SUMMARY PLAN DESCRIPTION

FOR

HEALTH REIMBURSEMENT ARRANGEMENT FOR MEDICARE EXCHANGE ENROLLEES

ADMINISTERED BY:

OneExchange™
from Towers Watson

PayFlex®

PLAN YEAR 2017

July 1, 2016 – June 30, 2017

Revised and Restated 4.2016

Introduction

The State of Nevada Public Employees' Benefits Program (PEBP) provides a Medicare Exchange Health Reimbursement Arrangement Plan (Medicare Exchange HRA Plan) for the purpose of allowing certain retirees covered under PEBP to obtain reimbursement of Eligible Medical Expenses incurred by such retirees and their family members. PEBP intends the Medicare Exchange HRA Plan to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and a medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended.

All provisions of this document contain important information. If you have any questions about your HRA account or your obligations under the terms of the plan, be sure to seek assistance from the Third Party Administrator. The Plan Information section provides contact information for the Plan Administrator and Third Party Administrators.

This Summary Plan Description document describes the Medicare Exchange HRA Plan provided to Medicare Retirees participating in the Public Employees' Benefits Program.

The Plan Sponsor and its designee(s) will have discretionary authority to determine the applicability of and interpret the provisions within this document.

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.

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Medicare Exchange Health Reimbursement Arrangement Plan

Plan Information

Name of Plan (The Plan):	Public Employees' Benefits Program Medicare Exchange Health Reimbursement Arrangement Plan (Medicare Exchange HRA Plan)
Plan Sponsor:	State of Nevada Public Employees' Benefits Program (PEBP)
Plan Administrator:	State of Nevada Public Employees' Benefits Program (PEBP)
Contact**:**	Quality Control Officer
Address**:**	901 South Stewart Street, Suite 1001 Carson City, NV 89701
E-mail Address**:**	memberservices@peb.state.nv.us
Telephone Number**:**	(775) 684-7000 or (800) 326-5496
Tax Identification Number**:**	88-0378065

Third Party Administrator for Medical Plan selection & coverage questions:
Towers Watson's OneExchange

Address:	10975 Sterling View Drive, Suite A1 South Jordan, UT 84095
Telephone Number:	(888) 598-7545
Website Address:	www.medicare.oneExchange.com/PEBP

Third Party Administrator for the Medicare Exchange HRA: PayFlex

Address:	P.O. Box 3039 Omaha, NE 68103-3039
Telephone Number:	(888) 598-7545
General Fax Number:	(402) 231-4300
Claims Fax Number:	(402) 231-4310
Website Address:	www.payflex.com
Plan Number:	EXCHANGE HRA
Effective Date:	July 1, 2011

Definition of Terms

Account Structure: A separate Medicare Exchange HRA Account will be established for an Eligible Retiree within a single family. An otherwise Eligible Retiree enrolled as a dependent of an Eligible Retiree will NOT receive a separate Medicare Exchange HRA Account.

Benefit Credit: The amount credited to an Eligible Retiree's Medicare Exchange HRA Account for the provision of benefits under the Medicare Exchange HRA Plan.

Code: The Internal Revenue Code of 1986 (Section 105), as amended from time to time.

Death: Dependents shall NOT continue to receive Benefit Credits after the Eligible Retiree's Death.

Eligible Dependent[1]: A dependent who is:

A. A Spouse or other dependent of an Eligible Retiree as defined in Internal Revenue Code (IRC) Section 152 (26 USC § 152).

B. A Spouse or other dependent of an Eligible Retiree as defined in PEBP's Master Plan Document.

C. HRA funds may not be used for a person who does not meet the IRS definition of dependent as defined in IRC section 26 USC § 152, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether PEBP provides coverage for the dependent.

Eligible Medical Expenses: Eligible Medical Expenses are the costs associated with the diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for eligible medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of medical equipment, supplies, and diagnostic services.

Eligible Medical Expenses must be primarily to treat or prevent a physical or mental illness. They do not include expenses that are provided only for the purpose of supporting general health, such as vitamins or vacations.

Eligible Medical Expenses include the premiums you pay for insurance that covers the expenses of medical care and the amounts you pay for transportation to get medical care.

[1] For complete eligibility information, please refer to the PEBP Enrollment and Eligibility Master Plan Document.

Medical expenses also include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.

Below are examples of Eligible Medical Expenses. Refer to Internal Revenue Service Publication 502 for a list of complete Eligible Medical Expenses and any applicable limitations.

- Acupuncture
- Chiropractic
- Contact Lenses
- Durable Medical Equipment
- Hearing Aids
- Insurance Premiums

PEBP reserves the right to change this section at any time.

Eligible Retiree[1]: An Eligible Retiree is a retiree who:

A. is eligible to be covered under PEBP pursuant to:

1) Nevada Revised Statutes Chapter 287;

2) Nevada Administrative Code Chapter 287, and

3) The PEBP Master Plan Document.

B. is eligible for premium free Medicare Part A

C. is eligible for Medicare Part B

D. elects coverage through the Individual Market Medicare Exchange sponsored by PEBP.

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.

HRA Contribution: Also referred to as a "Benefit Credit" is the amount of money determined by your Years of Service that is deposited into your HRA account on a schedule determined by the Plan Administrator. Retired public employees enrolled in a medical plan through the contracted Third Party Administrator 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 employer.

[1] For complete eligibility information, please refer to the PEBP Enrollment and Eligibility Master Plan Document.

A. The following monthly amount will be credited on behalf of Eligible Retirees:

1) For Eligible Retirees who retired prior to January 1, 1994, the dollar amount is equal to the base amount as determined by the Legislature during each Legislative Session. For detailed information regarding contribution amounts refer to PEBP's Master Plan Document located on the PEBP website at www.pebp.state.nv.us.

2) For Eligible Retirees who retired on or after January 1, 1994, the dollar amount is equal to the base amount as determined by the Legislature during each Legislative Session multiplied by the Years of Service credit (calculated pursuant to NAC 287.485) up to a maximum of 20 Years of Service. For detailed information regarding contribution amounts refer to PEBP's Master Plan Document located on the PEBP website at www.pebp.state.nv.us.

B. No amount will be credited for dependents and certain retirees who do not meet the requirements to receive a Years of Service Medicare Exchange HRA Plan contribution (pursuant to NRS 287.046).

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 above, the Eligible Retiree will NOT receive the PEBP HRA Contribution amount and will lose their PEBP sponsored benefits entirely 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.

NOTE: Effective July 1, 2015, the policy described under "HRA Contribution Eligibility" does not apply to Eligible Retirees or their Spouses who have health 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. PEBP will coordinate their enrollment with the Third Party Medicare HRA administrator.

Medicare Exchange Health Reimbursement Arrangement (HRA) Account: The account established by the Plan Administrator for an Eligible Retiree to hold his or her Benefit Credits.

Medicare Exchange HRA Plan: The health reimbursement arrangement sponsored by the Public Employees' Benefits Program.

Individual Market Medicare Exchange: The health care exchange for Medicare

eligible individuals (eligible for premium free Medicare Part A and Medicare Part B) operated by the Third Party Administrator, whose name and address is provided in the Plan Information section of this document, and its subcontractors.

Plan: Public Employees' Benefits Program Medicare Exchange Health Reimbursement Arrangement Plan (Medicare Exchange HRA Plan). Also referred to as The Plan.

Plan Year: The Plan Year as defined in the PEBP Master Plan Document, typically the 12-month period from July 1 through June 30. The PEBP Board has the authority to revise the Plan Year if necessary.

Protected Health Information (**PHI)**: As described in 45 C.F.R. § 164.103, and generally includes individually identifiable health information held by or on behalf of the Medicare Exchange HRA Plan.

Residing outside of the United States: If an otherwise Eligible Retiree (see definition of Eligible Retiree) resides outside the United States and suspends their Medicare coverage, that Eligible Retiree is not required to enroll with the Medicare Exchange. The Eligible Retiree should enroll in the PEBP CDHP PPO Plan and receive HRA funds as a CDHP participant. If the Eligible Retiree returns to the United States and establishes permanent residency in the United States, the Eligible Retiree is required to enroll in Medicare and the Medicare Exchange. The Eligible Retiree must contact PEBP prior to their return to the United States or immediately after returning to the United States. If the Eligible Retiree fails to notify PEBP of their return, their coverage under PEBP may be terminated. If you have questions about your eligibility, please contact PEBP.

Rollover of HRA Funds: Credits remaining in a Medicare Exchange HRA Account at the end of a Plan Year shall be carried over to the following Plan Year to reimburse Eligible Retirees for Eligible Medical Expenses incurred during subsequent Plan Years, up to a limit to be determined by PEBP at a later date.

Spouse: The retiree's lawful Spouse as determined by the laws of the State of Nevada**.** PEBP will require proof of the legal marital relationship. A legally separated Spouse or divorced former Spouse of an employee or retiree is not an eligible Spouse under this Plan.

Third Party Administrator: Towers Watson's OneExchange or Pay Flex. Also referred to as the contracted Third Party Administrator.

Timing of Benefit Credit: Benefit Credit (see definition of Benefit Credit) will be credited to Medicare Exchange HRA Accounts on the first business day of each calendar month as determined by PEBP.

Years of Service: Years of Service as calculated pursuant to NAC 287.485 and maintained in the eligibility records of PEBP. Retired public employees enrolled in a

medical plan through Towers Watson's OneExchange 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 employer.

Participation

Agreement to Participate: Participation in the Medicare Exchange HRA Plan shall begin on the date the Eligible Retiree fulfills the following requirements:

A. becomes eligible for coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare Parts A and B), and;

B. obtains an individual health insurance policy through the Plan Administrator's contracted Individual Market Medicare Exchange[3] (Third Party Administrator), and;

C. completes any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator.

Cessation of Participation: Participation in the Medicare Exchange HRA Plan will end:

A. on the date the Eligible Retiree ceases to be an Eligible Retiree for any reason, including but not limited to:

1) enrollment in PEBP PPO or HMO coverage, if eligible;

2) enrollment in other group coverage that may preclude enrollment in the individual Medicare plan, for example:

a. If a retiree is actively employed by an organization that does not participate in PEBP and the retiree enrolls in the active coverage of that organization. If the retiree declines their coverage, they can continue as a retiree in EH with an HRA.

b. If the retiree is the covered dependent of a Spouse who has employer group coverage because they are still actively employed, the retiree needs to obtain information from the current employer to determine if the termination of the PEBP group coverage is a qualifying event to change their other employer based coverage or if their other employer based coverage coordinates with Medicare and Medicare Supplement and/or Advantage plans.

3) obtains employment as an active employee of the State of Nevada or a participating local government;

4) ineligibility for coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare); or,

[3] Any Eligible Retiree who does not enroll in an individual health insurance policy through the contracted Third Party Administrator WILL LOSE their PEBP sponsored benefits (i.e. HRA funding, Life insurance, Dental Insurance, etc.)

5) Death of the Eligible Retiree;

B. on the effective date of any Medicare Exchange HRA Plan amendment that renders the Eligible Retiree ineligible to participate;

C. on the effective date of termination of the Medicare Exchange HRA Plan;

D. with respect to a Dependent, the date he or she ceases to be a Dependent for any reason, including but not limited to:

1) Death of the Dependent;

2) divorce from the Eligible Retiree;

3) if the dependent is otherwise no longer considered a dependent pursuant to IRS Code 152; or

4) the cessation of participation of the Eligible Retiree.

Funding

Funding: The benefits described in this document are provided by the Plan Administrator out of its assets, and no assets shall be segregated or earmarked for the purpose of providing benefits, nor shall any person have any right, title or claim to such assets prior to the submission and acceptance of a claim for Eligible Medical Expenses. As such, each Medicare Exchange HRA Account established pursuant to the Medicare Exchange HRA Plan shall be a hypothetical account which merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Eligible Retiree under the terms of the Medicare Exchange HRA Plan. In no event may any benefits under the Medicare Exchange HRA Plan be funded with Eligible Retiree contributions.

Benefit Credits: The Plan Administrator will credit the Medicare Exchange HRA Accounts of Eligible Retirees with the Benefit Credits as described under the definition of HRA Contribution.

Benefits

Provision of Benefits: The Medicare Exchange HRA Plan will reimburse Eligible Retirees for Eligible Medical Expenses, up to the unused amount in the Eligible Retiree's Medicare Exchange HRA Account. An Eligible Retiree shall be entitled to reimbursement under this Medicare Exchange HRA Plan only for Eligible Medical Expenses incurred after he or she becomes an Eligible Retiree in the Medicare Exchange HRA Plan and before his or her participation has ceased. In no event shall any benefits under this Medicare Exchange HRA Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Eligible Medical Expenses.

Amount of Reimbursement: At all times during a Plan Year, an Eligible Retiree shall be entitled to benefits under this Medicare Exchange HRA Plan for payment of Eligible Medical Expenses in an amount that does not exceed the balance of his or her Medicare Exchange HRA Account. Each reimbursement shall be deducted from the Eligible Retiree's Medicare Exchange HRA Account for Eligible Medical Expenses under the Medicare Exchange HRA Plan.

Expense Reimbursement Procedure

Timely Filing of HRA reimbursement claims: In accordance with NAC 287.610, all claims must be submitted to the Third Party Administrator within one year (12 months) from the date the service(s) were incurred. No plan benefits will be paid for any claim submitted after this period.

Claims Substantiation – How to file a claim for HRA reimbursement*:* PEBP's Third Party Administrator may require the Eligible Retiree to furnish a bill, receipt, cancelled check or other written evidence or certification of payment or of obligation to pay Eligible Medical Expenses. The Third Party Administrator will reimburse the Eligible Retiree for expenses that it determines are Eligible Medical Expenses up to the balance in the Eligible Retiree's Medicare Exchange HRA Account at such intervals as PEBP may deem appropriate (but not less frequently than monthly). PEBP's Third Party Administrator reserves the right to verify that all claimed medical expenses satisfy the definition of Eligible Medical Expenses prior to reimbursement.

A. Each request for reimbursement shall include the following information:

1) Requests for medical reimbursements must be attached to a claim form:

a. Obtain a claim form available on the PEBP website (www.pebp.state.nv.us).

b. Complete the Account Holder and Reimbursement Request Information sections of the claim form. Provide all requested information including your Social Security number.

c. You must sign the claim form and by signing you acknowledge the Eligible Retiree has not been and will not be reimbursed for the Eligible Medical Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Eligible Medical Expense under IRS Code Section 213, and;

d. Expenses eligible for coverage under any medical, HMO, dental, or vision care plans in which the Eligible Retiree or his or her Dependents are enrolled must be submitted first to all appropriate claims administrators for such plans before submitting the expenses to the Third Party Administrator for reimbursement under the Medicare Exchange HRA Plan. An Eligible Retiree who is entitled to payment or reimbursement under a health care reimbursement account in a cafeteria plan under IRS Code Section 125 must receive his or her maximum annual reimbursement under the health care reimbursement account in the cafeteria plan before he or she is entitled to any reimbursement under this Medicare Exchange HRA Plan.

e. Refer to the back of the claim form for additional submission information (i.e. what documents or medical information is necessary to support the claim.)

f. If you are submitting a reimbursement request for services provided by your physician, other health care practitioner, pharmacy or dentist, please attach the itemized bill of statement for professional services if it contains all of the following information:

- the amount of the Eligible Medical Expense for which reimbursement is requested;
- the date the Eligible Medical Expense was incurred;
- a brief description and the purpose of the Eligible Medical Expense for example;
  - Provider's name, address, phone number, and professional degree or license;
  - Date(s) the services or supplies were provided;
  - A description of the services or supplies provided including appropriate procedure codes;
  - Details of the charges for those services or supplies;
  - Patient's name;
  - A copy of the Explanation of Benefits provided by your health plan (e.g. Medicare or Medicare supplemental plan) indicating your financial responsibility.

- Reimbursement requests for prescription drugs must include an itemized receipt produced by the Pharmacy that provides the pharmacy name and address, patient's name, date the medication was dispensed, name of medication, and the amount that the patient paid.

2) Requests for premium reimbursements must be attached to a claim form:

   a. Obtain a claim form available on the PEBP website (www.pebp.state.nv.us).

   b. Complete the Account Holder and Reimbursement Request Information sections of the claim form. Provide all requested information including your Social Security number.

   c. You must sign the claim form and by signing you acknowledge the Eligible Retiree has not been and will not be reimbursed for the Eligible Medical Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Eligible Medical Expense under IRS Code Section 213.

   d. Refer to the back of the claim form for additional submission information (i.e. what documents or medical information is necessary to support the claim.)

   e. You must provide a copy of the premium statement from your Insurance Carrier (e.g. Medicare or Medicare supplemental plan) unless automatic reimbursement arrangements have been made. The statement must include the name of the person for whom the premium statement was incurred. If the person is not the Eligible Retiree requesting reimbursement, please provide the relationship of the person to such Eligible Retiree.

NOTE: If you pay your premiums directly to your carrier (e.g. Medicare or Medicare supplemental plan) on a quarterly basis, you will be reimbursed through your Medicare Exchange HRA account for the monthly premium and not for the entire quarter. For example, if you paid your quarterly premium on June 15 for the months of July, August and September, you will not receive reimbursement for the quarterly premium in a lump sum but will receive monthly reimbursements in July, August and September. Reimbursements will be based on your monthly premium amount or the available balance in your Medicare Exchange HRA account, whichever is less.

Claim Review Timing: Claims will be paid in the order in which they are received by the Third

Party Administrator and will be charged to the Medicare Exchange HRA Account of the Eligible Retiree who submits the claim. PEBP may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

The Third Party Administrator shall review received claims and respond within thirty (30) days of receipt. If the Third Party Administrator determines that an extension is necessary due to matters beyond the control of the Medicare Exchange HRA Plan, the Third Party Administrator will notify the claimant within the initial thirty (30) day period that the Third Party Administrator needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Third Party Administrator. The Third Party Administrator encourages you to submit the requested documentation as soon as possible. Please be reminded, in accordance with NAC 287.610, all claims must be submitted to the Third Party Administrator within one year (12 months) from the date the service(s) were incurred. No plan benefits will be paid for any claim submitted after this period.

Claims Denied

The Third Party Administrator shall provide to every claimant who is denied a claim for benefits (in whole or in part) the following in a written or electronic notice:

- the specific reason or reasons for the denial;
- specific reference to pertinent plan provisions on which denial is based;
- a description of any additional material or information necessary for the claimant to correct the claim and an explanation of why such material or information is necessary;
- a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
- a description of the Medicare Exchange HRA Plan's appeal procedures and the time limits applicable to such procedures.

Carryover (Rollover) of Account funds: To the extent an Eligible Retiree has a balance in his or her Medicare Exchange HRA Account at the end of a Plan Year; the balance shall be carried over to following Plan Years to the extent allowed by the Plan Administrator.

The Medicare Exchange HRA Plan funds may not be used for a person who does not meet the IRS definition of a dependent, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether

the Plan Administrator provides coverage for the dependent.

Loss of Coverage

When coverage through the Medicare Exchange is terminated by the Eligible Retiree, PEBP, the Insurance Carrier (due to non-payment of premiums), or by the Third Party Administrator, the Eligible Retiree shall receive no further Benefit Credits under the Medicare Exchange HRA Plan and;

A. his or her Eligible Medical Expenses incurred after such date will not be reimbursed even if Benefit Credits remain in the Eligible Retiree's Medicare Exchange HRA Account; and

B. the Eligible Retiree may submit claims for reimbursement for Eligible Medical Expenses incurred prior to his or her loss of coverage (e.g. break in coverage, loss of eligibility, etc.), provided the Eligible Retiree files such claims within one hundred eighty (180) days of loss of coverage. In other words, when your coverage ends and you are an eligible Medicare HRA retiree you will have one hundred eighty days (6 months) from the date your coverage ends to file a claim for reimbursement from your HRA account for Eligible Medical Expenses incurred during your coverage period.

Medicare Exchange HRA Claim Appeal Process

If your claim is denied, or if you disagree with the amount paid on a claim, you or your authorized representative may request a review from the Third Party Administrator or Plan Administrator within 180 days of the date you received the Explanation of Payment (EOP) with the initial claim determination. Failure to request a review in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan unless the Third Party Administrator or Plan Administrator determines that the failure was acceptable. The written request for appeal must include:

- The name and social security number, or member identification number, of the participant;
- A copy of the EOP and claim; and
- A detailed written explanation why the claim is being appealed.

In connection with such review, the claimant or his or her duly authorized representative may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits, and may submit issues and comments in writing. The Third Party Administrator shall make a decision promptly, but not later than sixty (60) days after the Third Party Administrator's receipt of a request for review. The decision on review shall be in writing, in a manner calculated to be understood by the claimant, and shall include:

- specific reasons for the decision;
- specific references to the pertinent plan provisions on which the decision is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
- a statement of the claimant's right to appeal any adverse benefit determination on review to PEBP, and, if necessary, to an external Independent Review Organization in accordance with Nevada Revised Statutes 695G.200 to 695G.310, inclusive, as amended by the 2011 Legislature.

An adverse benefit determination on review may be appealed to the Third Party Administrator or PEBP within one hundred eighty (180) days after receipt of the adverse benefit determination from the Third Party Administrator. The Third Party Administrator or PEBP shall make a decision promptly, but no later than twenty (20) days after receipt of an appeal. The decision shall be in writing in a manner to be understood by the claimant, and shall include:

- specific reasons for the decision;
- specific references to the pertinent plan provisions on which the decision is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
- a statement of the claimant's right to appeal any adverse benefit determination to an external Independent Review Organization in accordance with Nevada Revised Statutes 695G.200 to 695G.310, inclusive, as amended by the 2011 Legislature.

The claimant may request an external review of an adverse benefit determination to an Independent Review Organization. Within four (4) months of receipt of the denial of the appeal by the Third Party Administrator or Plan Administrator, the claimant must notify, in writing, the Nevada Office for Consumer Health Assistance pursuant to the provisions of Nevada Revised Statutes 695G.241 to 695G.310, inclusive, as amended by the 2011 Legislature. If the claimant requests an external review, the Independent Review Organization will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described above must be exhausted before a claimant can pursue an external review. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

A standard external review request form can be found on the PEBP website at www.pebp.state.nv.us.

General Provisions

Adoption by Affiliates: Any participating local government agrees to be bound by the terms of the Medicare Exchange HRA Plan, as amended from time to time by the Plan Administrator. Any local government who has not entered into an agreement with the Plan Administrator pursuant to Nevada Revised Statutes 287.025 but whose retirees are participating pursuant to Nevada Revised Statute 287.023 are considered to be participating local governments only for the purposes of those participating retirees.

Alienation of Benefits: No benefit under this Medicare Exchange HRA Plan may be voluntarily or involuntarily assigned or alienated and any attempt to do so shall be void and unenforceable.

Amendment and Termination: Although the Plan Administrator intends to maintain the Medicare Exchange HRA Plan for an indefinite period, PEBP reserves the right to amend, modify, or terminate this Medicare Exchange HRA Plan at any time, including but not limited to the right to modify persons eligible for participation, benefits paid by the Medicare Exchange HRA Plan, and the amount of Benefit Credits to be credited, and the right to reduce or eliminate existing Medicare Exchange HRA Accounts. The Plan Administrator shall have the authority to approve all technical, administrative, regulatory and compliance amendments to the Medicare Exchange HRA Plan, and any other amendments that will not increase the cost of the Medicare Exchange HRA Plan to the Plan Administrator, as the Plan Administrator shall deem necessary or appropriate.

Applicable Law: The Medicare Exchange HRA Plan shall be construed and enforced according to the laws of the state of Nevada, to the extent not preempted by any Federal law.

Death: In the event the Eligible Retiree dies, the Medicare Exchange HRA Account of the Eligible Retiree is immediately forfeited; provided, however, that his or her estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her Dependents prior to the Eligible Retiree's Death, as long as such claims are submitted no later than one-hundred eighty (180) days after the Eligible Retiree's Death.

Facility of Payment: If the Plan Administrator or its designee determines that you (Eligible Retiree) cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated, in a coma, or deceased, the Plan Administrator may, at its discretion, direct that payments be made for the benefit of the Eligible Retiree to any person or organization selected by the Plan Administrator who is providing your insurance coverage or your care and support. Any such payment of plan benefits will completely discharge the Plan's obligations to the extent of that payment.

Neither the Plan, Plan Administrator, Thirty Party Administrator(s), nor any other designee of the Plan Administrator, will be required to ensure that the benefits paid on behalf of a participant are applied to the charges and services submitted, other than standard claims processing which provides a remittance listing of benefits paid as covered by the Plan.

Lost Distributees: Any benefit payable under the Medicare Exchange HRA Plan shall be deemed forfeited if, after reasonable efforts, the Plan Administrator is unable to locate the Eligible Retiree to whom payment is due and funds will be returned to the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996: The Medicare Exchange HRA Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Medicare Exchange HRA Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Nondiscrimination: The Plan Administrator may limit, reallocate or deny any benefit to any Eligible Retiree who was a highly compensated individual (as defined in Code Section 105(h)) to the extent necessary to avoid discrimination under Code Section 105(h). Any action of the Plan Administrator under this Section shall be carried out in a uniform and non-discriminatory manner.

Nondiscriminatory Operation: All rules, decisions, interpretations and designations by PEBP under the Medicare Exchange HRA Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

PEBP Liability: Benefits under the Medicare Exchange HRA Plan are paid by PEBP out of its assets. The Plan Administrator shall be solely responsible for the payment of benefits to such Eligible Retiree and his or her family members under this Medicare Exchange HRA Plan. The Plan Administrator shall have no liability with respect to the payment of any benefits to any person not eligible for participation in the Medicare Exchange HRA Plan. The Plan Administrator will be responsible for collecting amounts due from local government entities whose retirees are participating in the Medicare Exchange HRA Plan pursuant to Nevada Revised Statutes 287.023.

Severability: If any provision of this Medicare Exchange HRA Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Medicare Exchange HRA Plan shall be construed and enforced as if such provision had not been included.

Status of Benefits: The Plan Administrator makes no commitment or guarantee that any amounts paid to or for the benefit of an Eligible Retiree under this Medicare Exchange HRA Plan will be excludable from the Eligible Retiree's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Eligible Retiree to determine whether each payment under this Medicare Exchange HRA Plan is excludable from the Eligible Retiree's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Eligible Retiree has any reason to believe that such payment is not so excludable. Any Eligible Retiree, by accepting a benefit under this Medicare Exchange HRA Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

Women's Health and Cancer Rights Act of 1998: To the extent the Medicare Exchange HRA Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas.

Administration

The Plan Administrator shall be responsible for the performance of all reporting and disclosure obligations under the Public Health Service Act, and all other obligations required to be performed by the Plan Administrator under the Public Health Service Act or the Code, except such obligations and responsibilities as may be delegated under the Medicare Exchange HRA Plan to such person or entity as the Plan Administrator designates. The Plan Administrator shall be the designated agent for service of legal process with respect to the Medicare Exchange HRA Plan.

Duties of the Plan Administrator

The Plan Administrator shall have the sole discretion and authority to control and manage the operation and administration of the Medicare Exchange HRA Plan.

The Plan Administrator shall have complete discretion to interpret the provisions of the Medicare Exchange HRA Plan, make findings of fact, correct errors, supply omissions, and determine the benefits payable under this Medicare Exchange HRA Plan. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Medicare Exchange HRA Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure below.

The Plan Administrator is responsible for the administration of the Medicare Exchange HRA Plan. The Plan Administrator's responsibilities include, but are not limited to, the following:

A. To implement procedures to be followed by Eligible Retirees in making elections under the Medicare Exchange HRA Plan and in filing claims under the Medicare Exchange HRA Plan;

B. To prepare and distribute information explaining the Medicare Exchange HRA Plan to Eligible Retirees;

C. To receive from Eligible Retirees and Dependents such information as shall be necessary for the proper administration of the Medicare Exchange HRA Plan;

D. To keep records of elections, claims, and disbursements for claims under the Medicare Exchange HRA Plan, and any other information required by the Public Health Services Act or the Code;

E. To appoint individuals or committees to assist in the administration of the Medicare Exchange HRA Plan and to engage any other agents as it deems advisable;

F. To make available election forms and claims forms to be used by Eligible Retirees, which may include electronic forms;

G. To determine and enforce any limits on benefit elections described in this document; and

H. Unless otherwise delegated by the Plan Administrator to the Third Party Administrator, the Plan Administrator is responsible to correct errors and make equitable adjustments for mistakes made in the administration of the Medicare Exchange HRA Plan, specifically, and without limitation, to recover erroneous overpayments made by the Medicare Exchange HRA Plan to an Eligible Retiree or Dependent, in whatever manner the Plan Administrator deems appropriate, including suspensions or recoupment of, or offsets against, future payments due that Eligible Retiree or Dependent.

Delegation of Duties: The Plan Administrator shall have the authority to delegate all or any part of its responsibilities under the Medicare Exchange HRA Plan to one or more of its employees or other associated entities, and in the same manner to revoke any such delegation of responsibility. Any action of the delegate in the exercise of such delegated responsibilities shall have the same force and effect for all purposes as if such action had been taken by the Plan Administrator. The delegate shall periodically report to the Plan Administrator concerning the discharge of the delegated responsibilities.

The Plan Administrator may employ such legal counsel, accountants, consultants, actuaries, and other agents as it shall deem advisable. The compensation of such legal counsel, accountants, consultants, actuaries and other agents and any other expenses incurred by the Plan Administrator in the administration or management of the Medicare Exchange HRA Plan or in furtherance of its duties shall be paid by the Plan Administrator.

Continuation Coverage

Continuation Coverage: The Medicare Exchange HRA Plan provides no Benefit Credits for Dependents. Therefore, there are no continuation rights for Dependents under this Medicare Exchange HRA Plan. However, dependents who are covered under the PEBP PPO, PEBP sponsored HMO or who may have coverage under a separate Individual Market Medicare Exchange (not PEBP sponsored) may continue that medical coverage following certain qualifying events as defined in the COBRA Continuation of Medical Coverage section of the PEBP Master Plan Document as long as any required monthly premium is paid when due or during the applicable grace period.

Notices: The Eligible Retiree is responsible for providing the proper notice of qualifying events to the Plan Administrator and the Third Party Administrator as required by the Plan Administrator's Master Plan Document.

Discontinuation of Reimbursement: Eligible Retirees may not receive reimbursement for any Eligible Medical Expense incurred by a Dependent after that Dependent ceases to be a Dependent regardless of their right to continue other medical coverage as allowed by the Plan Administrator's Master Plan Document.

HIPAA

Privacy, Confidentiality and Release of Records or Information

Any information collected by the Plan Administrator and its contracted vendors will be treated as confidential information and will not be disclosed to anyone without your written consent, except as follows:

- Information will be disclosed to those who require that information to administer the Plans or to process claims.
- Information with respect to duplicate coverage will be disclosed to the Plan or insurer that provides duplicate coverage.
- Information needed to determine if health care services or supplies are medically necessary (or if the charges for them are usual and customary) will be disclosed to the individual or entity consulted to assist the Plan Administrator or its designee in making those determinations.
- Information will be disclosed as required by law or regulation or in response to a duly issued subpoena.
- Information will be disclosed according to the HIPAA Federal Regulations, as outlined in the Privacy Notice in a previous section in this document, and with the following policy guidelines:

PEBP will not use or disclose Personal Health Information (PHI) other than as permitted or as required by law.

PEBP will ensure that any agents or subcontractors to whom PHI is supplied by PEBP, agree to the same restrictions and conditions that apply to PEBP, most commonly through the use of a HIPAA-compliant Business Associate Agreement and/or a Confidentiality Agreement.

PEBP will not use or disclose PHI for employment-related actions.

PEBP will report to the Privacy Officer or Security Officer any use or disclosure of the information that is inconsistent with the permitted uses or disclosures.

PEBP will make PHI available to Plan participants, consider their amendments and, upon request, provide them with an accounting of PHI disclosures.

PEBP will make its internal practices and records relating to the use and disclosure of PHI available to DHHS upon request.

Information You or Your Dependents Must Furnish to the Plan
In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan. If you fail to do so, you or your covered dependents may lose the right to obtain COBRA Continuation Coverage or to continue coverage of a dependent child with a disability.

Important 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.

By law, PEBP is required to protect the privacy of your personal medical information. PEBP is also required to give you this notice to tell you how PEBP may use and give out ("disclose") your personal medical information held by PEBP.

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.

PEBP must use and give out your personal medical information to provide information to you or someone who has the legal right to act for you (your personal representative),to a state or federal entity charged with making sure your privacy is protected, and where required by law.

PEBP has the right to use and give out your personal medical information to pay for your health care and to operate the programs offered by PEBP. PEBP considers this to be part of an organized health care arrangement. Examples include the following:

- PEBP uses your personal medical information for enrollment records, pay or deny your claims, to collect any premiums due, and to share your benefit payment with your other insurer(s) if applicable.
- PEBP may use your personal medical information to make sure you and other PEBP participants get quality health care, to provide customer service to you, to resolve any complaints you have, or to contact you about extra benefits or even research studies that may benefit you.
- PEBP may use or give out your personal medical information for the following purposes under limited circumstances;
    - to federal or other state agencies that have the legal right to receive PEBP data (such as audits to make sure PEBP is making proper payments),
    - for public health activities (such as reporting disease outbreaks),
    - for government health care oversight activities (such as fraud or abuse investigations),
    - for judicial and administrative proceedings (such as in response to a court order),
    - for law enforcement purposes (such as providing limited information to locate a missing person),
    - for research studies, including surveys, that meet all privacy law requirements (such as research related to the prevention of disease or disability),
    - to avoid a serious and imminent threat to health or safety,
    - to contact you about new or changed benefits under PEBP, and
    - to create a collection of information that can no longer be traced back to you.

By law, PEBP must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in this notice. You may take back ("revoke") your written permission at any time, except if PEBP has already acted based on your permission.

By law, you have the right to:

- see and get a copy of your personal medical information held by PEBP.
- have your personal medical information amended if you believe that it is wrong or if information is missing, and PEBP agrees. If PEBP disagrees, you may have a statement of your disagreement added to your personal medical information.
- get a listing of those getting your personal medical information from PEBP. The listing won't cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for PEBP operations, or that was given out for law enforcement purposes.
- ask PEBP to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- ask PEBP to limit how your personal medical information is used and given out to pay your claims and run the programs offered by PEBP. Please note that PEBP may not be able to agree to your request.
- get a separate paper copy of this notice.

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.

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

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.

This Notice of Privacy Practices for PEBP is effective July 1, 2013, 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 employers 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.