State of Nevada
Public Employees' Benefits Program

Master Plan Document for the
PEBP Enrollment and Eligibility

Plan Year 2017
July 1, 2016 – June 30, 2017

www.pebp.state.nv.us

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

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP provides a variety of benefits such as medical, dental, life insurance, long-term Disability, flexible spending accounts, and other voluntary insurance benefits for eligible State and local government Employees, Retirees, and their Eligible Dependents.

As a PEBP Participant, You may access whichever benefit plan (Consumer Driven Health Plan, Self-Funded Dental PPO Plan or HMO) is offered in your geographical area that best meets Your needs, subject to specific eligibility and plan requirements. You are also encouraged to research Plan Provider access and quality of care in Your service area.

All PEBP Participants choosing the Consumer Driven Health Plan should examine the Medical and Prescription Drug Benefit Master Plan Document (MPD) and the PEBP Self-Funded Dental PPO Plan Master Plan Document (MPD) to become more knowledgeable about their health benefits.

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

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

PEBP Master Plan Documents are a comprehensive description of the benefits available to You. Relevant statutes and regulations are noted throughout this document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the Participant Contact Guide.

PEBP encourages You to stay informed of the most up to date information regarding Your health care benefits. It is Your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,

Public Employees' Benefits Program

Words that are capitalized throughout this document are generally defined in the Plan Definitions section.

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

Introduction

This Master Plan Document describes the PEBP Eligibility and Enrollment policies.

- This PEBP Plan is governed by the State of Nevada.
- This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code 287 as amended and certain provisions of NRS 695G and NRS 689B.

The policies described in this document are effective **July 1, 2016**, and unless stated differently replace all other Eligibility and Enrollment policies outlined in documents/summary plan descriptions previously provided to You.

This document will help You understand the Eligibility and Enrollment policies determined and administered by the Public Employees' Benefits Program (PEBP). You should review it and also show it to members of Your family who are also covered under the Plan. This document will provide You with a better understanding of the policies regarding Eligibility and Enrollment.

All provisions of this document contain important information. If You have any questions about Your coverage or Your obligations under the terms of the plan, please contact PEBP at the number listed in the Participant Contact Guide. The Participant Contact Guide section provides You with contact information for the various components of the Public Employees' Benefits Program.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. As the Plan is amended from time to time, You will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, You should rely on the later information. Be sure to keep this document, along with notices of any Plan or Eligibility and Enrollment changes, in a safe and convenient place where You and Your family can find and refer to them.

This Plan is <u>not</u> established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The self-funded Plans administered by PEBP are funded with contributions from participating Employers and eligible Plan Participants, held in an internal service fund. An independent Claims Administrator pays benefits out of the fund's assets.

- The **benefits offered** are the Self-Funded Consumer Driven Health Plan, prescription drug plan and the Self-Funded PPO Dental Plan. The medical and prescription drug benefits are described in the Medical and Prescription Drug Benefit Master Plan Document (MPD). An independent Claims Administrator pays the claims for medical and dental benefits. An independent Claims Administrator pays the claims for prescription drug benefits. The Self-Funded Consumer Driven Health Plan also provides Health Savings Accounts (HSA) and Health Reimbursement Arrangement (HRA) benefits.

- The **fully insured benefits offered** include the HMO options (whose benefits are described in documents provided to You by the HMO insurance companies), Life Insurance, and Long Term Disability (LTD) Insurance is described in the Self-Funded PPO Dental Master Plan Document (MDP) which includes the summary of benefits for the Life and Long Term Disability Insurance. **For more information about the fully insured benefits, contact PEBP or visit the PEBP website.**

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

The Executive Officer or his designee makes all final determinations concerning eligibility (NAC 287.313).

Rescissions

This Plan will cause a Rescission of Coverage due to fraud or an intentional misrepresentation of a material fact. A Plan Participant may have the right to appeal a Rescission. See the Claim Appeal Process to learn how to initiate an appeal.

Suggestions for Using this Document: This document provides important information about Your benefits. We encourage You to pay particular attention to the following:

- **Review the Table of Contents.** The **Table of Contents** provides You with an outline of the sections.
- **Become familiar with PEBP vendors** and the services they provide by reviewing the **Participant Contact Guide**.
- Review the **Participant Rights and Responsibilities section** located in the Introduction section of this document.
- The **Definitions** section explains many technical and legal terms that appear in the text.
- **Review the Enrollment and Eligibility provisions.** These describe the Enrollment and Eligibility rules in detail. There are examples, charts and tables to help clarify key provisions and details in regards to PEBP Enrollment and Eligibility.
- **Refer to the General Provisions and Notices section** for information regarding Your rights and general provisions of the Plan.

Participant Rights and Responsibilities

You have the right to:

- Participate with Your health care professionals and Providers in making decisions about Your health care.
- Receive the benefits for which You have coverage.
- Be treated with respect and dignity.
- Privacy of Your personal health information, consistent with State and Federal laws, and the Plan's policies.
- Receive information about the Plan's organization and services, the Plan's network of health care professionals and Providers and Your rights and responsibilities.
- Candidly discuss with Your physicians and Providers appropriate or medically necessary care for Your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's Participants' rights and responsibilities policies.
- Express respectfully and professionally, any concerns You may have about PEBP or any benefit or coverage decisions the Plan (or the Plan's designated administrator) makes.
- Refuse treatment for any conditions, illness or disease without jeopardizing future treatment and be informed by Your physician(s) of the medical consequences.

You have the responsibility to:

- Establish a patient relationship with a participating primary care physician and a participating dental care Provider.
- Take personal responsibility for Your overall health by adhering to healthy lifestyle choices. Understand that You are solely responsible for the consequences of unhealthy lifestyle choices.
    - If You use tobacco products, seek advice regarding how to quit.
    - Maintain a healthy weight through diet and exercise.
    - Take medications as prescribed by Your Health Care Provider.
    - Talk to Your Health care Provider about preventive medical and dental care.
    - Understand the prevention/wellness benefits offered by the Plan.
    - Visit Your Health Care Provider(s) as recommended.
- Choose in-network participating Provider(s) to provide Your medical and dental care.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with Your Health Care Providers.
- Read all materials concerning Your health benefits or ask for assistance if You need it.
- Supply information that PEBP and/or Your health care professionals need in order to provide care.
- Follow Your physicians recommended treatment plan and ask questions if You do not fully understand Your treatment plan and what is expected of You.
- Follow all of the Plan's guidelines, provisions, policies and procedures.

- Inform PEBP if You experience any life changes such as a name change, change of address or changes to Your coverage status because of marriage, divorce, Domestic Partnership, birth of a Child(ren), or adoption of a Child(ren).
- Provide PEBP with accurate and complete information needed to administer Your health benefit plan, including if You or a covered Dependent has other health benefit coverage.
- Retain copies of the documents provided to You from PEBP and PEBP's vendors. These documents include but are not limited to:
    - Copies of the Explanation of Benefits (EOB) from PEBP's third party Claims Administrator. Duplicates of Your EOB's may not be available to you. It is important that You store these documents with Your other important paperwork.
    - Copies of Your Enrollment forms submitted to PEBP.
    - Copies of Your medical, vision and dental bills.
    - Copies of Your HSA contributions, distributions and tax forms.

The Plan is committed to:

- Recognizing and respecting You as a Participant.
- Encouraging open discussion between You and Your health care professionals and Providers.
- Providing information to help You become an informed health care consumer.
- Providing access to health benefits and the Plan's Network (Participating) Providers.
- Sharing the Plan's expectations of You as a Participant.

Participant Contact Guide

General Contacts	Service
Public Employees' Benefits Program (PEBP) 901 S. Stewart Street, Suite 1001 Carson City, NV 89701 Customer Service: (775) 684-7000 or (800) 326-5496 Fax: (775) 684-7028 www.pebp.state.nv.us	**Plan Administrator** • Enrollment and change of status • Certificate of Creditable Coverage • COBRA information and premium payments • Level 2 claim appeals • External Review coordination
Office for Consumer Health Assistance 555 E. Washington Avenue, Suite 4800 Las Vegas, NV 89101 Customer Service: (702) 486-3587 or (888) 333-1597 www.govcha.state.nv.us	**Consumer Health Assistance** • Concerns and problems related to coverage • Provider billing issues • External Review information
Nevada Secretary of State Office The Living Will Lockbox c/o Nevada Secretary of State 101 North Carson St., Ste. 3 Carson City NV 89701 Phone: (775) 684-5708 Fax: (775) 684-7177 www.livingwilllockbox.com	**Living Will Information** • Declaration governing the withholding or withdrawal of life-sustaining treatment • Durable power of attorney for health care decisions • Do not resuscitate order

Consumer Driven Health Plan Medical, Vision and Dental Contacts	Service
PEBP Statewide PPO Network Administered by Hometown Health Providers and Sierra Health Care Options Customer Service: (800) 336-0123 www.pebp.state.nv.us	**In-state PPO Medical Network** • Network Providers • Provider directory • Additions/deletions of Providers
National Network Providers First Health Network/HealthSCOPE Benefits P. O. Box 91603 Lubbock, TX 79403-1603 Customer Service: (800) 226-5116 www.myfirsthealth.com	**National Medical Network/Outside of Nevada** • Network Providers • Provider directory (website only) • Additions/deletions of Providers The National Medical Network is available to Participants who reside outside of Nevada, or who live in Nevada but choose to seek medical treatment outside of Nevada.

Consumer Driven Health Plan Medical, Vision and Dental Contacts	**Service**
Wise Provider Network 6995 Union Park Center #250 Cottonwood Heights, UT 84047 Customer Service: (866) 485-5205	**Preferred Provider Network offers benefits to members who use the network in:** • Utah • Wyoming • Idaho • Arizona • Colorado • Oregon • Nevada
Diversified Dental Services P O Box 36100 Las Vegas, NV 89133-6100 Customer Service: Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538 www.ddsppo.com	**Self-funded Dental PPO Network** • General information on statewide dental PPO Providers • General information on national dental PPO Providers • Dental Provider directory
HealthSCOPE Benefits Claims Submission: HealthSCOPE Benefits P O Box 91603 Lubbock, TX 79490-1603 Appeal of Claims: HealthSCOPE Benefits P O Box 2860 Little Rock, AR 72203 Group Number: NVPEB Customer Service: (888) 763-8232 www.healthscopebenefits.com	**Claims Administrator/** **Third Party Administrator** • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan benefit information • CDHP & Dental only ID Cards • Health Savings Account (HSA) Administrator • Health Reimbursement Arrangement (HRA) Administrator • In-network pricing tool
Hometown Health Providers Customer Service: (775) 982-3232 or (888) 323-1461 www.stateofnv.hometownhealth.com	**Medical Utilization Management & Case Management Services** • Pre-certification, for example: o Inpatient hospital admissions o Certain outpatient procedures o All spinal surgeries o All bariatric (weight loss) surgeries o Transgender services • Large Case & Complex Case Management

Consumer Driven Health Plan Medical, Vision and Dental Contacts	Service
Hometown Health Providers Customer Service: (775) 982-3232 or (888) 323-1461 www.stateofnv.hometownhealth.com	**Disease Management** • Disease Management for Diabetes

Consumer Driven Health Plan Prescription Drug Plan Contacts	Service
Retail Pharmacy Services: **Express Scripts** Customer Service and Prior Authorization (855) 889-7708 www.Express-Scripts.com You will need to create a User ID and Password **Express Scripts Home Delivery** PO Box 66566 St. Louis, MO 63166-6566 Customer Service: (855) 889-7708 Mail Order forms and online ordering: www.Express-Scripts.com You will need to create a User ID and Password **Specialty Drug Services** Accredo Customer Service: (800) 803-2523	**Prescription Drug Plan Administrator** • Prescription Drug Information • Retail Network Pharmacies • Prior Authorization • Non-network Retail Claims Payment • Price and Save tool • Mail Order Service and Mail Order Forms **Preferred Mail Order for Diabetic Supplies** • Specialty Drug Services Provider • Refills and order status

Fully Insured Product Contacts	Service
The Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html	**Basic Life Insurance** • Benefits • Filing a life insurance claim • Beneficiary financial counseling • MEDEX travel assistance
The Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html	**Long-Term Disability (LTD)** • Benefits • Filing a Long-Term Disability claim

Fully Insured Product Contacts	Service
Hometown Health Plan HMO Customer Service: (775) 982-3232 or (800) 336-0123 www.stateofnv.hometownhealth.com	**Northern Nevada Health Maintenance Organization (HMO)** • Medical claims • Pre-authorization • Provider network
Health Plan of Nevada HMO Customer Service: (702) 242-7300 or (800) 777-1840 www.stateofnv.healthplanofnevada.com	**Southern Nevada Health Maintenance Organization (HMO)** • Medical claims • Pre-authorization • Provider network
Towers Watson's One Exchange 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 Customer Service: (888) 598-7545 TTY: (866) 508-5123 www.ExtendHealth.com/PEBP **PayFlex** P.O. Box 3039 Omaha, NE 68103-3039 Customer Service: (888) 598-7545 General Fax: (402) 231-4300 Claims Fax: (402) 231-4310 www.payflex.com	**Medicare Exchange** • Supplemental or replacement medical coverage for Retirees and covered Dependents with Medicare Parts A and B **Health Reimbursement Arrangement** • Health Reimbursement Arrangement for Retirees with Medicare Parts A and B • Premium reimbursement

Voluntary Product Contacts	Service
The Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html	**Life Insurance – Additional** Voluntary life insurance benefits
The Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html	**Short-term Disability Insurance** Voluntary Short-term Disability benefits
Liberty Mutual Customer Service: (800) 637-7026 Gary.bishop@libertymutual.com	**Home and Auto Insurance** • Voluntary homeowners and auto insurance • Voluntary RV insurance
HealthSCOPE Benefits Claims Submission: HealthSCOPE Benefits P.O. Box 3627 Little Rock, AR 72203 Customer Service: (888) 763-8232 Fax: (877) 240-0135 Email: pebphsahra@healthscopebenefits.com Online Claims Submission: www.healthscopebenefits.com Click Member Type PEBP as the company name Click Flexible Spending Account (FSA) Status Login to Your Member Dashboard	**Flexible Spending Accounts** • Limited Scope Flexible Spending Account • Dental expenses • Dependent Care Flexible Spending Account
UNUM Provident Customer Service: (800) 227-4165 Option #4	**Long-Term Care Insurance** Voluntary long-term care insurance benefits

Summary of Benefit Options

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

Identification Cards

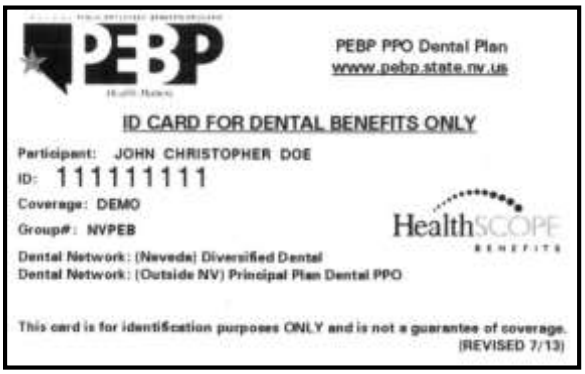
Medical and Pharmacy and Dental Benefits

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

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

The following is the PEBP Consumer Driven Health Plan ID card; this card is issued to **Participants who reside in Nevada** and who may need medical, pharmacy or dental services in Nevada or outside of Nevada.

The following is the PEBP Consumer Driven Health Plan ID card; this card is issued to **Participants who reside outside Nevada** and who may need medical, pharmacy or dental services outside of Nevada.


PEBP PPO Dental Plan
www.pebp.state.nv.us

ID CARD FOR DENTAL BENEFITS ONLY

Participant: JOHN CHRISTOPHER DOE
ID: 111111111
Coverage: DEMO
Group#: NVPEB

HealthSCOPE BENEFITS

Dental Network: (Nevada) Diversified Dental
Dental Network: (Outside NV) Principal Plan Dental PPO

This card is for identification purposes ONLY and is not a guarantee of coverage.
(REVISED 7/13)

Dental Only ID Card - Front

This card is issued to Retirees covered under the Medicare Exchange who elect the PEBP Self - Funded PPO Dental Plan and to active Employees and Retirees who elect one of the medical HMO


For dental claims status, benefits and eligibility information and PPO provider status, contact HealthSCOPE Benefits at 1-888-7NEVADA (1-888-763-8232)

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

Principal Financial Group

DDS, Inc.

Submit Claims to: HealthSCOPE Benefits, PO Box 91603, Lubbock, TX 79490-1603
EDI Payor ID#: 71063

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

Dental Only ID Card - Back

Enrollment Processes

Enrollment Options

Enrollment Online

Log on to the PEBP website at www.pebp.state.nv.us and click on the orange "Login" button, then follow the instructions to access Your account.

Most Enrollment events may be completed online and will eliminate having to complete a paper Enrollment form. If You are enrolling in the CDHP You may also establish Your Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) online.

Enrollment must include without limitation:

- The name, address and social security number of the Participant who is enrolling in the Plan; and
- The name, social security number of any Dependent that the Participant chooses to cover under the Plan and any required supporting documents.

A Participant who desires to Enroll or add a Dependent to the Plan must agree to the Authorization section of the Enrollment form by signing (submittal of the online Enrollment is considered a digital signature) and dating the Enrollment.

Paper Form Enrollment

If an event cannot be completed online or if an Employee or Retiree does not have internet access, Enrollment forms can be obtained from PEBP. Please note Enrollment forms must be completed in blue or black ink and the original must be submitted to PEBP. PEBP will not accept copies, faxes, or scanned forms sent via email in place of the original form.

Initial Enrollment

Initial Enrollment for Active Employees

Employees must Enroll or decline coverage online at www.pebp.state.nv.us or by completing the Employee Benefit Enrollment and Change Form and submitting any required supporting documents (if adding Dependents) to the PEBP office. Enrollment and the submission of any required supporting documents must be done within 15 days after the first day of employment or no later than the last day of the month coverage is scheduled to become effective.

Enrollment Requirement Example:

Date of Hire/Contract Date	Coverage Effective Date	Date Enrollment Must Be Completed	Date Supporting Documents Must be Submitted (if any)	Default Coverage Date
June 1st	June 1st	June 30th	June 30th	June 1st
June 2nd – 30th	July 1st	July 31st	July 31st	July 1st

Default Coverage – Failure to Enroll When Eligible

PEBP requires eligible Employees to Enroll in a medical plan or decline benefits within 15 days of their hire date or no later than the last day of the month coverage is scheduled to become effective. If an Employee fails to Enroll or decline coverage as specified above, the Employee will be automatically Enrolled in the Consumer Driven Health Plan (CDHP) with a Health Reimbursement Arrangement (HRA), in the "Employee-Only" tier without coverage for Dependents.

Initial Enrollment for Retirees

Retirees must Enroll by completing the Retiree Benefit Enrollment and Change Form (RBECF) and the Years of Service Certification Form that may be obtained from PEBP (this event is not available online). The completed forms must be submitted to PEBP within 60 days of the date of retirement. Eligible Dependents must be Enrolled at the same time as the Retiree.

Initial Enrollment for Survivors

Survivors who wish to be covered under PEBP must complete and submit the Retiree Benefit Enrollment and Change Form (RBECF) within 60 days of the date of death of the Employee or Retiree (this event is not available online).

Initial Enrollment for COBRA

Qualified beneficiaries who wish to elect COBRA Continuation Coverage must submit their election within 60 days of their qualifying event by completing the PEBP COBRA Election Notice (this event is not available online).

Open Enrollment

Open Enrollment is held May 1 – May 31 and any changes made during Open Enrollment will become effective on July 1 immediately following the Open Enrollment period.

During this time active Employees and Retirees may:

- enroll in a medical plan or change plan options; or
- add or delete Eligible Dependents to/from medical coverage; or
- decline coverage
- Retirees covered under the Medicare Exchange may:
  - opt-in/out of PEBP dental coverage (must be covered under a PEBP sponsored medical plan)
  - add or delete Dependents

Note: During a positive Enrollment period or if a medical plan option is discontinued and the covered Participant does not make a plan election during Open Enrollment for the new Plan Year, the Participant and any covered Dependents will be defaulted to the CDHP Plan (default plan).

Retiree Late Enrollment

A retired public officer or Employee of the State, NSHE, a participating local government, or his or her surviving Spouse, can reinstate insurance during an annual Open Enrollment if the retired

public officer or Employee did not have more than one period during which he or she was not covered under the PEBP Plan on or after October 1, 2011, or on or after the date of his or her retirement, whichever is later. Meaning, the above defined individuals will only have one opportunity to rejoin the PEBP Plan following retirement. To take advantage of the Retiree Late Enrollment, the Retiree should contact PEBP between April 1 and May 31 of any calendar year. A reinstated Retiree will not be eligible for basic or voluntary life insurance through PEBP.

Eligibility for Coverage

Summary of PEBP Eligibility and Enrollment Requirements

This chapter outlines the Enrollment processes and eligibility requirements for individuals eligible for coverage under the Public Employees' Benefits Program (PEBP). Information regarding the Enrollment process, coverage termination procedures, timeframes for completing Enrollment and submitting supporting documents and premium payments are detailed in this document.

- Any Spouse or Domestic Partner that is eligible for coverage as both a primary Participant and a Dependent shall be Enrolled as a primary Participant.
- A Child that is eligible as both a primary Participant and a Dependent of a primary Participant may continue coverage as a Dependent of the primary Participant until age 26 years.

Eligibility Determinations

Eligibility for PEBP coverage is determined in accordance with the NRS 287, NAC 287 and the provisions outlined in this document. All eligibility decisions are final and are not subject to appeal. Individuals have the right to request information as to why a determination was made. However, unless evidence supports that the decision does not coincide with the eligibility terms in this document, the original determination will not be reversed.

Eligibility for Active Employees

The following Full-Time Employees are eligible to participate in PEBP after satisfying their respective waiting period:

- Employees of a State and participating non-State agency.
- Employees of the Nevada Senate or Assembly.
- NSHE Employees under a letter of appointment with benefits.
- NSHE classified Employees.
- NSHE professional Employees under annual contract.

Eligibility for Retirees

Pursuant to NAC 287.135, Retirees with 5 or more years of service credit (8 or more years of service credit for retired Legislators; NRS 287.047) are eligible for PEBP coverage if the Retiree's last Employer is a participating public agency and the Retiree is receiving retirement benefit distributions from one or more of the following:

- Public Employees' Retirement System (PERS)
- Legislators' Retirement System (LRS)
- Judges' Retirement System (JRS)
- Retirement Plan Alternative (RPA) for professional Employees of the Nevada System of Higher Education
- A long-term Disability plan of the public Employer

Eligibility for Dependents

Your Spouse

For the purposes of this Plan, the Participant's Spouse is defined as opposite sex or same sex, as determined by the laws of the State of Nevada, is eligible for coverage under the PEBP Plan. Spouses that are eligible for health coverage through their current Employer Group Health Plan are typically not eligible for coverage under the PEBP Plan. If Your Spouse's Employer Group Health Plan satisfies PEBP's definition of "Significantly Inferior Coverage" and You comply with the items listed in the Exception section below, You may be able to Enroll or continue Your Spouse's coverage under PEBP. The definition of "Significantly Inferior Coverage" is provided in the definition section of this document.

The Plan requires proof of the legal marital relationship and completion of the Enrollment (paper or online) declaring that the Spouse is not eligible for an Employer Group Health Plan. A divorced Spouse of a Participant is not an Eligible Dependent under this Plan.

Your Domestic Partner

The Participant's Domestic Partner (DP), as determined by the laws of the State of Nevada, is eligible for coverage under the PEBP Plan. Domestic Partners that are eligible for Group Health Insurance through their current Employer are typically not eligible for coverage under the PEBP Plan. If Your Domestic Partner's employer sponsored health coverage satisfies PEBP's definition of "Significantly Inferior Coverage" and You comply with the items listed in the Exception section listed below, You may be able to Enroll or continue Your Domestic Partners coverage under PEBP. The definition of "Significantly Inferior Coverage" is provided in the definition section of this document.

The Plan requires a copy of the Domestic Partner Certification from the Nevada Secretary of State and completion of the Enrollment (paper or online) declaring that the Domestic Partner is not eligible for an Employer Group Health Plan. By completing an Enrollment election, the Participant acknowledges their responsibility for any federal income tax consequences resulting from the Enrollment of the Domestic Partner in the Plan. A Domestic Partner is not an Eligible Dependent after termination of the Domestic Partnership.

Exception: PEBP requires the Participant to provide an official summary of the coverage details from the employer of their Spouse/Domestic Partner outlining all health insurance coverage plans available to their Employees. PEBP has the authority to determine if the Spouse's/Domestic Partner's employer sponsored health plan meets the definition of "Significantly Inferior Coverage."

Your Children/Stepchildren

A Participant's Children, stepchildren, or Children of their Domestic Partner, under age 26 years, are eligible for coverage on:

- the day the Participant becomes eligible for coverage, or
- the day the Participant acquires the Eligible Dependent by birth, adoption or Placement for Adoption, or

- the first day of the month concurrent with or following the date of the Participant's marriage or certification of Domestic Partnership, or
- the first day of the month concurrent with or following the loss of coverage through an Employer Group Health Plan.

To Enroll Dependent Children, the Participant must complete an online Enrollment, or submit a completed Benefit Enrollment and Change Form. In the case of a stepchild or Domestic Partner's Child, a marriage certificate or certification of Domestic Partnership will also be required.

Dependent Children are automatically terminated from coverage on:

- the date of termination of the Participant's coverage;
- the end of the month in which a Dependent Child under permanent legal guardianship turns age 19 years;
- the end of the month in which the Dependent Child reaches age 26 years unless proof of disabled Dependent Child status has been provided to and approved by PEBP.

If a Child under age 26 years is Enrolled as a Dependent of a PEBP Participant and becomes eligible for their own PEBP coverage as a primary PEBP Participant, the Child has the option to remain as a Dependent or Enroll on their own as a primary PEBP Participant. A Child who Enrolls in the CDHP or HMO Plan as a primary PEBP Participant will be removed as a Dependent from their parent's coverage.

The Child has the option of declining coverage as a primary PEBP Participant and can remain on their parent's coverage.

Note: For more information, refer to the applicable sections in this document.

Your Newborn Child(ren)

Newborn Dependent Child(ren) will automatically be covered under a PEBP medical plan option from the date of birth to 31 days following the date of birth (referred to as the initial coverage period) (see NRS 689B.033). If the Dependent is covered under more than one health insurance plan, the PEBP Plan reserves the right to coordinate benefits as stated in the Coordination of Benefits section of the PEBP Consumer Driven Health Plan for Medical, Vision and Prescription Drug Benefits Master Plan Document or HMO Evidence of Coverage Certificate (as applicable).

To continue coverage beyond the initial coverage period, Enrollment must be completed within 60 days of the newborn's date of birth. A copy of the Child's hospital birth confirmation will be required to add the Child, followed by a copy of the Child's certified birth certificate and social security number within 120 days following the date of birth. A newborn Dependent Child may not be Enrolled for coverage unless the Participant is also Enrolled for coverage. If newborn Enrollment is not completed within 60 days of the date of birth, coverage of the newborn will end 31 days after the Child's date of birth.

Your Adopted Dependent Children

A newborn Child who is adopted or Placed for Adoption may be covered from the date of birth, if the Employee is Enrolled in coverage and Enrolls the newborn within 60 days of the date of the adoption or Placement for Adoption and submits any required supporting documents, (e.g., legal adoption or placement for adoption papers as certified by the public/private adoption agency, copy of the certified birth certificate, and the Child's social security number). PEBP will also require a copy of the court order for adoption, signed by a judge within 6 months of the adoption date.

A Dependent Child who is adopted or Placed for Adoption more than 60 days after the Child's date of birth will be covered from the 1st day of the same month that the Child is adopted or Placed for Adoption, whichever is earlier. To add the Dependent, PEBP will require the Enrollment request within 60 days of the adoption or Placement for Adoption and any required supporting documents (e.g., legal adoption or Placement for Adoption papers as certified by the public/private adoption agency, copy of the certified birth certificate, and the Child's social security number).

A Child is Placed for Adoption on the date the Participant first becomes legally obligated to provide full or partial support of the Child. However, if a Child is Placed for Adoption and the adoption does not become final, coverage of that Child will terminate on the last day of the month that the Participant no longer has a legal obligation to support the Child. PEBP must be notified of the ineligibility for Dependent coverage.

Legal Guardianship

Unmarried Children under age 19 who are under a legal permanent guardianship may be Enrolled as a Dependent. To continue coverage after age 19 (to age 26), the Child must be unmarried and either reside with the Participant or is Enrolled as a full-time student at an accredited institution and satisfies the following conditions:

1. Is eligible to be claimed as a Dependent on the federal income tax return of the Participant or his Spouse/Domestic Partner for the preceding calendar year; and

2. Dependent is a grandchild, brother, sister, step-brother, step-sister, or descendent of such relative.

The IRS allows the premiums for coverage of a person under age 19 (24 if a full time student) to be paid on a pre-tax basis (excluded from gross income) if certain criteria are met. If the criteria are met, the coverage will be provided on a pre-tax basis. If they are not met, or the Dependent is over age 24 as of the end of the calendar year, the subsidies associated with the coverage of the Dependent are taxable and the payroll deductions must be done after income tax is calculated. If the subsidies are deemed taxable, they will be included as income on an Employees' Form W-2.

Children under a temporary guardianship are **not** eligible for coverage as a Dependent under the PEBP Plan.

Disabled Dependent Child

To cover a Dependent Child with a Disability and who is 26 years old or older requires that the Dependent has maintained continuous medical coverage with no break in service and the

completion of the Certification of Disabled Dependent Child Form by the Participant and the Child's physician. To be eligible for coverage, the physician must diagnose the Child as having a mental or physical impairment causing incapability of self-sustaining employment and depending chiefly on the Participant and/or Participant's Spouse for support and maintenance. Evidence of Disability must be provided within 30 days after the Child reaches age 26 years (NAC 287.312(1)(d)). The Plan will require proof of support and maintenance through the submission of a copy of the preceding year's income tax return showing the Child was claimed as a tax Dependent in compliance with the IRS Code 152 (a) without regard to the gross income test.

If the Dependent is not deemed permanently disabled, PEBP will require proof of continuing Disability once each year. PEBP reserves the right to have the Child examined by a physician of PEBP's choice and at the Plan's expense to determine that the Child meets the definition of a Dependent Child with a Disability.

Children covered under legal guardianship are not eligible to continue benefits under this provision.

Grandchildren

Grandchildren under age 19 years are not eligible for coverage unless the Child(ren) are under a permanent legal guardianship. Please refer to the guardianship section of this document for more information.

Foster children

Foster Children are not eligible for Dependent coverage.

Survivors

Surviving Dependents include a Participant's Spouse or Domestic Partner and Dependent Children to age 26 years (or to age 19 years for Child(ren) under permanent legal guardianship) who are covered under the Participant's medical Plan on the date of the Participant's death.

Coverage for a surviving Dependent will end on the last day of the month of the Participant's death. To continue coverage the surviving Dependent(s) must Enroll within 60 days of the date of death of the Employee or Retiree.

Basic Life Insurance coverage and years of service subsidy is not available to survivors.

Survivors of Active Employees

If an active Employee dies with 10 or more years of service credit, the Employee's covered Dependent(s) are eligible to continue PEBP coverage as surviving Dependent(s). Any Dependent not Enrolled for coverage on the date of the Participant's death, is not eligible to Enroll for coverage as a survivor. A surviving Spouse may not Enroll Dependent Children who were not covered on the date of the Participant's death. Surviving Dependents include an Employee's covered Spouse or Domestic Partner and Child(ren) to age 26 years (or to age 19 years for a Child under permanent legal guardianship) on the date of the Employee's death. If an active Employee dies with less than 10 years of service credit, any covered Dependents will be offered 36 months of COBRA coverage.

A surviving Dependent Child shall pay the surviving/unsubsidized Spouse rate if there is no surviving Spouse or the surviving Spouse declines coverage.

Survivors of Retirees

Survivors of Retirees have the option either to continue or cancel PEBP coverage. Any Dependent that is not Enrolled at the time of the Retiree's death will not be eligible to Enroll as a survivor. A surviving Spouse may not Enroll Dependent Children who were not covered on the date of the Participant's death.

Survivors of Police Officer or Firefighter or Voluntary Firefighter Killed in the Line of Duty

Pursuant to NRS 287.021 and 287.0477, the surviving Spouse and any surviving Child of a police officer or firefighter who was employed by a participating public agency and who was killed in the line of duty may join or continue coverage under PEBP if the police officer or firefighter was eligible to participate on the date of the death of the police officer or firefighter. If the surviving Dependent elects to join or discontinue coverage under the Public Employees' Benefits Program pursuant to this section, the Dependent or Legal Guardian of the Dependent must notify the participating public agency that employed the police officer or firefighter in writing within 60 days after the date of death of the police officer or firefighter.

The surviving Spouse and any surviving Child of a volunteer firefighter who was killed in the line of duty and who was officially a member of a volunteer fire department in this State is eligible to join the Public Employees' Benefits Program. If such a Dependent elects to join the Public Employees' Benefits Program, the Dependent or Legal Guardian of the Child must notify the PEBP Board in writing within 60 days after the date of death of the volunteer firefighter.

The participating public agency that employed the police officer or firefighter shall pay the entire cost of the premiums or contributions to the Public Employees' Benefits Program for the surviving Dependent who meets the requirements. The State will pay the entire cost of the premiums or contributions to the Public Employees' Benefits Program for the surviving Dependent of a volunteer firefighter.

A surviving Spouse is eligible to receive coverage pursuant to this section for the duration of the life of the surviving Spouse. A surviving Child is eligible to receive coverage pursuant to this section until the Child reaches age 26 years. (A surviving Child under permanent guardianship of a deceased police officer or firefighter or voluntary firefighter killed in the line of duty is eligible for coverage to age 19 years.)

Unsubsidized Dependents Covered under a PEBP Plan

An unsubsidized Dependent is an otherwise eligible Spouse/Domestic Partner or Dependent Child who remains covered under PEBP while the primary Plan Participant transitions medical coverage to the Medicare Exchange.

Termination of a primary Participant's coverage will result in termination of the unsubsidized Dependents.

Unsubsidized Dependents Enrolled in the CDHP or HMO Plan can decline their coverage at any time (coverage ends the last day of the month of notification).

Unsubsidized Dependents Covered under the Medicare Exchange

An unsubsidized Dependent is an otherwise eligible Spouse/Domestic Partner who transitions to the Medicare Exchange and elects PEBP dental coverage, while the primary Plan Participant remains covered under a PEBP Plan.

Termination of a primary Participant's coverage will result in termination of the unsubsidized Dependent.

Unsubsidized Dependents Enrolled in the Medicare Exchange with PEBP dental coverage can decline their coverage at any time (coverage ends the last day of the month of notification).

Retirees with Tricare for Life and Medicare Parts A and B

Retirees who are otherwise eligible for the Health Reimbursement Arrangement (HRA) and who have Tricare for Life and Medicare Parts A and B are not required to Enroll in a medical Plan through the Medicare Exchange. To receive the monthly HRA contribution, PEBP will require a copy of the Tricare for Life ID card and a copy of the Retiree's Medicare Parts A and B card. The required documents must be submitted to PEBP within 60 days of the Medicare Parts A and B effective date, or within 60 days of the retirement date of the Employee, whichever date is later.

When Coverage Begins

Active Employees

New Hire

New Hire Employees are eligible for coverage on the first day of the month concurrent with or following the date of hire.

Reinstated Employee

Reinstated Employees are individuals who previously satisfied their benefit waiting period and reinstate employment with a State agency or the same non-State agency within 12 months of their termination of employment date. Coverage is reinstated on the first day of the month concurrent with or following their date of hire.

Rehired Employee

A rehire is an Employee who returns to work more than 12 months after the Employee's previous termination date. Rehire Employees are eligible for coverage on the first day of the month concurrent with or following the date of hire.

Retirees

A Retiree must Enroll in a PEBP-sponsored medical Plan within 60 days of their retirement date as determined by the Public Employees' Retirement System (PERS) or NSHE.

Retiree Premium Subsidy or Exchange HRA Contribution for certain Employees Initially Hired on or after January 1, 2010

Employees working for a PEBP participating agency with an "initial date of hire" on or after January 1, 2010, but prior to January 1, 2012 and who subsequently retire with less than 15 years of service are eligible to elect Retiree coverage, but will not qualify for a subsidy or Exchange HRA contribution unless the retirement occurs under a long-term Disability plan.

The initial date of hire is defined by NAC 287.059 as the first date on which service credit is earned by a Participant during the Participant's last period of continuous employment with a public Employer, as determined by PERS or NSHE.

Continuous employment as defined by NAC 287.021 includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more.

Retiree Years of Service Premium Subsidy or Exchange HRA Contribution for Employees Initially Hired with a PEBP Participating Agency on or after January 1, 2012

- Employees of a State agency, Judges, professional (contracted) Employees of the Nevada System for Higher Education, Legislators and Employees of participating local government entities with an initial date of hire on or after January 1, 2012, may participate in the program, but will not be eligible for a years of service premium subsidy or Medicare Exchange HRA contribution upon retirement.

- Eligibility for a subsidy at retirement is based on the initial date of hire as defined by NAC 287.059 as the first date on which service credit is earned by a Participant during the Participant's last period of continuous employment with a public Employer (as determined by PERS or NSHE). Continuous employment (defined by NAC 287.021) includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more.
- Pursuant to NRS 287.046 (8), this section does not apply to a person who was employed by the State on or before January 1, 2012, who has a break in service and returns to work for the State at the same or another participating State agency after that date, regardless of the length of the break in service, so long as the person did not withdraw from and was eligible to participate in the Public Employees' Retirement System (PERS) or the Retirement Plan Alternative for the Nevada System of Higher Education (NSHE) before or during the break in service.

State Retirees

Retirees whose last Employer is a State agency, NSHE, PERS, the Legislature, Legislative Counsel Bureau or a State board or commission are considered State Retirees.

Non-State Retirees

Retirees whose last Employer is a non-State public entity are considered non-State Retirees. Non-State Retirees are eligible to join PEBP only if their last Employer is a participating local government entity (a local government that is contracted with PEBP to provide coverage to their active Employees pursuant to NRS 287.025). If the participating local government entity leaves the PEBP Plan, the entity's Retirees will also be dis-Enrolled unless the Retiree was covered under PEBP as a Retiree continually since November 30, 2008. Retirees who were covered under PEBP as a Retiree on November 30, 2008 and continually since then may remain covered under PEBP as long as they continue to pay their premiums.

Dependents

Benefit coverage for any Eligible Dependent is effective on:

- the day an Employee or Retiree becomes eligible for medical coverage,
- the day an Employee or Retiree acquires an Eligible Dependent by birth, adoption, placement for adoption, or
- the first day of the month concurrent with or following a Qualifying Event.

Eligible Dependents may be Enrolled as long as:

- benefit coverage is in effect for the active Employee or Retiree on that day;
- any required supporting documents are received in the PEBP office within 60 days of the Qualifying Event (for example: birth certificate, marriage certificate, etc.); or
- within 30 days following the last day of Open Enrollment; or
- within 15 days after the first day of employment; and
- any required contribution for coverage of the Dependent(s) is paid.

Covered Dependents must be Enrolled in the same medical Plan option as the Employee or Retiree except as described in the Coverage Options for Individuals with Medicare section. Eligible Dependents include a Spouse, Domestic Partner, and/or Dependent Child(ren) (as defined in the Definitions section of this document). Anyone who does not qualify as a Spouse, Domestic Partner, or Dependent Child has no right to any benefits or services under this Plan. Any Retiree covered through the Medicare Exchange will have the option to Enroll in the CDHP or HMO Plan when a non-Medicare Eligible Dependent is Enrolled, subject to the rules described in the Coverage Options for Individuals with Medicare section and the rules of the plan chosen through the Medicare Exchange.

When Coverage Ends

In Case of Death

In all cases of death, coverage ends on the date of death of the Employee, Retiree, or Dependent.

Active Employees

For an active Employee, coverage ends on the last day of the month in which:

- employment ends;
- employment contract ends;
- Employee is no longer eligible to participate in the Plan;
- the last day of the month that precedes the effective date of the other employer's coverage if gaining coverage during an Open Enrollment offered through the employer of a Spouse or Domestic Partner;
- the last day of the Plan Year if the Employee declines coverage during Open Enrollment;
- premium payment was last received (see Termination for Non-payment); or
- the Plan is discontinued.

Retirees

Retiree coverage ends on the last day of the month in which:

- the Retiree no longer meets the definition of a Retiree;
- PEBP is notified of voluntary declination of coverage;
- premium payment was last received (see Termination for Non-payment);
- Retiree was covered under a medical plan through the Medicare Exchange; or
- the Plan is discontinued.

Dependents

Dependent Coverage Ends on the last day of the month in which:

- the active Employee or Retiree coverage ends;
- the covered Spouse, Domestic Partner, or Dependent Child(ren) no longer meet the definition of Spouse, Domestic Partner, or Dependent Child(ren) as provided in the Definitions section of this document;
- premium payment was last received (see Termination for Non-payment);
- Dependent was covered under a medical Plan through the Medicare Exchange; or
- the Plan is discontinued.

Surviving Spouse/Domestic Partner of a Retiree

Coverage for a surviving Spouse/Domestic Partner of a Retiree ends on the last day of the month in which:

- PEBP is notified of voluntary declination of coverage;

- premium payment was last received (see Termination for Non-payment);
- surviving Spouse/Domestic Partner was covered under a medical Plan through the Medicare Exchange; or
- the Plan is discontinued.

Unsubsidized Dependent

Coverage for an unsubsidized Dependent ends on the last day of the month in which:

- the covered Dependent no longer meets the definition of Dependent as provided in the Definitions section of this document;
- premium payment for the primary Plan Participant or the covered Dependent was last received;
- PEBP is notified of declination of coverage; or
- the Plan is discontinued.

Dependent Children of a Surviving Spouse or Domestic Partner of a Retiree

Coverage for Dependent Children of a surviving Spouse or Domestic Partner of a Retiree ends on the last day of the month in which:

- the covered Dependent Child(ren) no longer meets the definition of Dependent Child(ren) as provided in the Definitions section of this document;
- premium payment was last received (see Termination for Non-payment); or
- the Plan is discontinued.

Notice to the Plan When a Dependent Ceases to be Eligible for Coverage

An Employee, Spouse/Domestic Partner, or any Dependent Child(ren) must notify the Plan no later than 60 days after the date:

- of a divorce or dissolution of a Domestic Partnership;
- on which a Dependent Child ceases to meet the definition of Dependent as defined in the Definitions section of this document; or
- on which a Dependent Child over age 26 years ceases to have a physical or mental impairment where the Child no longer has a Disability.

Failure to give such a notice within 60 days will cause the Spouse/Domestic Partner, and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or will cause the coverage of a Dependent Child with a Disability to end when it otherwise might continue. For information regarding other notices that must be furnished to the Plan, see General Provisions.

Qualified Medical Child Support Orders (QMCSO) or National Medical Support Notice (NMSN)

The Plan Administrator shall Enroll for immediate coverage under this Plan any Child who is the subject of a QMCSO/NMSN if such Child is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) shall mean a notice that contains the following information:

1. Name of the issuing authority;
2. Name and mailing address (if any) of an individual who is a primary Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the Child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipient(s)); and
4. Identity of an underlying Child support order.

According to federal law, a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) is a Child support order of a court or state administrative agency that usually results from a divorce that has been received by the Plan, and that:

- Designates one parent to pay for a Child's health Plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each Child covered by the QMCSO/NMSN;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined; and
- States the period for which the QMCSO/NMSN applies.

An order is not a QMCSO/NMSN if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an Employee who is not eligible for coverage by the Plan to provide coverage for a Dependent Child, except as required by a state's Medicaid-related Child support laws. For a state administrative agency order to be a QMCSO/NMSN, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

Upon receiving a QMCSO/NMSN, the Plan Administrator shall:

1. Notify the issuing authority with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
    a. Whether the Child is covered under the Plan; and
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of an Employee, PEBP will determine if that order is a QMCSO/NMSN as defined by federal law. That determination will be binding on the Employee, the other parent, the Child, and any other party acting on behalf of the Child. PEBP will notify the parents and each Child if an order is determined to be a QMCSO/NMSN and if the Employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

If the Employee is a Plan Participant, the QMCSO/NMSN may require the Plan to provide coverage for the Employee's Dependent Child(ren). If the Employee is covered by a medical Plan option that will not cover the Dependent Child(ren) specified in the QMCSO/NMSN (for example, the child lives outside an HMO coverage area), the Participant will be Enrolled in the Base Plan option that allows compliance with the QMCSO/NMSN. Coverage under the new medical Plan option begins on the first day of the month following receipt of the QMCSO/NMSN in the PEBP office and may not be reverted until the next Open Enrollment period.

If the QMCSO/NMSN orders a covered Employee to provide coverage for the Dependent Child(ren) named in the QMCSO/NMSN, PEBP will Enroll the Dependent Child(ren) specified in the QMCSO/NMSN. If the Employee is in declined coverage status, but is otherwise eligible for coverage, PEBP will Enroll the Employee and the Dependent Child(ren) specified in the QMCSO/NMSN in an appropriate medical Plan option to cover the Employee and the Dependent Child(ren). Coverage will become effective on the first day of the month concurrent with or following the date the QMCSO/NMSN is received by PEBP.

Coverage of the Dependent Child(ren) named in the QMCSO/NMSN will be subject to all terms and provisions of the Plan, including limits on selection of Provider and requirements for authorization of services, as permitted by applicable law. No coverage will be provided for any Dependent Child under a QMCSO/NMSN unless the Employee (as applicable) and Dependent contributions are paid, and all of the Plan's requirements for coverage of that Dependent Child have been satisfied. Coverage of a Dependent Child under a QMCSO/NMSN will terminate when coverage of the Employee-parent terminates for any reason, including failure to pay any required contributions, subject to the Dependent Child's right to elect COBRA Continuation Coverage if that right applies. For additional information regarding the procedures for payment of claims under a QMCSO/NMSN, see the Claims Information section of this document. Also refer to the COBRA section for information on the Dependent's right to elect COBRA, if applicable.

If the Dependent listed on the QMCSO/NMSN is also covered under another PEBP Plan Participant, the Dependent will be dropped from the non-QMCSO/NMSN Participant's Plan and added to the QMCSO/NMSN Participant's Plan.

If a QMCSO/NMSN is rescinded the Participant has the option to continue coverage for the Dependent(s) or remove the Dependent(s). If the Participant would like to remove the

Dependent(s), coverage will end at the end of the month of receipt of the order. The primary Participant must continue coverage under the same medical Plan until the next Open Enrollment period.

Any dispute over terms of a QMCSO/NMSN must be appealed directly to the issuing Child support enforcement agency.

Restoration of Benefits by a Hearing Officer

Restoration of health care coverage when included in the decision of a Hearing Officer will be implemented as follows:

1. If health care coverage was provided to the Employee and their Eligible Dependents under the CDHP, coverage will be restored retroactively to the date specified by the Hearing Officer. Any retroactive health insurance subsidy due from the agency will be paid to PEBP. Any retroactive health insurance premiums due from the Employee will be paid by the Employee to PEBP within 60 days of the Hearing Officer's decision. The amount due to PEBP will be determined by PEBP.
    a. Restoration of coverage will be in compliance with NRS 287, NAC 287 and this Master Plan Document.
    b. Upon restoration of coverage, PEBP will notify its third party administrator, Pharmacy Benefits Manager, Life Insurance vendor and any other applicable vendors of the restoration of coverage.
    c. If the Employee and/or their eligible covered Dependents incurred medical, dental, vision or prescription drug expenses, PEBP will assist the Employee with obtaining reimbursement for the eligible health care expenses.
2. If health care coverage was provided to the Employee and their Eligible Dependents under one of the PEBP-sponsored Health Maintenance Organizations (HMOs), coverage will be restored retroactive to a date not to exceed six (6) months prior to PEBP's receipt of the notice from the Hearing Officer. Any retroactive health insurance subsidy amounts due to PEBP by the Employee's agency will be paid to PEBP by the agency. Any retroactive health insurance premiums due to PEBP by the Employee will be paid by the Employee to PEBP within 60 days of the Hearing Officer's decision. The amount due to PEBP will be determined by PEBP.
3. If an Employee chooses not to proceed with a retroactive effective date for health insurance coverage, coverage shall be reinstated on the first day of the month following the Hearing Officer's decision.
4. Coverage will be restored to the same coverage that was in place before the suspension of benefits. If a new Plan Year intervenes, the Employee will be allowed to indicate the desired coverage retroactive to the beginning of the new Plan Year.
5. Any premiums associated with Voluntary Insurance products are the Employee's responsibility.

PEBP and Medicare

Premium free Medicare Part A

Retirees and their covered Dependents who are eligible for premium free Medicare Part A are required to Enroll in premium free Medicare Part A coverage.

Most people age 65 years or older who are citizens or permanent residents of the United States are eligible for premium free Medicare hospital insurance (Part A).

You are eligible for premium-free Medicare Part A if:

- You receive or are eligible to receive Social Security benefits; or
- You receive or are eligible to receive railroad retirement benefits; or
- You or Your Spouse (living or deceased, including divorced Spouses to whom you were married at least 10 years) worked long enough in a job where Medicare taxes were paid.

To determine your eligibility for premium-free Medicare Part A, contact the Social Security Administration (SSA) approximately three months before Your 65th birthday.

Premium free Medicare Part A Enrollment Timeframe

Retirees and/or their covered Dependents who are eligible for premium free Medicare Part A are required to Enroll in Part A coverage three months prior to their 65th birthday.

Disabled Retirees and/or their covered Dependents who are eligible for Social Security Disability insurance must Enroll in premium free Medicare Part A and purchase Medicare Part B coverage.

You must submit a copy of Your Medicare card indicating Your effective date with Part A and Part B to the PEBP office as follows:

- For birthdays occurring on the first day of the month, Your Medicare card must be received no later than the last day of the month the individual turns 65.
- For birthdays NOT occurring on the first day of the month, Your Medicare card must be received no later than the last day of the month, following the 65th birthday month.
- For newly retiring Employees, Your Medicare card must be received within 60 days of the retirement coverage effective date.
- Disabled Retirees and/or their covered Dependents who are entitled to Social Security Disability benefits must Enroll in premium-free Medicare Part A and purchase Medicare Part B coverage and submit a copy of their Medicare card to PEBP within 60 days of their Medicare effective date.

If You are not eligible for Premium Free Medicare Part A

If You are **not eligible** for premium free Medicare Part A, PEBP will require a copy of the Medicare benefit verification letter, sometimes referred to as a Medicare Award letter from Social Security. The letter will indicate that You are not eligible for premium free Medicare Part A. Retirees who are not eligible for premium free Medicare Part A may remain on the PEBP CDHP or HMO Plan.

You must submit a copy of the Medicare benefit verification letter/Medicare Award letter to the PEBP office as follows:

- For birthdays occurring on the first day of the month, a copy of the benefit verification letter/Medicare Award letter must be received no later than the last day of the month the individual turns 65.
- For birthdays NOT occurring on the first day of the month, a copy of the benefit verification letter/Medicare Award letter must be received no later than the last day of the month, following the 65th birthday month.
- For newly retiring Employees, a copy of the benefit verification letter/Medicare Award letter must be received within 60 days of the retirement coverage effective date.

NOTE: Failure to provide PEBP with the required documentation will result in termination of coverage for the Retiree and any covered Dependents.

Medicare Part B

Retirees and Dependents of Retirees who are eligible for Medicare Part B are required to purchase Medicare Part B. Eligibility is determined by the Social Security Administration. Contact the Social Security Administration to inquire about purchasing Medicare Part B. Failure to provide proof of Medicare Part B Enrollment (through the submission of the individual's Medicare card) will result in termination of coverage.

If You are a retiring active Employee (or a Dependent of a retiring active Employee) eligible for Medicare, You will be required to purchase Medicare Part B.

If You are under age 65 years and are eligible for Medicare because of a Disability, this Plan requires You to purchase Medicare Part B and provide a copy of Your Medicare card to PEBP indicating that You have both Medicare Parts A and B.

A copy of the Part B card must be submitted to the PEBP office as follows:

- For birthdays occurring on the first day of the month, the Part B card must be received no later than the last day of the month the individual turns 65 years of age.
- For birthdays NOT occurring on the first day of the month, the Part B card must be received no later than the last day of the month, following the 65th birthday month.
- For Retirees and covered Dependents under age 65 who become eligible for Medicare due to a Disability, proof of Medicare Part B Enrollment must be received within 60 days of the Medicare Part A effective date.
- For newly retiring Employees, the Part B card must be received within 60 days of the retirement coverage effective date.
- Disabled Retirees and/or their covered Dependents who are entitled to Social Security Disability benefits must Enroll in premium-free Medicare Part A and purchase Medicare Part B coverage and submit a copy within 60 days of Medicare effective date.

NOTE: Failure to provide proof of Medicare Part B coverage (through submission of a copy of the Medicare Part B card) will result in termination of coverage.

NOTE: Retirees eligible for premium free Medicare Part A are required to purchase Medicare Part B and Enroll in a medical Plan and maintain medical coverage through the Medicare Exchange to receive a years of service Health Reimbursement Arrangement (HRA) contribution (if applicable).

Exceptions:

- Retirees who are eligible for premium-free Medicare Part A and who have purchased Medicare Part B coverage and who cover a non-Medicare Dependent(s) may Enroll in the PEBP CDHP or HMO Plan with the non-Medicare Dependent(s) until all covered Dependents become Medicare eligible.
- Retirees who permanently reside outside the United States may remain on the PEBP CDHP Plan.

Medicare Retirees Covered through the Medicare Exchange

Retirees who are eligible for premium-free Medicare Part A must Enroll in a medical Plan through the Medicare Exchange no later than the last day of the month, following the Medicare Part A and B effective date, or no later than the end of the month following the date of retirement, whichever occurs later.

Contributions to a Retiree's Health Reimbursement Arrangement through the Medicare Exchange will become effective concurrent with the Retiree's medical Plan effective date through the Medicare Exchange.

Dependents are not eligible for a Health Reimbursement Arrangement contribution through the Medicare Exchange.

Medicare Retirees Covered under the Medicare Exchange who have break in coverage

Retirees who experience a break in medical coverage or who terminate medical coverage through Medicare Exchange will also terminate the years of service HRA contribution, PEBP dental coverage, Basic Life Insurance, and Voluntary Life Insurance (if applicable). Coverage may be terminated permanently. See the Retiree Late Enrollment section for re-Enrollment rights.

Medicare Retirees Not Eligible for Premium Free Medicare Part A

Retirees who are not eligible for premium-free Medicare Part A and who purchase Medicare Part B and/or cover one or more non-Medicare Eligible Dependents may remain on the PEBP CDHP or HMO Plan.

NOTE: A Retiree/survivor covered under the PEBP CDHP or HMO that experiences a qualifying event that changes their eligibility status to Participant only, must Enroll in a medical Plan through the Medicare Exchange.

Medicare Part B Premium Credit

Retirees who are covered under the PEBP CDHP or HMO Plan and who have Medicare Part B will receive a premium credit in an amount determined by PEBP. Dependents are not eligible for the Part B premium credit.

The premium credit will apply concurrent with the Medicare Part B effective date or the first of the month concurrent with or following PEBP's receipt of the Retiree's Medicare Part B card, whichever is later.

Medicare Part D Coverage

Retirees and covered Dependents Enrolled in the PEBP CDHP who Enroll in Medicare Part D prescription coverage will lose CDHP prescription drug coverage for the remainder of that Plan Year. There will be no reduction in premium cost and PEBP's prescription drug coverage will not be reinstated until the next Plan Year with proof of dis-Enrollment of Medicare Part D.

Medicare Exchange HRA Contribution Eligibility

To receive the PEBP HRA contribution, an Eligible Retiree must obtain and maintain an individual medical insurance policy through the PEBP sponsored Medicare Exchange. In other words, to receive the PEBP HRA contribution amount, the Eligible Retiree must Enroll in and maintain a medical insurance policy through the PEBP sponsored Medicare Exchange. If the Eligible Retiree does not Enroll and maintain medical coverage as described, the Eligible Retiree will NOT receive the PEBP HRA contribution amount and will lose their PEBP sponsored benefits entirely and permanently including but not limited to life insurance and dental insurance. This policy also applies to Eligible Retirees who are covered under their Spouse's employer sponsored health Plan.

Tricare for Life and Medicare Parts A and B

Enrollment in the Medicare Exchange as described in the section titled "Medicare Exchange HRA Contribution Eligibility" does not apply to Eligible Retirees or their (PEBP retired) Spouses who have healthcare coverage under TRICARE for Life and Medicare parts A and B. To receive the PEBP HRA contribution, these individuals must submit a copy of their military ID card(s) to PEBP. If the Eligible Retiree does not provide a copy of the military ID card(s) within the specified time the Enrollment and Eligibility Events Quick Reference Tables. Eligible Retiree will NOT receive the PEBP HRA contribution amount and will lose their PEBP sponsored benefits entirely and permanently including but not limited to life insurance and dental insurance. Upon receipt of the military ID card(s), PEBP will coordinate the Eligible Retirees Enrollment with the Third Party Medicare HRA administrator.

Retiree Years of Service Benefit

Years of Service Eligibility

Retirees eligible for a subsidy (NAC 287.485) must submit a Years of Service Certification Form with the appropriate Enrollment documents.

Retirees who retired prior to January 1, 1994, receive a premium subsidy or HRA contribution equal to the base amount or 15 years of service.

Retirees who retired on or after January 1, 1994, receive a premium subsidy or HRA contribution based on the sum of the total years and months of service credit earned from all Nevada public employers, excluding purchased service (minimum 5 years; maximum 20 years).

Employees with an initial date of hire on or after January 1, 2010, but prior to January 1, 2012 and who retire with less than 15 years of service are eligible for PEBP Retiree coverage. These Retirees will not qualify for a subsidy or a Retiree HRA contribution unless they retire under a long-term Disability plan.

Initial Date of Hire is defined by NAC 287.059 as "the first date on which service credit is earned by a Participant during the Participant's last period of continuous employment with a public Employee, as determined by the appropriate certifying agency. Continuous employment as defined by NAC 287.021, includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more.

Employees with an initial date of hire on or after January 1, 2012, may continue to participate in the Program but will not be eligible for any subsidy or Exchange HRA contribution upon retirement. The Retiree will have to pay the entire premium or contribution for the coverage selected.

Years of Service Premium Subsidy

Retired public Employees Enrolled in the CDHP or HMO Plan may qualify for a premium subsidy based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public Employee.

Years of Service HRA Contribution for Medicare Retirees Enrolled in a Medical Plan Through the Medicare Exchange

Retired public Employees Enrolled in a medical plan through Medicare Exchange may qualify for an HRA contribution based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public Employee.

Health Reimbursement Arrangement for Retirees Covered Through the Medicare Exchange

The Medicare Exchange HRA accounts are Employee-owned accounts established on behalf of eligible Retirees covered in a medical Plan through the Medicare Exchange.

The Medicare Exchange HRA funds can be used to pay for qualified medical expenses as defined by the IRS including medical Plan premiums. Funds placed in the Medicare Exchange HRA for a Retiree's use is based on the years of service of the Retiree. Dependents and surviving Dependents are not eligible to have an Exchange HRA. For more information see Publication 502 at www.irs.gov.

For more information regarding uses, contribution amounts, and other rules, see the Medicare Exchange HRA Summary Plan Document available on the PEBP website.

Medicare Exchange HRA Contribution Eligibility: To receive the PEBP HRA contribution, an Eligible Retiree must obtain and maintain an individual medical insurance policy through the PEBP sponsored Individual Market Medicare Exchange. In other words, to receive the PEBP HRA contribution amount, the Eligible Retiree must Enroll in and maintain medical coverage an individual health insurance policy through the PEBP sponsored Individual Market Medicare Exchange. If the Eligible Retiree does not Enroll and maintain medical coverage as described above, the Eligible Retiree will NOT receive the PEBP HRA contribution amount and will lose their PEBP sponsored benefits entirely.

NOTE: This policy does not apply to Eligible Retirees or their (PEBP retired) Spouses who have health coverage under TRICARE for Life and Medicare. These individuals must submit a copy of their military ID card(s) to PEBP. PEBP will coordinate their Enrollment with the HRA administrator.

Summary of Supporting Eligibility Documents

Dependent Type	Social Security Number	Marriage Certificate	Birth Certificate	Hospital Birth Confirmation	Adoption Decree	Nevada Certification of Domestic Partnership	Legal Permanent guardianship signed by a judge	Physician's Disability Certification
Newborn Child	✓		✓	✓				
Child: Birth-Age 26 Yrs	✓		✓					
Adopted Child	✓		✓		✓			
Permanent Legal Guardianship (child)	✓		✓				✓	
Stepchild	✓	✓	✓					
Domestic Partner's Child	✓		✓			✓		
Domestic Partner's Adopted child	✓		✓		✓	✓		
Disabled Child	✓		✓					✓
Disabled Stepchild	✓	✓	✓					✓
Domestic Partner's Disabled Child	✓		✓			✓		✓
Spouse	✓	✓						
Domestic Partner	✓					✓		

- When adding a Dependent, other Dependents cannot be dropped for the same qualifying event. Enrollment of a newly acquired Spouse, Domestic Partner, and/or Dependent Child(ren) must occur no later than 60 days after the date of the qualifying event. In all cases, required supporting documentation must be submitted to PEBP within the same timeframe.
- Employees in declined coverage status and who experience a change in number of Dependents may opt to Enroll for coverage mid-year if adding a newly acquired Dependent.
- All foreign documents must be translated to English.

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Disabled Child age 26 years or older	Within 31 days of the Dependent Child turning age 26 years	• Certification of Disabled Dependent Child (completed by primary Participant and Child's physician) • SSN of Child • If not the Participant's Child, copy of the marriage or Nevada Domestic Partner certificate • Verification that the Child has had continuous health insurance since the age of 26 years; and proof of support and maintenance through the submission of a copy of the Participant's preceding year's income tax returns showing the Child is a tax Dependent. The Plan will thereafter require proof of the Child's continuing incapacity and dependency not more than once a year beginning 2 years after the Child attains age 26 NRS 689B.035	• If already covered under PEBP, coverage will continue • If new to PEBP Plan, coverage becomes effective on the first day of the month concurrent with or following the qualifying event	Not applicable

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Permanent Guardianship of a Child to age 19	Within 60 days of the event date	• Copy of legal guardianship papers (signed by a judge) • SSN of Child • Copy of birth certificate • If not the primary insured's Child, a copy of the marriage certificate or Nevada Domestic Partnership certificate	• Coverage effective on the first day of the month concurrent with or following the legal guardianship papers signed by a judge • Coverage is provided only up to age 19 years	May add the Child(ren) to age 19 years and other Eligible Dependent(s) in the Family Unit
Permanent Guardianship of Unmarried Child age 19 to age 26 currently Enrolled in a PEBP Plan	Within 60 days of the event date	• Completion of the Legal Guardianship Certification Form and any required supporting documents listed in the certification	• Coverage continues to age 26 assuming Child continues to meet eligibility requirements as set forth in Legal Guardianship Certification Form • Coverage ends the last day of the month Child turns age 19 or last day of the month PEBP determines the Child is no longer eligible	Not applicable

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)	Within 60 days of issuance of QMCSO or Release of QMCSO	• Copy of QMCSO appropriately signed	• 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 Dependent(s) as stated in the QMCSO May add other Eligible Dependent(s) in the Family Unit
Dependent Loses Coverage Spouse/Domestic Partner or Eligible Dependents experience a change of status resulting in a loss of eligibility from another Employer Group Health Plan	Within 60 days of the event date	• HIPAA certificate(s) from other employer group coverage stating the insurance end date and identity of Covered Individual(s) for each Dependent being added to Your coverage • SSN for all Dependent(s) being added • Copy of marriage or Nevada Domestic Partnership certificate • If adding Dependent Child(ren), a copy of the Child(ren)'s birth certificates	Coverage effective on the first day of the month concurrent with or following the date of the loss of coverage	May add the Spouse or Domestic Partner and all other Eligible Dependent(s) in the Family Unit who experienced a loss of coverage

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Dependent Gains Coverage Spouse/ Domestic Partner or Eligible Dependent experiences a change of status resulting in a gain of eligibility from another Employer Group Health Plan	Within 60 days of the event date	• Confirmation of coverage letter from other employer group coverage stating the insurance effective date and identity of Covered Individual(s) for each Dependent being deleted from Your coverage	Coverage terminates on the last day of the month the event occurs	Must delete Spouse or Domestic Partner if coverage is employer based; and may delete any Dependent(s) that are being added to the Employer Group Health Plan
Establish Domestic Partnership	Within 60 days of the event date	• SSN for Domestic Partner and/or covered Child(ren) • Copy of the Nevada Domestic Partnership certificate • If adding Dependent Child(ren), a copy of the Child(ren)'s birth certificates	Coverage effective on the first day of the month concurrent with or following the date of registration of Domestic Partnership with the Nevada Secretary of State's office	May add Domestic Partner and other Eligible Dependent(s) in the Family Unit

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Marriage	Within 60 days of the event date	• SSN for the Spouse and/or covered Child(ren) • Copy of the certified marriage certificate • If adding Dependent Child(ren), a copy of the Child(ren)'s birth certificates	Coverage effective on the first day of the month concurrent with or following the date of marriage	May add Spouse and other Eligible Dependent(s) in the Family Unit
Divorce, Annulment or Termination of Domestic Partnership	Within 60 days of the event date	• Copy of the divorce/ annulment decree signed by the judge (all pages) • 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 divorce decree is signed by the judge or termination of Domestic Partnership is filed with the Secretary of State's office • If the divorce decree/ termination of Domestic Partnership is received more than 60 days after the divorce, coverage ends at the end of the month of receipt of the divorce decree/termination of Domestic Partnership	Must delete ex-Spouse or ex-Domestic Partner and all other Ineligible Dependent(s)

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Employer of Spouse/ Domestic Partner Offers an Open Enrollment Period	Within 60 days of the event date	• Proof of Open Enrollment from the employer • Confirmation of coverage letter from the insurance carrier stating the effective date of new coverage and the identity(ies) of the newly Covered Individual(s)	• If deleting Dependent Child(ren) from that other employer's Group Health Plan and Enrolling them in PEBP coverage, the effective date is the first day of the month concurrent with or following the coverage end date • If declining PEBP coverage, the coverage terminates on the last day of the month prior to the month the other coverage becomes effective	Participant and any covered Dependents may decline PEBP coverage to newly Enroll in the other employer's coverage; or Participant and Eligible Dependent in declined status with PEBP may re-Enroll in PEBP coverage if the other employer coverage is terminated
PEBP's Open Enrollment Period	Typically May 1- May 31 of each year	• If adding a dependent, refer to the Summary of Supporting Eligibility Documents provided in this document • Required supporting documents are due by June 15	Coverage effective date is July 1 immediately following Open Enrollment Period	May add or delete Dependents, change Plan options or decline coverage

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Participant death*	Within 60 days of the event date	Copy of certified death certificate	• Participant coverage terminates on the date of death; and • Coverage for any covered Dependent terminates on the last day of the month concurrent with the Participant's date of death	Covered Dependents may qualify for re-Enrollment in Survivor's coverage if he/she meets the eligibility requirements as stated in this document
Dependent Death*	Within 60 days of the event date	Copy of certified death certificate	Coverage for the deceased Dependent terminates on the date of death	Must delete the deceased Dependent from coverage and any Ineligible Dependent(s) (e.g. Children of Domestic Partner or stepchildren)

***Late Notification of Death**
Adjustments in premiums resulting from the death of a covered Participant or Dependent will be refunded if notification of death is received within 60 days of the Participant's or Dependent's date of death. Notification of death beyond the 60 day period will not be refunded.

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Retiree/ Dependent or survivor's entitlement to Medicare Parts A and/or B	End of the month following the date the individual becomes eligible for Medicare	• Copy of Medicare Part A and Part B card • If ineligible for premium-free Part A, must provide PEBP with a copy of the Medicare benefit verification from the Social Security Administration (SSA) • If covered under Tricare for Life, must provide a copy of military ID card to PEBP • BECF (only if Medicare entitlement includes Parts A and B and changing health Plans to the Medicare exchange)	Coverage under Medicare Exchange becomes effective within 60 days of Medicare effective date or retirement date, whichever is later Note: If the Medicare Retiree covers a non-Medicare Spouse/DP and the Retiree Enrolls through the exchange, the Spouse/DP cannot decline coverage until open Enrollment	• Must Enroll in a Medicare exchange Plan if Retiree and all covered Dependents (if any) are eligible for free Part A; otherwise, coverage is terminated • If one person in the Family Unit is not eligible for free Part A, the entire Family Unit may continue PEBP CDHP or HMO coverage or the Part A individual may choose coverage through the Medicare Exchange

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Declination of Coverage for Dependent Child(ren) who become eligible for and Enrolled in Medicare	Within 60 days of the event date	• Copy of Medicare card	Coverage terminates on the last day of the month preceding the Medicare coverage effective date	May delete the Dependent who becomes entitled to Medicare
Declination of Coverage for Dependent Child(ren) who become eligible for and Enrolled in Medicaid and/or Nevada Check Up		• PEBP requires proof of eligibility and/or coverage effective date	Coverage for Dependent Child(ren) will terminate on the last day of the month, PEBP receives proof of Medicaid and/or Nevada Check Up effective date	Covered Dependent Child(ren) may decline coverage due to Enrollment in Medicaid and/or Nevada Check Up
Loss of Coverage for Dependent Child(ren) under Medicaid or Nevada Check Up		• Creditable Coverage letter indicating the name of the Dependent Child(ren) and coverage end date • Copy of birth certificate(s) for each Dependent Child(ren) being added to the Plan	Coverage for Dependent Child(ren) will become effective on the first day of the month following PEBP's receipt of loss of coverage from Medicaid and/or Nevada Check Up	Eligible Dependent Child(ren) may be added to the Employee/Retiree's health Plan

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Declination of Coverage due to Marriage and Enrollment in Spouse's Employer Group Health Plan	Within 60 days of the event date	• Copy of certified marriage certificate • Confirmation of coverage letter from the Spouse's employer/insurance carrier stating the effective date of new coverage and the identity(ies) of the newly Covered Individual(s)	Coverage ends the last day of month Participant marries	Primary Participant may decline coverage
Medicare Part B Premium Credit	No later than the end of the month prior to the Part B effective date	• Copy of Medicare Part B card; or • Copy of the Medicare Part B award letter	Part B premium credit starts on the first of the month following receipt of required supporting document	Premium credit will only apply to primary Retirees covered under the Consumer Driven Health Plan or an HMO Plan

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Survivor of Police/ Firefighter	Within 60 days of the police officer's or firefighter's date of death	• RBECF • Written notification to employer of the Survivor's intent to Enroll in Survivor's coverage • Copy of death certificate • SSN and copy of marriage certificate • If adding Dependent(s), a copy of Child(ren)'s birth certificate(s)	Coverage for eligible survivors is effective on the first of the month following the police officer's or firefighter's date of death	May qualify for Survivor's coverage if the Dependent meets the Survivor's eligibility requirements
Survivor	Within 60 days of the primary Participant's date of death		Coverage for eligible survivors is effective on the first day 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
Settlement Agreement	Within 60 days of Settlement Agreement	Copy of Hearing Officer's decision	• Retroactive to date established by the Hearing Officer decision under the CDHP; or • Not more than 6 months prior to PEBP's receipt of the Hearing Officer's decision for the HMO; or • The first month after the decision is received by PEBP if the Employee chooses not to pay back premiums	• Employee may re-Enroll in coverage; or • Decline coverage

Qualifying Events

Federal regulations generally require that Plan coverage remain in effect, without change, throughout the Plan Year unless a qualifying event occurs during the year (mid-year).

Qualifying events include the birth of a Child, marriage, divorce, etc. (for a detailed list of qualifying events, see the Qualifying Events Quick Reference Table in this document). Any change made to health care benefits must be determined by PEBP to be necessary, appropriate, and consistent with the change in status. The Plan must be notified in writing within 60 days of the qualifying event; otherwise, the request will not be accepted and the change cannot be made until the subsequent Open Enrollment period. As a result of a qualifying event, only those changes that are consistent with the change of status will be allowed. Only coverage for an individual who has lost eligibility from an Employer Group Health Plan as a result of a change of status (or who has gained eligibility and Enrolled in coverage from an Employer Group Health Plan) can be added or dropped mid-year from this Plan.

Any qualifying event that creates a situation in which the Retiree/survivor and all remaining covered Dependents are eligible for premium-free Medicare Part A creates a requirement that the Retiree/survivor and all remaining covered Dependents choose coverage through the Medicare Exchange. Failure to Enroll in a medical Plan through the Medicare Exchange will result in termination of coverage.

Dependent Loses Other Employer Group Health Care Coverage

An eligible Spouse, Domestic Partner or Dependent that ceases to be covered by another Employer Group Health Plan may be added to the Participant's coverage if Enrollment and proof of loss of coverage is provided within 60 days after the termination of coverage under that other Employer Group Health Insurance policy or plan if that other coverage terminated because:

- loss of eligibility as a result of divorce, dissolution of a Domestic Partnership, cessation of Dependent status (such as attaining the limiting age for a Dependent Child), death, termination of employment, or reduction in hours; or
- an HMO or other arrangement in the employer group market that does not provide benefits to individuals who no longer reside or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; or
- a plan no longer offers any benefits to a class of similarly situated individuals; or
- the termination of COBRA Continuation Coverage for any of the following reasons:
  - when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
  - when the individual no longer resides or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
  - the 18-month, 24-month, 29-month or 36-month period of COBRA Continuation Coverage has expired.

However, if an Employee or Dependent lost other health care coverage as a result of the individual's voluntary cancellation of coverage, termination of coverage through the state health exchange (Affordable Care Act (ACA)), failure to pay premiums, reduction or elimination of

employer financial payment of premiums, or for cause, such as making a fraudulent claim, that individual does not have Enrollment rights.

Gain of Other Employer Group Health Care Coverage

If an otherwise eligible Spouse/Domestic Partner gains health care coverage through their employer, they are no longer eligible to maintain PEBP coverage. For additional information, see the section on Significantly Inferior Coverage.

PEBP must be notified within 60 days of the effective date of the Spouse's or Domestic Partner's coverage under the Spouse's or Domestic Partner's Employer Group Health Plan. Notification after 60 days will result in coverage terminating at the end of the month PEBP receives proof of other employer coverage. Premium refunds will not be given for late notification.

If a Dependent Child gains coverage through their employer, the Dependent Child can be removed from coverage by the Participant or the Child can remain on the PEBP Plan and the order of benefit determination rules as described in the Coordination of Benefits section of the PEBP Consumer Driven Health Plan for Medical, Vision and Prescription Drug Benefits Master Plan Document or HMO Evidence of Coverage Certificate to determine establish which plan is the primary plan (pays first) and which is secondary (pays second).

An unsubsidized Dependent who gains coverage through a state health exchange or through another Employer Group Health Plan is eligible to decline PEBP sponsored coverage.

Open Enrollment for Employer of Spouse or Domestic Partner

If the employer of an eligible Spouse or Domestic Partner offers an Open Enrollment period for their Employees, the primary Participant and any covered Dependents may opt to accept the other employer's coverage and decline PEBP coverage during the Spouse's/Domestic Partner's Open Enrollment period. This option only applies when the Participant's coverage is new under the Spouse's/Domestic Partner's plan.

The Participant will be required to submit a Benefit Enrollment and Change Form (BECF) along with proof of the Open Enrollment period, effective date of coverage, including the names of covered Dependents within 60 days of the new coverage effective date.

Change of Residence

A Qualifying Event may be initiated by a Participant's change in place of residence, if that change impairs the ability of a Participant to access the services of in-network health care Providers. Participants who move outside an HMO coverage area must select another coverage option by updating their information with PEBP within 30 days after moving out of the previous service area. If a Participant notifies PEBP of a change of address to a location that is outside the geographic service area of the HMO but does not select a coverage option that is available at the new address within 30 days, the Participant will be defaulted into the CDHP with an HRA. If the Participant subsequently moves to an address that is serviced by the original coverage option under which the Participant was covered, the Participant may not change coverage options until the next Open Enrollment. If the Enrollment update is not received within 30 days, the change will be

made for the first of the month following submission of the change of address. Any overpayments due to lack of notification within 30 days will not be refunded.

Retirees covered through the Exchange who move out of the United States may select coverage under the CDHP. Retirees who are eligible for premium-free Medicare Part A and who move back into the United States must select coverage through the Exchange.

Declining Active Employee Coverage

An Employee may decline coverage at initial Enrollment, during PEBP's annual Open Enrollment, during the Spouse's/Domestic Partner's Open Enrollment period or marriage (see Open Enrollment for Employer of Spouse or Domestic Partner section). An Employee will not receive a financial incentive or compensation when in declined coverage status and will not be eligible for Basic Life and Long Term Disability insurance or any voluntary products.

Declining Retiree or Survivor's Coverage

Retirees and survivors may decline coverage at any time during the year. Coverage will terminate on the last day of the month PEBP receives the written request to decline coverage. Declining coverage will terminate medical, dental, vision, prescription drug coverage, Basic Life Insurance, Voluntary Life Insurance, years of service premium subsidy and HRA contribution (if applicable). See the Retiree Late Enrollment section for re-Enrollment rights.

Declining Unsubsidized Dependent Coverage

Unsubsidized Dependents Enrolled in a PEBP-sponsored medical Plan may decline coverage at any time during the year. Coverage will terminate on the last day of the month PEBP receives the written request to decline coverage.

Significantly Inferior Coverage

If PEBP determines the coverage available to the Spouse/Domestic Partner by their employer meets the definition of "Significantly Inferior Coverage," the Spouse/Domestic Partner is required to decline such coverage from their employer prior to being enrolled as a Dependent on the Participant's PEBP Plan.

The PEBP Board has defined Significantly Inferior Coverage as either:

1. A mini-med or other limited benefit plan; or
2. A catastrophic coverage plan with a deductible equal to or greater than $5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement.

In order for PEBP to make the determination to allow a Spouse/Domestic Partner with "Significantly Inferior Coverage" to Enroll as a Dependent in the PEBP Plan, an official summary of the coverage details from Spouse/Domestic Partner's employer outlining the health insurance coverage plans available to their employees must be provided to PEBP.

If Your Spouse/Domestic Partner cannot decline coverage from their employer until the annual Open Enrollment period, the decline of coverage at that time will be considered a qualifying event to add the Spouse/Domestic Partner to the Participant's PEBP Plan.

Leaves of Absence

Family and Medical Leave Act (FMLA)

The FMLA entitles an eligible Employee up to 12 weeks of paid and/or unpaid, job-protected leave during a rolling 12-month period measured backward from the date an Eligible Employee uses any qualifying FMLA leave. The FMLA also includes a special leave entitlement that permits eligible Employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period, measured forward from the first day of usage.

During FMLA leave, the Employer must maintain the Employee's health coverage under any Employer Group Health Plan on the same terms as if the Employee had continued to work, regardless of whether the Employee is on paid or unpaid leave. Upon return from FMLA leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Employees are eligible for FMLA leave if they have worked for the State of Nevada for 12 months and for 1,250 hours over the previous 12 months. For an overview of FMLA provided by the Department of Administration, Human Resource Management visit http://dop.nv.gov/FMLAOverview.pdf.

Employees who return to work promptly at the end of that leave, regardless of whether they kept their coverage while on leave, may continue or reinstate the same Plan option and Coverage Tier without any additional limits or restrictions imposed on account of the leave. If an Employee declines coverage while on family or medical leave, coverage will be reinstated to the same Plan option and Coverage Tier on the first of the month in which the Employee is in paid status 80 hours using a combination of FMLA and/or paid time.

The National Defense Authorization Act of 2008 (NDAA) expanded provisions of the FMLA. The NDAA extends family medical leave entitlements to the relatives of members of the armed services (including the National Guard and Reserves). NDAA makes two significant changes to FMLA: (i) an Eligible Employee who is a Spouse or Domestic Partner, son, daughter, parent or "next of kin" of a covered service member is now entitled to a total of 26 weeks of FMLA during a 12 month period to care for the serious injury or illness of the wounded/disabled service member; and (ii) an Employee will be entitled to FMLA on account of a "qualifying exigency" that occurs because the Spouse or Domestic Partner, son, daughter, or parent of the Employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

Any changes in the Plan's terms, rules or practices that went into effect while an Employee is away on leave will apply to the Employee and any Dependents in the same way they apply to all other Employees and their Dependents. Employees should contact their Agency Representative to find out more about their entitlement to family or medical leave as required by Federal and/or State law, and the terms on which it may be entitled.

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 effect prior to taking that leave.

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

Employees who go into active military service for up to 31 days can continue their health care coverage during that leave period if they continue to pay their contributions for that coverage during the period of that leave.

State Employees who go into active military service for 31 days or more are eligible to Enroll in health care coverage provided by the military the day the Employee is activated for military duty. This coverage is also available to Dependents. The Employee is also eligible to purchase continued health care coverage through PEBP 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. Questions regarding entitlement to this leave and to the continuation of health care coverage should be referred to PEBP. Questions regarding reemployment rights should be addressed with the Employer.

Worker's Compensation Leave

Employee and Dependent health care coverage during a period of Worker's Compensation leave will automatically be continued for a period of up to 9 months. To continue coverage, Employees must pay their contribution for that coverage during the period of that leave directly to PEBP by the date on the bill. Late payment will result in termination of coverage. Coverage terminated for non-payment may not be reinstated until the Employee returns to work. Employees may elect to discontinue Dependent coverage while on Workers' Compensation leave.

Following the 9-month period during which the Employee has been on Worker's Compensation leave, the Employee will be required to make the full, unsubsidized payment for health care coverage for themselves and their Dependents. Once the Employee returns to work, insurance coverage will be reinstated exactly the way it was before the Employee was placed on Workers' Compensation leave, unless the Employee selected different coverage during an Open Enrollment period.

Payment for Coverage

Most Eligible State Employees are provided a subsidy toward the cost of Plan coverage. To obtain information about subsidy amounts, service calculations, and premium information, please visit the PEBP website (www.pebp.state.nv.us) or call Member Services (775-684-7000 or 800-326-5496). Survivors, Dependents, legislators and Employees on leave without pay are not eligible for a subsidy. The option of electing additional voluntary products at cost may be available to an Employee or Retiree.

Retirees eligible for a subsidy must submit the required Years of Service Certification Form to the PEBP office by the last day of the month preceding the retirement effective date in order to receive the first month's subsidy.

To receive a Medicare Part B premium credit, eligible Retirees must send a copy of their Medicare Card to PEBP. The Medicare Part B premium credit will be applied to the Retiree account the first day of the month following the receipt of the Medicare Card, but no earlier than the effective date of the Medicare Part B coverage. The Medicare Part B premium credit is for retirees on the CDHP or HMO only.

Premiums for CDHP or HMO coverage are automatically deducted from the Participant's paycheck or pension. Each monthly premium pays for coverage for that same month. In the following circumstances, premiums shall be paid directly to PEBP on a monthly basis:

- The Employee is on unpaid leave;
- The Retiree's pension is not large enough to cover the premium amount, or if PERS payroll deductions rules cause the PEBP contribution to not be taken;
- The participant is a Retiree of the Nevada System of Higher Education who participates in an alternative retirement plan;
- The Participant is an active legislator;
- The Participant is on COBRA coverage;
- The individual is an unsubsidized Dependent; or
- For survivor's who do not receive a PERS pension benefit.

If COBRA coverage is terminated due to non-payment, that individual will not be able to re-Enroll in the Plan under COBRA. If Employee coverage is terminated due to non-payment, that Employee will not be able to re-Enroll in the Plan until the next Open Enrollment or until the Employee returns from leave and the account has been paid in full. If coverage of a Retiree, survivor or unsubsidized Dependent is terminated for non-payment that individual will not be able to re-Enroll in the Plan until the next Open Enrollment period (if eligible) and until such time as the account is paid in full.

Participants will be billed via premium invoice and will be required to pay the following directly to PEBP:

- contributions resulting from retroactive coverage changes; or
- claims incurred by the Participant or their Dependents who access the Plan during a period when they are ineligible for coverage.

Premium overpayments due to lack of proper notification by the Participant will not be refunded. Participants who fail to pay their premiums or ineligible claims may be reported to the State Controller's office or to a private collection agency for collection of past due amounts. Collection costs may also be assessed to the Participant.

PERS deduction for the Medicare Exchange Plan

Federal rules for the Medicare Exchange require the individual to pay medical insurance premiums directly to the carrier. PEBP will not take automatic deductions from retirement distributions to pay for coverage provided through the Medicare Exchange except dental coverage provided by PEBP if the Retiree elects to Enroll in the PEBP Self-funded PPO Dental Plan.

Late Notification of Death

Adjustments in premiums resulting from the death of a covered participant or Dependent will be refunded if notification of death is received within 60 days of the participant's or Dependent's date of death. Notification of death beyond the 60 day period will not be refunded.

Billing Errors

It is the Participant's responsibility to ensure the premiums paid by the Participant are accurate. Refunds for premiums billed in error and paid by the Participant more than six months old are at the sole discretion of PEBP.

Termination for Non-payment

Payment for the current month's coverage is due on the 20th of each month. Acceptance and deposit of a payment does not in itself guarantee coverage. If the participant fails to meet Eligibility and Enrollment requirements, coverage may be terminated and the payment refunded to the Participant.

Any account 30 days past due is subject to termination retroactive to the last day of the month for which premium payment was received in full. Participants will be billed for any claims incurred and paid by the Plan after the effective date of termination.

Change to Years of Service Re-Audit Results for Retirees

Years of service premium subsidy and years of service Exchange HRA contribution are effective upon the date of retirement, based on the audit from either the Public Employees' Retirement System (PERS) or the Nevada System of Higher Education (NSHE). Changes to the years of service premium subsidy and years of service Exchange HRA contribution resulting from a future audit will occur on the first (1st) day of the month concurrent with or following the date PEBP receives the audit results from the PERS or NSHE. (NAC 287.485)

COBRA Continuation of Medical Coverage

This notice is a summary of rights and obligations under the Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage law. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that You and Your Dependents take the time to read this notice carefully and be familiar with its contents.

Entitlement to COBRA Continuation Coverage

In compliance with a federal law commonly called COBRA, this Plan offers its Employees, Retirees and their covered Dependents (called "qualified beneficiaries" by the law) the opportunity to elect a temporary continuation ("COBRA Continuation Coverage") of the group health coverage sponsored by PEBP, including medical coverage (the "Plan"), when that coverage would otherwise end because of certain events (called "qualifying events" by the law). The Participant must be covered by the group health coverage sponsored by PEBP the day before the Qualifying Event in order to continue coverage under COBRA. Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

A Qualified beneficiary is entitled to elect COBRA Continuation Coverage when a qualifying event occurs, and as a result of that qualifying event, that person's health care coverage ends, either as of the date of the qualifying event or as of some later date.

Qualified Beneficiary

Under the law, a qualified beneficiary is any Employee, Retiree, Spouse or Dependent Child of an Employee or Retiree who was covered by the Plan when a qualifying event occurred, and who is therefore entitled to elect COBRA Continuation Coverage. A Child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Employee or Retiree during a period of COBRA Continuation Coverage is also a qualified beneficiary. A Dependent that had previous coverage under the primary insured Participant can be added to COBRA coverage if a qualifying event occurs, however they can only have the COBRA coverage as long as the primary Participant maintains COBRA coverage.

Qualifying Event

Qualified beneficiaries are entitled to COBRA Continuation Coverage when qualifying events (which are specified in the law) occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. A qualifying event triggers the opportunity to elect COBRA when the Covered Individual loses health care coverage under this Plan. If a Covered Individual has a qualifying event but does not lose their health care coverage under this Plan (*e. g.,* Employee continues working even though entitled to Medicare), then COBRA will not be offered.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which qualifying event occurred, measured from the time the qualifying event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another area of this section on extending COBRA in cases of Disability). That period may also be cut short for the reasons set forth in the section When COBRA Continuation Coverage May Be Cut Short that appears later in this section.

Who is entitled to COBRA Continuation Coverage (the qualified beneficiary), when (the qualifying event), and for how long is shown in the following chart:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making Employee ineligible for the same coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee or Retiree becomes divorced.	N/A	36 months	36 months
Employee becomes entitled to Medicare.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months
Retiree coverage is terminated or substantially eliminated within one year before or after PEBP files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Life	Life plus 36 months after death of Retiree	Life plus 36 months after death of Retiree

Certificates of Creditable Coverage

PEBP shall issue certificates of Creditable Coverage (HIPAA Certificates) to a covered person: (a) whose coverage terminates; and (b) to individuals upon their written request while the individual is covered under the Plan and within 24 months of the date of coverage termination, as required by federal law. Procedures for requesting certificates of Creditable Coverage may be obtained from PEBP. See the COBRA section for an explanation of when and how those certificates of coverage will be provided.

Health Insurance Marketplace Coverage Options

There may be other coverage options for You and Your family through the Health Insurance Marketplace. In the Marketplace, You could be eligible for a tax credit that lowers Your monthly premiums. You can also see what your premium, deductibles, and out-of-pocket costs will be before You make a decision to Enroll. Being eligible for COBRA does not limit Your eligibility for coverage for a tax credit through the Marketplace. For information on the Nevada Silver State Health Insurance Exchange (Marketplace), call 855-768-5465. Additionally, You may qualify for a special Enrollment opportunity for another Employer Group Health Plan for which You are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if You request Enrollment within 30 days of loss of PEBP coverage.

General Provisions and Notices

General Provisions

Name of the Plan

Public Employees' Benefits Program (PEBP)

Plan Administrator

Public Employees' Benefits Program (PEBP)
901 South Stewart Street, Suite 1001
Carson City, NV 89701
Phone: (775) 684-7000 or (800) 326-5496

Tax Identification Number (TIN)

88-0378065

Type of Plan

Group Health Plan including medical expense benefits.

Type of Administration

PEBP is liable for all expenses associated with the benefits of the CDHP medical and dental Plans outlined in this document. An independent Claims Administrator administers the benefits for the CDHP and the Self-funded PPO Dental Plan. Refer to the Participant Contact Guide in this document for the name and address of the Claims Administrator.
Per NRS 287.0485 no officer, Employee, or Retiree of the State has any inherent right to benefits provided under the PEBP.

Agent for Service of Legal Process

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

Public Employees' Benefits Program (PEBP)
901 South Stewart Street, Suite 1001
Carson City, NV 89701
Phone: (775) 684-7000 or (800) 326-5496

Plan Year

The Plan's CDHP and Self-Funded Dental PPO Plan benefits are administered on a Plan Year typically beginning July 1 and ending June 30. PEBP has the authority to revise the benefits and premium rates if necessary each Plan Year. For medical, dental, vision and pharmacy benefits, all deductibles, out-of-pocket maximums and Plan Year maximum benefits are determined based on the Plan Year. Fiscal records are kept on a 12-month period basis beginning on July 1 and ending on June 30.

Plan Amendments or Termination of Plan

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

Discretionary Authority of Plan Administrator and Designees

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

No Liability for Practice of Medicine

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

Right of Plan to Require a Physical Examination

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

When You Must Repay Plan Benefits

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

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

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

Vision and Prescription Drug Benefits Master Plan Document or HMO Evidence of Coverage Certificate).

Privacy Notice

Disclosure and Access to Medical Information

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

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

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

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

Definitions

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

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

Uses and Disclosures of Your Protected Health Information

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

Your Authorization – Except as outlined below, we will not use or disclose Your PHI unless You have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the Group Health Plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

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

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

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

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

Other Products and Services – We may contact You to provide information about other health-related products and services that may be of interest to You. For example, we may use and disclose Your PHI for the purpose of communicating to You about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to Your Group Health Plan.

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

- We may use or disclose Your PHI for any purpose required by law. For example, we may be required by law to use or disclose Your PHI to respond to a court order.
- We may disclose Your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose Your PHI to the proper authorities if we suspect Child abuse or neglect; we may also disclose Your PHI if we believe You to be a victim of abuse, neglect, or domestic violence.

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

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

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

Rights That You Have

Access to Your PHI – You have the right of access to copy and/or inspect Your PHI that we maintain in designated record sets. Certain requests for access to Your PHI must be in writing, must state that You want access to Your PHI and must be signed by You or your representative (e.g., requests for medical records provided to us directly from Your Health Care Provider). Access request forms are available from PEBP at the address provided below. We may charge You a fee for copying and postage.

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

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of Your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, Your accounting requests must be in writing and signed

by You or Your representative. The first accounting in any 12-month period is free; however, we may charge You a fee for each subsequent accounting You request within the same 12-month period.

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

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

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

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

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

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

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

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

Office of Civil Rights
Dept. of Health & Human Services
907 7th St., Ste. 4-100
San Francisco CA 94103
(800) 368-1019 Phone
(415) 437-8329 Fax
TDD (800) 537-7697

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

By law, PEBP is required to follow the terms in this privacy notice. PEBP has the right to change the way Your personal medical information is used and given out. If PEBP makes any changes to the way Your personal medical information is used and given out, You will get a new notice within 60 days of the change.

Effective Date

This Notice of Privacy Practices for PEBP is effective July 1, 2016, and replaces all other privacy notices that have been in effect since April 14, 2003.

PEBP Security Practices

By law, PEBP is required to:

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

Other Notices Provided by PEBP

National Defense Authorization Act (NDAA)

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

The NDAA also permits an Employee to take FMLA leave for "any qualifying exigency (as the Secretary [of Labor] shall, by regulation, determine) arising out of the fact that the Spouse/ Domestic Partner, or a son, daughter, or parent of the Employee is on active duty (or has been

notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation."

You can read more about the National Defense Authorization Act by going to the US Department of Labor website at: www.dol.gov.

Heroes Earning Assistance and Relief Tax Act (HEART Act)

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

Uniformed Services Employment and Reemployment Rights Act

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

The Americans with Disability Amendments Act

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

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 is effective for PEBP on July 1, 2010. This legislation requires that full parity be established between mental health/ substance abuse benefits and other surgical and medical benefits offered under the Plan. You can find more information at: www.govtrack.us/congress and searching for The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) was enacted May 21, 2008. Title I (regarding genetic nondiscrimination in Group Health Plans) is effective for Plan Years beginning after May 21, 2009. Title II (regarding genetic nondiscrimination in employment) becomes effective November 21, 2009. GINA amends ERISA, the Code and Public Health Service Act to prevent Group Health Plans and health insurance companies from basing Enrollment decisions, premium costs, or Participant contributions on genetic information. Group Health Plans and group insurers will be prohibited from requiring that individuals undergo genetic testing. Employers are preventing conditioning of hiring or firing decisions on the basis of genetic

information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information in regards to either employment or the determination of benefits. Genetic testing is a Plan exclusion.
You can read more about GINA by visiting www.genome.gov/10002328.

NAC and NRS Regarding the PEBP Plan and Your Coverage

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

NAC 287.095 – Definition of persons who are eligible to participate in the Program.

NAC 287.135 – The five year service credit requirement in the definition of "retired officer or Employee", the participation requirements for those retired officers who are eligible to participate in the PEBP because they are receiving a distribution from a public Employer's long-term Disability plan. The five year full time participation requirement for those eligible to participate in the PEBP because they are receiving a distribution of benefits from a retirement program offered by the Nevada System of Higher Education.

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

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

NAC 287.357 – All opt-out plans are considered covered entities by PEBP and are subject to HIPAA's privacy regulations.

NAC 287.440 – Except as otherwise provided in this section, retired officers and Employees shall pay their premiums or contributions directly to the Program. Retired officers and Employees who receive a retirement benefit from the Public Employees' Retirement System shall pay their premiums or contributions to the Program through an automatic deduction from that benefit unless the retirement benefit is less than the premium or contribution

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

NAC 287.520 – If a covered person qualifies as both an Employee and a Dependent

- Except as otherwise provided in NAC 287.530, if a person qualifies to be covered by the Program as both an Employee and a Dependent, the person:
  - If the person is a Spouse or Domestic Partner:
    - May be covered by the Program as an Employee; and
    - May not be covered by the Program as a Dependent.
  - If the person is a Child, may be covered by the Program as an Employee or Dependent.
- If a participating officer or Employee changes his or her status to that of a Dependent because he or she no longer qualifies as an Employee, he or she must Enroll as a Dependent

within 60 days after losing status as an Employee to be eligible for coverage and insurance as a Dependent. If a Participant complies with the requirements of this subsection, his or her coverage or insurance is not limited by any waiting period that would otherwise apply.

NAC 287.530 - If the Participant and his or her Spouse or Domestic Partner who are retired officers or Employees who retired before July 1, 2004, and elect to participate in the Program, one may elect to be the Dependent of the other. A Spouse or a Domestic Partner who elected to be the Dependent pursuant to this subsection may elect to become a primary insured during Open Enrollment. If the retired officer or Employee designated as the primary insured dies, the Spouse or Domestic Partner who elected to be the Dependent becomes the primary insured.

- A person who retires on or after July 1, 2004, and who is eligible to participate in the Program as a primary insured may not elect to be a Dependent of his or her Spouse or Domestic Partner who is a primary insured in the Program.

- A surviving Spouse or Domestic Partner who:
  - Retired before July 1, 2004;
  - is Enrolled in the Program as a surviving Dependent; and
  - Is eligible to participate in the Program as a primary insured,

  may elect to change his or her status to Retiree status during Open Enrollment. A person who chooses such an election pursuant to this subsection must meet the requirements of NAC 287.485 to be eligible for a subsidy.

- A person who is a surviving Dependent of a deceased officer or Employee of a participating public agency, or a deceased retired officer or Employee, and who, at the time of his or her death, was a Participant under the Program, may maintain the coverage or insurance from the Program if:
  - The surviving Dependent receives retirement benefits from which premiums or contributions can be deducted or such Dependent pays the premium or contribution directly to the Program; and
  - Within 60 days after the date of death of the Participant, the surviving Dependent:
    - Notifies the last public Employer of the deceased Participant that the surviving Dependent intends to Enroll in or continue coverage by re-Enrolling in the Program; and
    - Enrolls or re-Enrolls, as appropriate, in the Program.
- Continued coverage provided to a surviving dependent who re-Enrolls in the Program in accordance with this section may not be changed until the next period of Open Enrollment.
- If the surviving Spouse or Domestic Partner has a Dependent who is not covered under the Program at the time of death of the officer or Employee of a participating public agency, or retired officer or Employee, or acquires a Dependent by marriage, adoption or birth, the Dependent is not eligible for coverage or insurance.
- A retired officer or Employee who wishes to Enroll or re-Enroll in the Program more than 60 days after his or her official date of retirement or total Disability must comply with the requirements of NRS 287.0475.

NAC 287.540 – Coverage of participating Employee of State who re-Enrolls upon retirement or total Disability. If at the time of retirement or total Disability was:

- Employed by a participating State agency; and

- A participant in the Program; and
  - Within 60 days after the official date of retirement or total Disability must notify the participating State agency that employed the Participant at the time of retirement or total Disability of the intent to continue coverage in the Program. If the Participant re-Enrolls in the Program, the Participant will have uninterrupted benefits and is not subject to any waiting period. Upon re-Enrollment, the Participant may change their choice of coverage, e.g. CDHP to HMO or vice versa.

NAC 287.542 - Coverage of an Employee of a participating local governmental agency who retires on or before September 1, 2008, and re-Enrolls upon retirement or total Disability**.**
A person who is a retired officer or Employee on or before September 1, 2008 and is a retired officer or Employee on or before September 1, 2008 and at the time of retirement or total Disability was:

- Employed by a participating local governmental agency; and was a Participant in the Program; and within 60 days after the official date of retirement or total Disability:
  - Notifies the participating local governmental agency that employed him or her at the time of retirement or total Disability of his or her intent to continue coverage in the Program; and
  - Re-Enrolls in the Program, will have uninterrupted benefits and is not subject to any waiting period.
  - Upon re-Enrollment, the Participant may change their choice of coverage, e.g. CDHP to HMO or vice versa.
- Coverage continues until the person chooses to terminate or decline the coverage. If the person chooses to terminate or decline the coverage after November 30, 2008, the person may subsequently only reinstate in the Program pursuant to NRS 287.023 and 287.0475.

NAC 287.544 - Coverage of an Employee of a nonparticipating local governmental agency who retires on or before September 1, 2008, and Enrolls upon retirement or total Disability.
A person who is a retired officer or Employee on or before September 1, 2008 and at the time of retirement or total Disability was:

- Employed by a participating local governmental agency; and was not a Participant in the Program; and within 60 days after the official date of retirement or total Disability:
  - Notifies the participating local governmental agency that employed him or her at the time of retirement or total Disability of his or her intent to Enroll in the Program; and
  - Enrolls in the Program, is subject to a 60-day waiting period.
- Coverage continues until the person chooses to terminate or decline the coverage. If the person chooses to terminate or decline the coverage after November 30, 2008, the person may subsequently only reinstate in the Program pursuant to NRS 287.023 and 287.0475.

NAC 287.546 - Coverage of participating Employee of local governmental agency who retires after September 1, 2008, and re-Enrolls upon retirement or total Disability.

- A person who becomes a retired officer or Employee after September 1, 2008 and at the time of retirement or total Disability, was:
  - Employed by a participating local governmental agency; and a Participant in the Program; and within 60 days after the official date of retirement or total Disability:

- Notifies the participating local governmental agency that employed him or her at the time of retirement or total Disability of his or her intent to continue coverage in the Program; and
- Re-Enrolls in the Program, will have uninterrupted benefits and is not subject to any waiting period.
- Continued coverage provided to a person described in in this section may be changed by the person at the time of re-Enrollment, e.g. CDHP to HMO or vice versa.

- Coverage of a person pursuant to this section terminates on the date on which the participating local governmental agency that employed the person at the time of retirement or total Disability terminates its participation in the Program. If the participating local governmental agency subsequently reestablishes its participation in the Program pursuant to NAC 287.310, the person may subsequently reinstate in the Program pursuant to NRS 287.023 and 287.0475.

NAC 287.548 - Coverage of non-participating Employee of local governmental agency who retires after September 1, 2008.

- A person who becomes a retired officer or Employee after September 1, 2008; and at the time of retirement or total Disability:
  - Was employed by a participating local governmental agency; and
  - Was not a Participant in the Program, may only Enroll or re-Enroll in the Program pursuant to the provisions of NRS 287.0475.
- Coverage provided to a person pursuant to this section terminates on the date on which the participating local governmental agency that employed the person at the time of retirement or total Disability terminates its participation in the Program. If the participating local governmental agency subsequently reestablishes its participation in the Program pursuant to NAC 287.310, the person may subsequently reinstate in the Program pursuant to NRS 287.023 and 287.0475.

NAC 287.680 – An appeal request for a Level 2 Review must include a copy of the Level 1 review request, a copy of the decision made on review, and any other documentation provided to the Claims Administrator by the Participant.

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

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

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

NRS 287.0435 - Creation; investment; disbursements; administration by State Treasurer; checking account for payment of claims, specifically disbursements from the Program Fund must be made as any other claims against the State are paid and may only be made for the benefit of the Participants in the Program.

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

- The State Retirees' Health and Welfare Benefits Fund is created as an irrevocable trust fund.
- The purpose of the Retirees' Fund is to account for the financial assets designated to offset the portion of the current and future costs of health and welfare benefits paid pursuant to subsection 2 of NRS 287.046.

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

NRS 287.047 - Retention by certain retired State officers and Employees and Dependents' of membership in coverage under Program. If the retention is consistent with the terms of any agreement between the State and the insurance company which issued the policies pursuant to the Program or with the Plan of self-insurance of the Program.

NRS 287.0475 – A retiring officer or Employee of a local governmental agency who had not been a Participant in the PEBP at the time of his or her retirement is no longer eligible to participate as a Retiree, nor is he or she eligible to be reinstated at a later date.

NRS 689B.020 – Group Health Insurance is any group health policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of Hospital, Nursing, medical, Dental or surgical services, Home Health Care or health supportive services for members of the family or Dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group. Group Health Insurance is declared to be that form of health insurance covering groups of two or more persons, formed for a purpose other than obtaining insurance.

NRS 689B.033- Coverage for newly born and adopted Children and Children Placed for Adoption. This Plan provides coverage for any medical, surgical, hospital or dental expenses for Children with respect to:

- A newly born Child of the Plan Participant from the moment of birth;
- A Child adopted by the Plan Participant from the date the adoption becomes effective
- A Child placed with the Plan Participant for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement. The coverage of the Child will cease if the adoption proceedings are terminated as certified by the public or private agency making the placement.
- This Plan does not exclude premature births.

This Plan requires that the Plan Participant notify PEBP of:

- The birth of a newly born Child;
- The effective date of adoption of a Child; or
- The date of Placement of a Child for adoption.

Payments of the required premium, if any, must be furnished to PEBP within 31 days after the date of birth, adoption or Placement for Adoption in order to have the coverage continue beyond the 31-day period.

NOTE: For more information, refer to the applicable sections in this document.

NRS 689B.287 – PEBP will not deny a claim, cancel a policy, or refuse to issue a policy solely due to a claim resulting from an injury sustained while intoxicated or under the influence of a controlled substance. PEBP may enforce any provisions to deny a claim, cancel a policy, or refuse to issue a policy in which a contributing cause of injury in a claim was the attempt or commission of a felony.

NRS 689B.035 – Required provision concerning termination of coverage on Dependent Child.

NRS 695G.164- if You are seeing a Provider that is in network and that Provider leaves the network, and You are actively undergoing a medically necessary course of treatment and You and Your Provider agree that a disruption to Your current care may not be in Your best interest or if continuity of care is not possible immediately with another in network Provider, PEBP will pay that Provider at the same level they were being paid while contracted with PEBP's PPO network, if the Provider agrees. If the Provider agrees to these terms, coverage may continue until:

- the 120th day after the date the contract is terminated; or
- if the medical condition is pregnancy, the 45th day after:
  - The date of delivery; or
  - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Plan Definitions

The following are definitions of specific terms and words used in this document, or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Annual: For the purposes of this Plan, Annual refers to the 12 month period starting July 1 through June 30.

Base Plan: The Self-funded Consumer Driven Health Plan (CDHP). The Base Plan is also defined as the "default Plan" where applicable in this document and other communication materials produced by PEBP.

Business Day: Refers to all weekdays, except Saturday or Sunday, or a state or federal holiday.

Child(ren): See the definition of Dependent Child(ren).

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

COBRA: means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how Plan benefits are payable when a person is covered by two or more health care plans. (See also the Coordination of Benefits section of the PEBP Consumer Driven Health Plan for Medical, Vision and Prescription Drug Benefits Master Plan Document or HMO Evidence of Coverage Certificate).

Coverage Tier: the category of rates and premiums or contributions for coverage that correspond to:

- An eligible Participant only;
- An eligible Participant and Eligible Spouse;
- An eligible Participant and Eligible Dependent Child(ren);
- An eligible Participant, their Eligible Spouse, and their Eligible Child(ren);
- An eligible Participant and Eligible Domestic Partner;
- An eligible Participant and Eligible Domestic Partner's Child(ren); or
- An eligible Participant, their Eligible Domestic Partner, and their Eligible Child(ren).

Covered Individual: Any Employee or Retiree (as those terms are defined in this Plan), and that person's eligible Spouse or Dependent Child who has completed all required formalities for Enrollment for coverage under the Plan and is actually covered by the Plan.

Creditable Coverage means prior continuous health coverage and includes prior coverage under:

- another Employer Group Health Plan;

- group or individual health insurance coverage issued by a state regulated insurer or an HMO;
- COBRA;
- Medicaid;
- Medicare;
- State Children's Health Insurance Program (SCHIP);
- the Active Military Health Program;
- Tricare;
- American Indian Health Care Programs;
- a state health benefits risk pool;
- the Federal Employees Health Plan;
- the Peace Corp Health Program;
- a public health plan, including plans established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government; or
- a foreign country that provides health coverage to individuals who are Enrolled in the plan (for example, coverage through the United States Veterans Administration and coverage from a state or federal penitentiary).

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

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

- natural Child,
- Child(ren) of a Domestic Partner,
- stepchild,
- legally adopted Child or Child placed in anticipation for adoption (the term Placed for Adoption means the assumption and retention by the Employee of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child and the Child must be available for adoption and the legal adoption process must have commenced),
- Child who qualifies for benefits under a QMCSO/NMSN (see the Eligibility section for details on QMCSO/NMSN),
- unmarried Child under age 26 years for whom You have permanent legal guardianship under a court order signed by a judge.

Dependent Coverage Ends: Coverage of a Dependent Child ends at the end of the month in which that Child:

- reaches his or her 26th birthday,
- enters the military .

Disability: A determination by the Plan Administrator or its designee (after evaluation by a Physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as mental retardation, cerebral palsy, epilepsy, neurological disorder or psychosis.

Domestic Partner/Domestic Partnership: The Participant's Domestic Partner, as determined by the laws of the State of Nevada. The Plan will require the Participant to provide a copy of the Domestic Partner Certification from the Nevada Secretary of State. The Participant must also provide a statement acknowledging the Participant's responsibility for any federal income tax consequences resulting from the Enrollment of the Domestic Partner in the Plan. A Domestic Partner is not eligible for coverage as a Dependent after termination of the Domestic Partnership.

Eligible Dependent: Your Spouse/ Domestic Partner and Your Dependent Child(ren). An Eligible Dependent may be Enrolled for coverage under the Plan by following the procedures required by the Plan.

Employee: Unless specifically indicated otherwise when used in this document, Employee refers to a person employed by an agency or entity that participates in the PEBP Program, and who is eligible to Enroll for coverage under this Plan.

Employer: Unless specifically indicated otherwise when used in this document, Employer refers to an agency or entity that participates in the PEBP Program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.
Employer Group Health Plan: Any Employer who sponsors a health plan for their active Employees.

Enroll, Enrollment: The process of completing Enrollment, either by use of the online e-PEBP Enrollment tool or submitting a written form, indicating that coverage by the Plan is requested by the Employee or Retiree. An Employee or Retiree may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan.

Family Unit: The covered Employee or Retiree and the family members who are covered as Dependents under the covered Employee's or Retiree's Plan.

Full-Time Employment: Employees working 80 hours a month**.**
Employer Group Health Plan; Group Health Insurance: Group Health Insurance is any group health policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of Hospital, Nursing, medical, Dental or surgical services, Home Health Care or health supportive services for members of the family or Dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group. Group Health Insurance is declared to be that form of health insurance covering groups of two or more persons, formed for a purpose other than obtaining insurance (NRS 689B.020.

Health Reimbursement Arrangement: A Health Reimbursement Arrangement (HRA) is an Employee-funded spending account that can be used to pay qualified medical expenses. The HRA is 100% funded by the Employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted or insurance coverage kicks in. The contribution amount per Employee is set by the Employer, and the Employer determines what the funds can be used to cover and if the dollars can be rolled over to the next year. In most cases, if the Employee leaves the Employer, they can't take remaining HRA funds with them.

Health Care Provider: A health care practitioner, hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility.

Health Savings Account: An account that allows individuals to pay for current health expenses and save for future qualified medical and Retiree health expenses on a tax free basis.

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal Regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain Employees and Dependents who experience a loss of other employer group coverage and when there is an adoption, placement for adoption, birth, marriage or a Domestic Partner certification from the office of the Nevada Secretary of State.

Ineligible Dependents: Individuals living in the covered Employee or Retiree's home but who are not eligible as defined above are not Eligible Dependents under this Plan.

Legal Guardian: A person recognized by a U. S. court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Part A: Hospital insurance provided by the Federal Government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the Federal Government that helps pay for medically-necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the Federal Government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.

National Medical Support Notice (NMSN)/Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an Employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services.

Open Enrollment Period: The period during which Participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently Enrolled in the Plan may Enroll for coverage. The Plan's Open Enrollment Period is described in the Eligibility section of this document.

Over age Child with a Disability or Disabled Dependent Child over the age of 26 years: As determined by the Plan Administrator or its designee, is an unmarried Child who has reached his or her 26th birthday who, as evaluated by a physician, has a permanent or continuing mental or physical impairment and is incapable of self-sustaining employment or self-sufficiency as a result of having that impairment; Dependent chiefly on the Participant or the Participant's Spouse for support and maintenance and whom the Participant claims as a Dependent on IRS tax forms under the IRS Code 152(1) (without regard to the gross income test). This Plan will require proof of having a Disability at reasonable intervals during the two years following the date the Dependent reaches the limiting age of 26 years and after this two-year period the Plan Administrator may require proof not more than once each year. The Plan Administrator reserves the right to have the Dependent examined by a physician of the Plan Administrator's choice (and at the Plan's expense) to determine that the Dependent meets the definition of a Disabled Dependent Child over the age of 26 years. Children covered under legal guardianship are not included in this definition.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent Children, see the definition in the section on Adopted Dependent Children in the Eligibility section.

Plan, The Plan, This Plan: In most cases, the Programs, benefits and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Participant: The Employee or Retiree or their Enrolled Spouse or Dependent Child(ren) or a surviving Spouse of a Retiree.

Plan Year: Typically the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates if necessary each Plan Year. For medical, dental, vision and pharmacy benefits, all deductibles, out-of-pocket maximums and Plan Year maximum benefits are determined based on the Plan Year.

Positive Open Enrollment: This process requires that each Participant affirmatively make their benefit elections during the PEBP Open Enrollment period. Even if they do not want to make any coverage changes, they must affirmatively make their elections or they will be defaulted to self-coverage only under the PEBP Base Plan.

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

Provider: See the definition of Health Care Provider.

Qualified Medical Child Support Order (QMCSO)/National Medical Support Notice (NMSN): A court order that complies with requirements of federal law requiring an Employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services.

Rescission: A cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a Rescission if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.

Retiree: Unless specifically indicated otherwise, when used in this document, Retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP Program and who is eligible to Enroll for coverage under this Plan.

Significantly inferior coverage: A "mini-med" or other limited benefit plan; or a catastrophic coverage plan with a deductible equal to or greater than $5,000 with no employer contributions to Health Savings Accounts or Health Reimbursement Arrangements or any other coverage. PEBP will determine if an Employer sponsored Group Health Plan meets the definition of Significantly Inferior Coverage.

Spouse: The Employee's lawful Spouse (opposite sex or same sex) as determined by the laws of the State of Nevada**.** The Plan will require proof of the legal marital relationship. A former Spouse or Domestic Partner of an Employee or Retiree is not an eligible Spouse under this Plan.

State: when capitalized in this document, the term State means the State of Nevada.

Tier of Coverage: The category of rates and premiums or contributions for coverage that correspond to either an eligible Participant only, or an eligible Participant and one or more Eligible Dependents.

Unsubsidized Dependent of a Retiree: An unsubsidized Dependent is defined as the eligible Spouse/Domestic Partner and/or Eligible Dependent(s) of a Retiree who remains covered under the Consumer Driven Health Plan (CDHP) or HMO Plan while the primary Participant transitions coverage to the Medicare Exchange. Note: Unsubsidized Dependents can only be added or removed during Open Enrollment or as a result of a Qualifying Event.

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