 719.76
Employee + Child(ren)	\$ 616.23	\$ 0.00	\$ 616.23
Employee + Family	\$ 969.03	\$ 0.00	\$ 969.03

Non-State employees: contact your payroll department regarding the final cost of your coverage and/or pre-tax/post-tax deductions.

Completing the Employee Benefit Enrollment and Change Form

After you have read the enclosed material and made your plan selection, complete the Employee Benefit Enrollment and Change Form as follows:

Employee Benefit Enrollment and Change Form (BECF)

- Section 1: Select your employee category, e.g., New Hire, Rehire or Reinstatement
Date of Event: Enter the effective date of your coverage
- Section 2: Enter Participant information
- Section 3: Select your health plan, e.g., Self-funded PPO Plan, Hometown Health Plan or Health Plan of Nevada. If declining coverage, place a check-mark in the Decline/waive coverage box. Note: By declining coverage, you lose your eligibility for all PEBP-sponsored benefits.
- Section 4: HMO plans only: Enter the Primary Care Physician Code (to locate the PCP code, visit www.pebp.state.nv.us, select Vendor Contact Information, then select the applicable HMO plan).
- Section 5: Choose your coverage tier
- Participant Only
 - Participant + Spouse
 - Participant + Participant's Child(ren)
 - Participant + Family (employee, spouse and children)
 - Participant + Domestic Partner (DP)
 - Participant + DP's Child(ren)
 - Participant + DP + Participant's Child(ren) + DP's Child(ren)
 - Participant + Participant's Child(ren) + DP's Child(ren)
 - Participant + DP + DP's Child(ren)
 - Participant + DP + Participant's Child(ren)
- Section 6: Enter the information for any dependents you are adding to your coverage. Refer to page 2 for supporting documentation requirements.
- Section 7: Read, sign and date the form using black or blue ink (BECF must be an original form, faxes or copies will not be accepted).

Return the completed BECF and copies of supporting documents (if adding dependent(s)) to your designated Agency Representative within 7 days of receiving this packet.

Life and AD & D Beneficiary Designation



The enclosed Beneficiary Designation and Change Form is required for all *enrolled* PEBP participants. This designation applies to Basic Life/AD & D and Voluntary Life (if purchased separately) insurance under the Group Insurance Policy. Designations are not valid unless signed, dated, and delivered to Standard Insurance Company during your lifetime.

Note: This beneficiary designation form is separate from the survivor's beneficiary designation form available from the Public Employees' Retirement System (PERS).

Mail completed Beneficiary Designation and Change Forms to:

State of Nevada Life Insurance Team
Mestmaker Insurance Services
P.O. Box 2302
Bakersfield, CA 93303-2302

Beneficiary Information

- Your designation revokes all prior designations (applies to Reinstated or Rehired employees who previously submitted a designation).
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).

If you name two or more Beneficiaries in a class (Primary or Contingent):

- Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, The Standard will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, The Standard will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiary(ies) pro-rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
- If only one Beneficiary in a class survives, The Standard will pay the total death benefits to that Beneficiary.
- Dependents Insurance, if any, is payable to you, if living, or as provided under the provisions of the Group Policy.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary Designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated xx-xx-xx."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.

For additional questions regarding the Beneficiary Designation Form, contact The Standard at 888-288-1270.

Voluntary Flexible Spending Accounts (FSA) For State Employees Only



The Health Care FSA is a tax-free account that allows you to pay for essential health care expenses that are not covered, or are partially covered, by your medical, pharmacy, dental and vision insurance plans. By contributing a portion of your payroll dollars into your FSA on a pre-tax basis, you can save from 25% to 40% on the cost of eligible expenses you are already incurring.

When you enroll in an FSA, you decide how much to contribute to each account for the remaining months in the plan year (July 1, 2010 - June 30, 2011). The amount you elect to contribute is then deducted from your second monthly paycheck, pre-tax (before Federal & State income taxes and FICA taxes are deducted) in equal amounts over the course of the months remaining in the plan year. After you incur expenses that qualify for reimbursement, you submit reimbursement requests (claims) to ASIFlex to request tax-free withdrawals from your Health Care FSA.

The Health Care FSA allows you to set aside up to \$6,000 per FSA plan year pre-tax. Your election amount is typically fixed for the entire plan year (unless you have a qualifying event).

- Any funds you are unable to submit valid claims for at the end of the claims run out period (September 15, 2011) will be forfeited, so estimate your expenses carefully and set money aside accordingly.
- Expenses for any of your tax dependents are eligible for reimbursement even if they are not covered on your health plan.

The Dependent Care FSA creates a tax break for dependent care expenses (typically child care or day care expenses) that enable you to work. Additionally, if you have an older dependent who lives with you at least 8 hours per day and requires someone to come into the house to assist with day-to-day living, you can claim these expenses through your Dependent Care FSA. If you are married, your spouse must be working, looking for work or be a full-time student. If you have a stay-at-home spouse, you should not enroll in the Dependent Care FSA.

- IRS regulations disallow Dependent Care FSA reimbursement for services that have not yet been provided. You can only claim service periods that have already occurred.
- Eligible expenses include day care and baby sitting for dependents under the age of 13; or for older dependents that live with you at least 8 hours each day and are incapable of self-care.
- The IRS allows no more than \$5,000 per household (\$2,500 if you are married and file a separate tax return) be set-aside in the Dependent Care FSA in a calendar year.

Domestic Partner Eligibility

The expenses of an employee's spouse qualify for reimbursement under the Health Care FSA. However, the IRS does not recognize a qualified domestic partner for tax purposes. A domestic partner does not generally qualify for the Health Care FSA unless they qualify as a dependent under the definition of a qualifying relative. If you have questions regarding your eligibility to enroll in an FSA, please contact ASI Flex at (800) 659-3035.

To learn more about Flexible Spending Accounts, visit www.pebp.state.nv.us, www.asiflex.com or call ASIFlex at 800-659-3035.

Voluntary Group Life, AD & D and Short-Term Disability (STD) Insurance



Employee Group Voluntary Life and Accidental Death and Dismemberment (AD & D)

You may purchase Voluntary Life coverage in units of \$20,000, to a maximum of \$500,000. If you want to become insured for an amount of Voluntary Life Insurance greater than the *guarantee issue* amount of \$100,000, then you must provide satisfactory evidence of insurability. This means you will have to answer medical questions or provide additional medical information or take a physical exam to purchase coverage in excess of \$100,000.

If you do not apply for coverage when initially eligible, you may apply (or increase coverage) at any time. However, except as provided below, late application and requests for coverage increases require you to provide satisfactory evidence of insurability.

Spouse or Domestic Partner Voluntary Life Coverage

Coverage for your spouse or domestic partner is available in units of \$10,000, to a maximum of \$250,000, but not to exceed 100% of your combined Basic and Voluntary Life coverage. If you elect an amount of Voluntary Life insurance for your spouse or domestic partner greater than the *guarantee issue amount of \$20,000*, then you must provide satisfactory evidence of insurability. This means your spouse or domestic partner will need to answer a medical questionnaire or provide additional medical information, or take a physical exam to qualify for coverage in excess of \$20,000.

Dependent Children Voluntary Life Coverage

Coverage for your dependent child(ren) is available in units of \$2,500 to a maximum of \$10,000, but not to exceed 100% of your combined Basic and Voluntary Life coverage.

Voluntary Short Term Disability (STD)

STD Insurance is designed to pay a weekly benefit to you in the event you cannot work because of a covered illness or injury. If you enroll when first eligible, and your STD claim is approved by The Standard, STD benefits become payable at the end of the elected Benefit Waiting Period for disabilities caused by accidents, physical disease, pregnancy or mental disorder.

Benefit Waiting Period Option	Weekly STD Benefit
Option A - 7 days	60% of the first \$2,500 of your weekly earnings (as defined in the group insurance policy), reduced by deductible income. The maximum STD benefit is \$1,500 per week.
Option B - 14 days	
Option C - 30 days	

If you do not apply for Voluntary STD coverage when you are initially eligible, then during the first year you are insured under the Voluntary STD plan, the Benefit Waiting Period will be 60 days from the date of your disability. This is called Late Enrollment Penalty. Late Enrollment Penalty does not apply to a disability resulting from an accidental injury.

It's easy to enroll for Voluntary Life and STD coverage, simply complete the form available for download at http://www.standard.com/mybenefits/nevada/vol_std.html and mail to the address indicated on the form. For more information, contact The Standard at 888-288-1270.

Voluntary Auto, Home, RV and Renters Insurance and Long-Term Care Insurance

Employees have the option of purchasing a variety of insurance products, such as auto, home, renters, condo, boat, RV, etc., at special group discounts. Both carriers offer convenient payment options, such as automatic deductions from your checking account, payroll deduction and online payments. To receive an insurance quote or for additional information, contact the carrier directly.

	Liberty Mutual 800-637-7026	Travelers' Insurance 888-695-4640	
---	--	--	---

Long-term Care Insurance Offered By UNUM Provident

Long term care is the assistance received when someone needs help with two or more Activities of Daily Living such as dressing, bathing, going to the bathroom, eating or moving about or when someone suffers a severe cognitive impairment. This care could be provided in the home, in an assisted living or residential care facility, or in a skilled nursing facility such as a nursing home.

As a new eligible employee you have 30 days to sign up for Guarantee Issue coverage once your PEBP coverage becomes effective. If you wait to enroll after 30 days following your medical plan coverage effective date, or if you choose benefits over the Guarantee Issue limits, you will be required to complete a medical questionnaire.

All Family Members must complete the Benefit Election form, the Long-Term Care Insurance application (medical questionnaire) and must be approved for coverage in order to enroll.

For questions regarding the Voluntary Long Term Care plan, please call UNUM Provident at 800-227-4165.



Benefit Duration	3 Years	6 Years	Unlimited Duration
Facility Benefit Amount In Increments of \$1,000	\$1,000 to \$8,000	\$1,000 to \$8,000	\$1,000 to \$8,000
Assisted Living Facility Percent	60%	60%	60%
Lifetime maximum Per \$1,000 Increments	\$36,000	\$72,000	Unlimited
Professional Home Care	50%	50%	50%
Total Home Care Option	50%	50%	50%
Inflation Protection Option	Simple Capped	Simple Capped	Simple Capped

Qualifying Events Quick Reference Table

Event Type	Notification Period	Required Documents As Applicable for the Event	When Coverage Begins or Ends	Allowable Changes Based Upon the Type of Event
Adoption or placement for adoption more than 60 days after the child's date of birth	Within 60 days of the event date	<ul style="list-style-type: none"> • BECF • Copy of legal adoption papers (signed by a judge), followed by the final legal adoption papers within 60 days of issuance, and • If not the primary insured's child, a copy of the marriage or domestic partnership certificate 	Coverage effective on the first day of the month in which the child is adopted or placed for adoption, whichever date is earlier	May add the designated adopted child(ren) and other eligible dependent(s) in the family unit
Newborn	Within 60 days of the event date	<ul style="list-style-type: none"> • BECF • Copy of the hospital birth confirmation, and • If not primary insured's child, a copy of the marriage or domestic partnership certificate • SSN must be provided within 120 days of the date of birth 	<ul style="list-style-type: none"> • Newborn coverage is effective on the date of birth • Coverage for other dependents effective on the first day of the month concurrent with or following the newborn's date of birth 	May add newborn child and other eligible dependent(s) in the family unit
Permanent guardianship of a child	Within 60 days of the event date	<ul style="list-style-type: none"> • BECF • Copy of the legal guardianship papers (signed by a judge), • Copy of the birth certificate(s) 	Coverage is effective on the first day of the month concurrent with or following the date in which the guardianship papers are signed by the judge	May add child(ren) as designated in the legal guardianship order and other eligible dependent(s) in the family unit
Marriage/domestic partnership	Within 60 days of the event date	<ul style="list-style-type: none"> • BECF • Copy of the marriage or Nevada domestic partnership certificate • If adding dependent(s), a copy of the child (ren)'s birth certificate(s) 	Coverage effective on the first day of the month concurrent with or following the date of the event	May add spouse or domestic partner and other eligible dependent(s) in the family unit
Divorce/Annulment or Termination of Domestic Partnership	Within 60 days of the event date	<ul style="list-style-type: none"> • BECF • Copy of the divorce/annulment decree signed by the judge • Copy of the Termination of Domestic Partnership filed with the Nevada Secretary of State's office 	Coverage terminates on the last day of the month in which the divorce decree is signed by the judge or the Termination of Domestic Partnership is filed with the Nevada Secretary of State's office	Must delete ex-spouse or ex-domestic partner and all other ineligible dependent(s)
Spouse or domestic partner experiences a change of work status resulting in a loss of eligibility and coverage from other employer group health plan	Within 60 days of the event date	<ul style="list-style-type: none"> • BECF • HIPAA certificate(s) of prior creditable coverage for each dependent being added • Copy of the marriage or Nevada Domestic Partnership Certificate • If adding dependent(s), a copy of the child(ren)'s birth certificate(s) 	Coverage effective on the first day of the month concurrent with or following the date of the event	May add spouse or domestic partner and other eligible dependent(s) in the family unit

Qualifying Events Quick Reference Table

Event Type	Notification Period	Required Documents As Applicable for the Event	When Coverage Begins or Ends	Allowable Changes Based Upon the Type of Event
<p>Spouse or domestic partner experiences a change of work status resulting in a <i>gain</i> of eligibility and coverage under another employer group health care plan</p> <ul style="list-style-type: none"> • Gain Child Status • Unmarried child(ren) age 19 through age 23 becomes a full-time student • Child between the age of 19 through 23 becomes disabled • Child loses group health care coverage 	<p>Within 60 days of the event date</p>	<ul style="list-style-type: none"> • BECF • Confirmation of coverage letter stating the effective date of new coverage and the identity of covered individual(s) 	<p>Coverage terminates on the last day of the month prior to the month the new coverage begins</p>	<p>May delete spouse or domestic partner and other dependent(s) in the family unit that have gained coverage in the other plan</p>
<ul style="list-style-type: none"> • Gain Child Status • Unmarried child(ren) age 19 through age 23 becomes a full-time student • Child between the age of 19 through 23 becomes disabled • Child loses group health care coverage 	<p>Within 60 days of the event date</p>	<ul style="list-style-type: none"> • BECF • Statement of full-time student status from accredited educational program • Copy of birth certificate • Certification of Disabled Dependent Child (available from PEBP), completed by the participant and the child's physician • HIPAA certificate of creditable coverage (with no break in coverage greater than 63 days), if not already enrolled in PEBP 	<p>Coverage effective on the first day of the month concurrent with or following the date of the event</p>	<p>May enroll the eligible child(ren) for coverage</p>
<ul style="list-style-type: none"> • Loss of Child Status • Child is no longer a full-time student • Child marries • Step child loses eligibility due to a divorce • Child enters the military • Child greater than age 18 no longer resides in the household • Child gains other group health care coverage 	<p>Within 60 days of the event date</p>	<ul style="list-style-type: none"> • BECF • Copy of the of participant's divorce decree signed by the judge • Copy of the Termination of Domestic Partnership as filed with the Nevada Secretary of State's office • Confirmation of coverage letter stating the effective date of new coverage and the identity of covered individual(s) 	<p>Coverage terminates on the last day of the month in which the event occurs.</p>	<p>May delete the child(ren) from coverage</p>

Qualifying Events Quick Reference Table

Event Type	Notification Period	Required Documents As Applicable for the Event	When Coverage Begins or Ends	Allowable Changes Based Upon the Type of Event
Dependent declines coverage due to Medicare or Medicaid entitlement	Within 60 days of the event date	<ul style="list-style-type: none"> • BECF • Copy of Medicare card • HIPAA certificate of creditable coverage from Medicaid 	Coverage terminates on the last day of the month preceding the Medicare or Medicaid effective date	May delete the dependent who becomes entitled to Medicare or Medicaid
Retiree/Survivor's Entitlement to Medicare Parts A and/ or B	Within 60 days of the event date	<ul style="list-style-type: none"> • Copy of Medicare card • PPO participants only: Medicare Direct Form • BECF (only if Medicare entitlement includes Parts A and B and changing health plans to a Medicare Advantage Plan) 	If enrolling in a Medicare Advantage Plan, coverage under the new plan is effective on the first of the month concurrent with the Medicare entitlement date, or as approved by the Medicare Advantage Plan	May enroll in a Medicare Advantage Plan (MAP) if Medicare entitlement includes Parts A and B and the participant resides in an eligible MAP coverage area
Participant death	Within 60 days of the event date	<ul style="list-style-type: none"> • Original death certificate 	Decedent coverage terminates on the date of death. Coverage for any covered dependents terminates on the last day of the month concurrent with the decedent's date of death	Covered dependents may qualify for re-enrollment in Survivor's coverage if they meet the eligibility requirements as stated elsewhere in this document
Dependent death	Within 60 days of event	<ul style="list-style-type: none"> • BECF • Original death certificate 	Coverage for the decedent terminates on the date of death	Must delete the decedent from coverage
Survivor	Within 60 days of the primary participant's date of death	<ul style="list-style-type: none"> • BECF 	Coverage for eligible survivors is effective on the first of the month following the primary participant's date of death	May qualify for Survivor's coverage if the dependent meets the Survivor's eligibility requirements as stated elsewhere in this document
Qualified Medical Child Support Order (QMCSO)	Within 60 days of issuance of QMCSO or Release of QMCSO	<ul style="list-style-type: none"> • Copy of birth certificate(s) for the dependents named in the QMCSO 	<ul style="list-style-type: none"> • QMCSO: First of the month concurrent with or following the date PEBP receives the QMCSO • Release of QMCSO: Coverage terminates on the last day of the month concurrent with or following the date PEBP receives the Release of QMCSO 	Must add dependents as stated in the QMCSO
Employee retires	Within 60 days of the retirement	<ul style="list-style-type: none"> • BECF • Years of Service Certification Form • Copy of Medicare card (if applicable) 	Coverage effective on the first of the month concurrent with or following the date of retirement	May add dependents and/or select new plan option

Coordination of Benefits (COB)

Coordination of Benefits (COB)

The rules and procedures applicable to the determination of how plan benefits are payable when an insured person is covered by two or more health care plans.

How Duplicate Coverage Occurs

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

- Another group health care plan;
- Medicare;
- Other government program, such as Medicaid, Tricare/CHAMPUS, or a program of the U.S. Department of Veterans Affairs, motor vehicle (but not limited to) no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or
- Workers' Compensation.

Note: The PPO Plan does not coordinate benefits with prescription medications, or any covered Over-the-Counter (OTC) medications obtained through retail or mail order pharmacy programs.

When and How Coordination of Benefits (COB) Apply

Many families have more than one family member working outside the home who are covered by more than one medical or dental plan. If this is the case with your family, you must let the Plan Administrator know about the other coverage when you submit a claim.

Coordination of Benefits (COB) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called secondary plan) may then pay additional benefits.

If the PPO Plan is secondary coverage, the participant will be required to meet the PEBP plan year medical and dental deductibles.

For more information about Coordination of Benefits (COB), refer to the Self-funded PPO Plan Master Plan Document, or the applicable HMO Evidence of Coverage Certificate located at www.pebp.state.nv.us.

Important Information About Your Coverage

Copayment, Copay

The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms), or health care facilities. This can be in addition to coinsurance amounts due on the same incurred charges.

Coinsurance

That portion of eligible medical expenses for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses in excess of the plan's deductible. The coinsurance varies depending on whether in-network or out-of-network providers are used.

Declining/Opting Out of Coverage

An active employee may only decline (opt-out of) enrollment in a PEBP medical plan at initial enrollment or during PEBP's annual open enrollment. Employees who decline PEBP coverage also decline all other associated benefits, e.g., medical, pharmacy, vision, dental, basic life, accidental death and dismemberment, long term disability insurance and all voluntary products.

Deductible - Self-funded PPO Plan

The Self-funded PPO Deductible Plan has two deductibles, depending on the coverage level (tier) selected. Deductibles for Individual or Family coverage accumulate separately for in-network provider expenses and out-of-network provider expenses. If both in-network and out-of-network providers are used, the deductible will have to be met twice—once for in-network and once for out-of-network.

- For single coverage individuals, the Self-funded PPO Plan has a \$800 Individual deductible.
- For coverage of two or more persons, this plan has a \$1,600 Family deductible. The Family deductible could be met by any combination of eligible medical expenses from two or more members of the same family tier. No one single family member would be required to contribute more than the equivalent of the Individual deductible toward the Family deductible.

Example

1. Family tier member #1 incurs \$2,500 in eligible in-network medical expenses. Only \$800 (equivalent to the Individual deductible) would be applied toward the total Family deductible.
2. Family tier member #2 incurs \$2,000 in eligible in-network medical expenses. \$800 would be applied toward the Family deductible. The total Family deductible amount of \$1,600 has now been met.

Important Information About Your Coverage

Dual PEBP Coverage Not Permitted

PEBP participants (employees and/or their dependents) are not permitted to be covered under two PEBP accounts. If a dependent becomes eligible for coverage as a primary insured, that individual must select primary coverage and be deleted from PEBP coverage as a dependent.

Moving from one enrollment coverage area to another enrollment coverage area

HMO participants who move outside of their designated HMO plan's coverage area may select a new medical plan to coincide with their new coverage area. To change medical plans, the participant must complete the Employee Benefit Enrollment and Change Form. The effective date of the change will be the first day of the month following the date of the move. If the move occurs on the first day of the month, the change will be effective on that day.

Open Enrollment

The annual Open Enrollment period provides employees the opportunity to change existing medical plan elections, e.g., from/to PPO/HMO plan and/or add new or delete existing covered dependents. Changes made during Open Enrollment become effective on the first day of the new plan year. The Open Enrollment period is held annually in May with the new plan year beginning on July 1. Open Enrollment announcements are mailed to employees' homes approximately 2 - 3 weeks before the scheduled Open Enrollment period.

PPO Pre-certification Review

Pre-certification review is a procedure, administered by PEBP's utilization management vendor, APS Healthcare, to assure health care services meet or exceed accepted standards of care, and the admission and length of stay in a hospital, skilled nursing/sub acute facility, surgery and other health care services are medically necessary.

Pre-Existing Conditions

Pre-existing conditions do not apply to employees and/or their eligible dependents.

Employee Leave(s) of Absence

Family Medical Leave of Absence

If you have completed 12 months or 1,250 hours of employment, you are entitled by law for up to 12 weeks each year of unpaid family medical leave for specified family or medical purposes, such as a birth or adoption of a child, or provide care of a spouse/domestic partner or child or parent who is seriously ill, or for your own serious illness. This plan uses a rolling 12-month period, measured from the date an employee uses any FMLA leave.

Employees on family or medical leave can maintain health care coverage for themselves and any covered dependents in effect during that family or medical leave period by continuing to pay any required contributions during that period.

At the conclusion of the family or medical leave period, employees returning from leave shall have their coverage reinstated (on the first day of the month in which the employee resumes working 80 hours) to the same medical plan and coverage tier that was in place prior to taking the leave.

Leave Without Pay (LWOP)

A state agency that employs an individual who is on LWOP shall NOT pay any amount of the cost of premium or contributions for group insurance for that employee, unless the employee receives a minimum compensation of 80 hours in the month for work actually performed, accrued annual leave or sick leave, or any combination thereof.

An employee who is on approved LWOP may pay the full cost of premiums for their coverage and insurance to PEBP. An employee on LWOP is not eligible for coverage as a dependent of another PEBP covered participant (spouse/domestic partner, child, etc.).

At the initial start of leave, it is the employee's responsibility to inform PEBP of their coverage preference while on leave. If the employee fails to inform PEBP of his or her coverage preference while on leave, PEBP will continue the same medical plan and coverage tier that the employee had in affect prior to taking that leave.

Employee Leave(s) of Absence

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

- Employees on active military service (for up to 31 days) may elect to continue health care coverage during that leave period by paying any premium contributions due for that coverage while on leave.
- If the employee go into active military service for 31 days or more, the employee is eligible to enroll him/herself and family in health care coverage provided by the military the day the employee is activated for military duty. The employee is also eligible to purchase continued health coverage for him/herself and their family for up to 24 months in a manner similar to the provisions of COBRA. When the employee returns from military leave within the required reemployment period, there will be an immediate reinstatement of PEBP-sponsored medical coverage with no waiting period .

Workers' Compensation Leave

Employee health care coverage during a period of Workers' Compensation leave will automatically be continued for a period of up to 9 months. The employee may continue coverage for employee and dependents by paying premiums directly to PEBP. At the end of the 9-month period during which the employer has contributed to the employer's cost share for health care coverage during that leave period, the employer's portion of the payments for such coverage will cease, and the employee is now required to make the full payment for health care coverage for themselves and their dependents. When the employee returns to work, insurance coverage will be reinstated exactly the way it was before the employee was placed on Workers' Compensation leave.

It is the employee's responsibility to inform the participating public agency (employer) whether or not they want to continue coverage for themselves and/or their dependents at the *initial start* of a leave. If the employee fails to inform the participating public agency (employer) of their intent to continue coverage for themselves and their dependents covered under the plan before taking the leave, the participating public agency shall inform PEBP to continue coverage for the employee and their covered dependents (if applicable) in the same coverage/tier that the employee had in place before taking the leave.

Public Employees' Benefits Program

901 S. Stewart Street, Suite 1001
Carson City, NV 89701

Initial COBRA Notification

To Covered Participant, Covered Spouse/Domestic Partner, and all Covered Dependents

It is important that all covered individuals (employee, spouse/domestic partner and eligible dependent children) take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent whose legal address is not yours, please provide written notification with the attached COBRA Address Notification Form to PEBP so a notice can be sent to them as well.

Under the federal Consolidated Omnibus Reconciliation Act (COBRA) laws, PEBP is required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the health plan (a medical and/or dental plan) would otherwise end due to certain qualifying events. This notice is intended to inform you (and your covered dependents), in a summary fashion, of your potential future options and obligations under the continuation coverage provisions of the COBRA law. Should an actual qualifying event occur in the future, PEBP will send you additional information. Please take special note of your notification obligations which are detailed on the next page.

Qualifying Events for a Covered Employee – If you are the covered employee, you may have the right to elect health plan continuation coverage if you lose your Public Employees' Benefits Program (PEBP) group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or reduction in your hours of employment.

Qualifying Events for a covered spouse/domestic partner– If you are the covered spouse/domestic partner of an employee, you may have the right to elect health plan continuation coverage for yourself if you lose your PEBP group health coverage because of any of the following reasons:

- A termination of your spouse/domestic partner's employment (for reasons other than gross misconduct) or reduction in your spouse/domestic partner's hours of employment;
- The death of your spouse/domestic partner;
- Divorce;
- Your spouse/domestic partner becomes entitled to Medicare.

Qualifying Events For Covered Dependent Children – If you are the covered dependent child of an employee, you may have the right to elect health plan continuation coverage for yourself if you lose your PEBP group health coverage because of any of the following reasons:

Initial COBRA Notification

- A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
- The death of the employee;
- Parents divorce;
- The employee becomes entitled to Medicare;
- You cease to be a "dependent child" under the terms of the health plan.

Important Employee, Spouse/Domestic Partner and Dependent Notifications Required.

Under the law, the employee, spouse/domestic partner, or other family member has the responsibility to notify PEBP of a divorce or a child losing dependent status while covered by a group health plan. This notification must be made within 60 days from the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event whichever date is later. The notification may be made through your Agency Representative who has the necessary form; if this is not possible, you may notify PEBP **in writing**, including the following information: the name and address of the covered employee, the name and address of the covered dependent(s), documentation must accompany the notification, such as a HIPAA certificate from another employer, or a copy of a divorce decree.

If this notification is not completed according to the above procedures and within the required 60-day notification period, then rights to continuation coverage will be forfeited. Please familiarize yourself with the dependent eligibility rules contained in the Master Plan Document. PEBP will notify the PEBP-sponsored health plan of the employee's termination of employment, reduction in hours, or death.

Election Period and Coverage. Once PEBP has received notice that a qualifying event has occurred, PEBP will then notify covered individuals (also known as qualified beneficiaries) of their rights to elect continuation coverage. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect continuation coverage. The 60 day election window is measured from the date health plan coverage is lost due to the event or from the date of COBRA notification whichever is later. **This is the maximum period allowed to elect COBRA as the plan does not provide an extension of the election period beyond what is required by law.** If a qualified Beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end and they cease to be a qualified beneficiary.

If a qualified beneficiary elects continuation coverage, they will be required to pay the entire cost for the medical and/or dental insurance, plus a 2% administration fee. PEBP is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your coverage as well.

Length of Continuation Coverage – 18 months. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event.

Initial COBRA Notification

Social Security Disability. The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of continuation coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to PEBP within 60 days after the date of determination and before the original 18 months expire.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension. If coverage is extended, and the disabled qualified beneficiary has elected the extension, then the applicable premium rate is 150% of the premium rate. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at 102% level. It is also the qualified beneficiary's responsibility to notify PEBP within 30 days if a final determination has been made that they are no longer disabled.

Secondary Events. Another extension of the 18 month continuation period can occur, if during the 18 months of continuation coverage, a second event takes place (divorce, death, Medicare entitlement, or a dependent child ceasing to be a dependent). If a second event occurs, then the original 18 months of continuation coverage can be extended to 36 months from the date of the original qualifying event date for the eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify PEBP in writing within 60 days of the second event and within the original 18 month COBRA timeline. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not considered a second event for COBRA purposes.

Length of Continuation Coverage – 36 months. If the original event causing the loss of coverage was the death of the employee, divorce, Medicare entitlement, or a dependent child ceasing to be a dependent child under a PEBP sponsored group health plan, then each qualified beneficiary will have the opportunity to continue coverage for a total of 36 months from the date of the qualifying event.

Eligibility, Premiums, and Potential Conversion Rights. A qualified beneficiary does not have to show they are insurable to elect continuation coverage; however, they must have been actually covered by the plan to be eligible for COBRA continuation coverage. An exception to this rule is if while on continuation coverage a baby is born or adopted by a covered employee qualified beneficiary. If this occurs, the newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of birth or date of adoption. Please contact PEBP for the procedures and timelines for adding these individuals to your coverage. PEBP reserves the right to verify COBRA eligibility status and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of facts.

Initial COBRA Notification

A qualified beneficiary will have to pay all of the applicable premium plus a 2% administration charge for continuation coverage. These premiums will be adjusted in the future if the applicable premium amount changes. In addition, there will be a maximum grace period of 30 days for the regularly scheduled monthly premiums. There is no option with your plan to enroll in an individual conversion health plan at the end of the 18 months or three years of continuation coverage.

Cancellation of Continuation Coverage. The law provides COBRA continuation coverage will end prior to the maximum continuation period for any of the following reasons:

- PEBP ceases to provide any group health plan to any of its participants;
- Any required premium for continuation coverage is not paid in a timely manner;
- After the date of COBRA election, a qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to pre-existing condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996;
- After the date of the COBRA election, a qualified beneficiary becomes entitled to Medicare;
- A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
- A qualified beneficiary notifies PEBP that they wish to cancel COBRA continuation coverage;
- For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

Notification of Address Change - To ensure all covered individuals receive information in a timely manner, it is important you promptly notify PEBP of any address change as soon as possible. Failure on your part to do so will result in delayed COBRA notifications or a loss of continuation coverage options.

If you are a covered individual and do not understand the information in this summary notice, the Self-funded PPO Master Plan Document can supply more information concerning your obligations. Please contact PEBP Member Services at 775-684-7000 or 800-326-5496. This document is also available on the PEBP website at www.pebp.state.nv.us.

Public Employees' Benefits Program

901 S. Stewart Street, Suite 1001
Carson City, NV 89701

COBRA ADDRESS NOTIFICATION FORM

If you have a dependent who is covered by PEBP and whose legal residence is not yours (dependent child covered by court order, living with an ex-spouse/domestic partner, etc.) you are required to provide us with the proper address so an initial COBRA notice can be sent to them as well. This does NOT include a dependent child whose legal residence is still yours, but is away at school. Should you have any questions, please call PEBP Member Services at 775-684-7000 or 800-326-5496.

This information must be provided to PEBP upon commencement of coverage:

1. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent: _____

Name of Guardian, ex-spouse/domestic partner,
etc.: _____

Street Address: _____

City: _____ State: _____ Zip: _____

2. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent: _____

Name of Guardian, ex-spouse/domestic partner,
etc.: _____

Street Address: _____

City: _____ State: _____ Zip: _____

3. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent: _____

Name of Guardian, ex-spouse/domestic partner, etc.: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Self-funded PPO Plan Contacts

Self-funded PPO Medical, Vision, Dental, and Pharmacy

<ul style="list-style-type: none"> • In-State PPO Medical Network • Network Providers • Provider directory • Additions/deletions of providers 	<p>PEBP Statewide PPO Network Administered by Hometown Health Partners and Sierra Healthcare Options Customer Service: (800) 336-0123 www.pebp.state.nv.us</p>
<ul style="list-style-type: none"> • Out-of-State PPO Medical Network • Network Providers • Provider directory • Additions/deletions of providers 	<p>Beech Street Customer Service (800) 432-1776 www.beechstreet.com</p>
<ul style="list-style-type: none"> • Self-funded Dental PPO Network • Statewide dental PPO providers • Dental provider directory 	<p>Diversified Dental Services Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538</p>
<ul style="list-style-type: none"> • Self-funded PPO Medical and Dental Claims Administrator • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan benefit information 	<p>UMR - United Medical Services, Inc. P.O. Box 2876 Clinton, IA 52733-2876 Customer Service: (877) 963-8232 Group Number: 220701 http://www.umar.com Email: service@umar.com</p>
<ul style="list-style-type: none"> • Self-funded PPO Prescription Drug Plan Administrator • ID cards and prescription drug information • Retail network pharmacies • Prior authorization • Non-network retail claims payment • Mail order service and mail order forms 	<p>Retail Pharmacy Services Catalyst Rx Customer Service: (702) 869-4600 or (888) 869-4600 or (800) 799-1012 Mail Order Services Walgreens Mail Order Customer service (866) 845-3590 www.catalystrx.com User Name: nevada Password: benefit</p>
<p>APS Healthcare</p> <ul style="list-style-type: none"> • Pre-certification • Case Management 	<p>APS Healthcare Pre-certification and Customer Service 2450 Fire Mesa Rd. Suite 160 Las Vegas, NV 89128 (888) 323-1461 www.apshealthcare.com</p>
<p>U.S. Preventive Medicine</p> <ul style="list-style-type: none"> • Live Well, Be Well Prevention Plan Diabetes Care Management 	<p>U.S. Preventive Medicine (USPM) The Prevention Plan (877) 800-8144 12740 Gran Bay Parkway, Suite 2400 Jacksonville, FL 32258 www.ThePreventionPlan.com/NevadaPEBP</p>

Fully Insured Product Contacts

<p>Medical, prescription and vision claims administrator</p> <ul style="list-style-type: none"> • Provider network • Provider directories • Appeals • Benefit Information • Additions/deletions of providers 	<p>Hometown Health Plan Customer Service: (775) 982-3232 or (800) 336-0123 http://stateofnv.hometownhealth.com or www.pebp.state.nv.us</p>
<p>Medical, prescription and vision claims administrator</p> <ul style="list-style-type: none"> • Provider network • Provider directories • Appeals • Benefit Information • Additions/deletions of providers 	<p>Health Plan of Nevada Customer Service: (702) 242-7300 (800) 777-1840 http://stateofnv.healthplanofnevada.com or www.pebp.state.nv.us</p>
<p>Life and AD&D Insurance</p> <ul style="list-style-type: none"> • Life insurance benefits information • Claim filing • MEDEX travel assistance • Beneficiary designation forms 	<p>Standard Insurance Company Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html or www.pebp.state.nv.us</p>
<h3>Voluntary Product Contacts</h3>	
<p>Life Insurance - Additional</p> <ul style="list-style-type: none"> • Information on voluntary life insurance • Short-Term Disability Insurance 	<p>Standard Insurance Company Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html or www.pebp.state.nv.us</p>
<p>Long-Term Care Insurance</p>	<p>Colonial Life UNUM Customer Service: (877) 433-5334 www.pebp.state.nv.us</p>
<p>Flexible Spending</p> <ul style="list-style-type: none"> • Health care • Dependent care <p>Enrollment forms: www.pebp.state.nv.us</p>	<p>ASI Flex Customer Service: (800) 659-3035 Fax: (866) 381-9682 P.O. Box 6044, Columbia, MO 65205 www.asiflex.com</p>
<p>Home and Auto Insurance</p>	<p>Liberty Mutual Customer Service: (800) 637-7026 gary.bishop@libertymutual.com</p> <p>Travelers' Customer Service: (888) 695-4640 www.travelers.com/nevada</p>